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42-53. The experience of counselor stereotyping, bias, and misunderstanding is often very real for those who participate in adult, consensual, non-diagnosable paraphilic sexuality, commonly referred to as kink. A created Counselor Self-Reported Competency Scale, drawn from American Counseling Association competencies, and the Attitudes about Sadomasochism Scale were used to assess counselor knowledge and attitude for working with kink clients. This research suggests competence with kink clients increases as clinical experience working with kink clients increases. The ability to maintain a nonjudgmental attitude and open therapeutic environment seems linked to increased clinical experience with this sexual subculture.

Submissions

If you are interested in submitting your work to *JCSSW* for consideration for publication, you can locate our submission requirements at https://digitalcommons.unf.edu/jcssw/styleguide.html. The *JCSSW* editorial team is committed to ensuring an efficient review process and aims to communicate all initial decisions within 90 days of submission. Please also feel free to contact Robert J. Zeglin (Editor) or Megan Speciale (Associate Editor) with any questions.

"When a Tornado Hits Your Life:" Exploring Cyber Sexual Abuse Survivors' Perspectives on Recovery

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Introduction: Forty-eight US states and 11 countries have enacted legislation criminalizing the act of revenge porn, or cyber sexual abuse. This represents a shift in recognition of the effects of cyber sexual abuse, as survivors continue to face societal norms of victim-blaming. By capturing stories of individuals who consider having overcome their experience of cyber sexual abuse, we aim to understand the process of recovery. **Methods:** We conducted qualitative interviews with 15 adults who indicated, through a digital eligibility form, that they had "overcome" their incident of cyber sexual abuse. Utilizing a grounded theory approach, the authors coded the data, met to determine consistency, and arrived at consensus on the themes. **Results:** Analysis identified six themes, with the fourth theme characterizing the temporal relationship between the first three and the last two: (1) Survivors exhibited externalized and internalized stigma; (2) Survivors experienced varying levels of professionalism and support from law enforcement and legal professionals; (3) A substantial burden on the survivor to educate and explain about cyber sexual abuse; (4) The "Fuck it!" point: The point where there is a noticeable shift in survivors' attitudes and behaviors in their stories; (5) All survivors were forced to become their own advocate, many an advocate for others; (6) Survivors embraced an acceptance of a "new normal." **Discussion:** Future research needs to focus on how changing structured protocols and trainings can contribute to shifting the burden of blame in cases of cyber sexual abuse from the survivor to the abuser.

Keywords: cyber sexual assault, sexual assault, qualitative, interviews

Introduction

The normalization of cyber-based engagement has changed the ability of communities to interact with one another on a global level. One such result has been the steady rise of cyber sexual abuse, mainly in the form of non-consensual image sharing (henceforth referred to as NCIS). Also known colloquially as revenge porn or non-consensual pornography, NCIS entails the sharing of intimate and/or explicitly images or video "via electronic media to be viewed by people without the participant's consent" (Holladay, Hagedorn, & Boote, 2021, p. 2). 2020 saw the rise of non-consensual image sharing by 114%. In a study performed across New Zealand, Australia, and the UK, 1 in 3 individuals had reported experiencing image-based sexual abuse (Martin, 2021). Survivors of cyber sexual abuse report similar negative mental health outcomes as survivors of generalized sexual violence, including depression, suicidal ideation, and degeneration of well-being (Washington, 2014).

Legislative efforts to criminalize cyber sexual abuse, and NCIS in particular, while gaining traction since 2015, have been slow compared to the rate by which cyber-socializing has become normalized as a means of global communication. Nearly 60% of the global population in 2021—4.6 billion people—actively utilize the internet, a rise from 413 million in 2000. In the United States, 82% of people 12 years and over are active on social media platforms (Johnson, 2021). In a hearing to introduce the Intimate Privacy Protection Act, Senator Martin Heinrich stated that cyber sexual abuse "isn't a digital problem, it isn't a social media problem…it is a conduct problem, it is a criminal problem, and unfortunately it is a cultural problem" (Meiselman, 2017, para. 6). Approaches to reducing incidents of cyber sexual abuse reflect deeper societal beliefs that place the onus of blame on the survivor. Factors such as shame, social isolation, and fear of re-experiencing their trauma also affect rates of reporting (Haskell & Randall, 2019).

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Extent of the Problem

Approximately 90% of cyber sexual abuse survivors identify as women (Holladay et al., 2021). Campaigns and curriculums addressing the prevention of sexual assault often utilize "risk management" tactics, in which emphasis is placed on the survivor to alter their behavior to avoid situations in which sexual assault may occur (Bates, 2016). This may include advising women not to walk alone late at night, to dress modestly, and to minimize behaviors that would arguably lead to poor decision-making skills and lower levels of situation awareness (such as alcohol and drug use). Tactics to prevent cyber sexual abuse and NCIS take on similar patterns, emphasizing responsibility on the part of the survivor instead of the perpetrator. In a study examining the effects of revenge porn on mental health, Samantha Bates recalls an online blog that "lists '8 sexting rules' to avoid becoming a victim of revenge porn, suggesting that women should not send naked photos unless they have been in a relationship with the recipient for more than one year, and to only send naked photos if their head is not in the photo" (Bates, 2016, p. 25).

The concept of "sexual double standards" based on gender identity and sex roles is ingrained in several cultures and societies (Lefkowitz, Shearer, Gillen, & Espinosa-Hernandez, 2014). This includes the theory of "the male gaze," a politicized editing tactic to "invite the viewer to identify with men's characters and marginalize and objectify women's characters" (Kempton, 2020, para. 4). These concepts encourage perpetuation of a cycle in which women are tasked with the responsibility of presenting as sexual beings for the benefit of others while facing consequences should they choose to express their sexuality/sexual autonomy. While men are celebrated for their health, strength, and vitality when choosing to post their bodies online, women are sexualized and shamed for similar actions (Salter, 2016). The accountability of men is largely ignored, instead connecting sexual prowess to the idea of masculinity and gender norms (de Villiers, Duma, & Abrahams, 2021). Making a case that this messaging creates a cycle of sexual abuse, author Kelsey Thompson notes celebrity instances of revenge porn, in which we see these societal views demonstrated in how the stories are reported, as well as commentary and reactions. When celebrity Blac Chyna accused Rob Kardashian of posting intimate photos on the internet without her consent, reactions followed a pattern in which the survivor is "chastised as sexually promiscuous based on their sexual relationships, while men like Kardashian bask in hyper-masculine glory though betrayal in the form of a tweet" (Thompson, 2017, para. 14).

While many survivors identify as women, NCIS extends to men and non-binary folks as well (Holladay et al., 2021). These populations of survivors may face stigmas in an entirely different way, since societal norms associate victimization with being female, as being weak, vulnerable and with an inability "to protect themselves and in need of help and assistance" (Martinez, 2018, p. 2).

Should survivors of sexual assault choose to pursue legal recourse against their perpetrator, they may face unwanted publicity and instances of victim-blaming that potentially deter them from proceeding further with their case (Kamal & Newman, 2016). While 48 states plus the District of Columbia have passed laws criminalizing non-consensual sharing of intimate photos, data is not available on the percentage of survivors in these areas who actively seek legal recourse. Aforementioned risks of re-traumatization and publicity, fueled by gender role expectations, may lead to survivors reporting at a lower rate and enables the victim-blaming cycle to continue without further intervention at the legislative and policy-making level (Haskell & Randall, 2019).

What about Recovery?

While there is a dearth of literature on NCIS and its impacts overall, virtually no studies focus on the assets that have helped survivors of NCIS to overcome their experience. Although cyber sexual abuse survivors share similarities in mental health outcomes with those of cyber bullying survivors, including suicidal ideation and depression (Edwards, 2016), there has not been a focus in the literature on cyber sexual abuse survivors' recovery process. Similarly, studies on resiliency of survivors of sexual assault have not included NCIS within their definition, an absence that reflects the ongoing public discourse on whether NCIS is "considered" sexual assault (MSW@USC, 2021).

By conducting a qualitative study on survivors who report having overcome their experience of cyber sexual abuse, we aim to understand how future survivors can overcome the trauma of their experience, while concurrently contributing to the argument that NCIS is on the spectrum of generalized sexual violence.

Methods

Positionality

Author SC has a background in interdisciplinary health research, focusing on adolescent sexual health and sexuality, sexual communication, online and offline social networks, and prevention of sexual assault. Author RA has a background in child welfare, specializing in healthy relationships, sexual health promotion and LGBTQ best practices within the foster care community. Both authors RA and SC began the research study by reflecting on our individual perspectives related to the topic of cyber sexual abuse. Our status as NCIS survivors (mentioned in recruitment materials) afforded us unique access to other survivors and gave participants additional comfort in participating in a digitally

based research study. Our experiences of NCIS were vastly different, from the events that transpired, to their effects, to the way the crime was handled, and the eventual "resolution." Our diverse backgrounds and diverse NCIS experiences offer the study an integrative and orientative value.

Recruitment

We began recruitment for this study in March 2019 through an online support group for survivors of cyber sexual abuse. Thirteen participants were digitally recruited from the only existing support group focused on NCIS, "Battling Against Demeaning and Abusive Selfie Sharing," or BADASS, which is housed on Facebook. Two additional participants were recruited via snowball sampling. Prospective participants were provided with a link to an online eligibility form. Inclusion criteria were: 18 years of age or older; proficient in reading/writing/speaking English; having "overcome" their experience of cyber sexual abuse. This last criterion was of particular importance, as participants could define what that meant. The strengths-based approach to recruitment meant that we had participants in our study who could explain how they were able to overcome the trauma of cyber sexual abuse. Eligible participants were provided with a digital informed consent document to be signed electronically and returned to the Research Associate. Eligible participants must have indicated a willingness to be audio-recorded for their interview. Prior to the interview, participants were provided with a link to a digital demographic survey in which they provided their age, race/ethnicity, gender, and place of residence. Interviews, demographic questionnaires, and eligibility surveys were not linked together, and interviews were coded as numerical IDs to ensure anonymity. Following completion of the interview, participants were provided with a list of resources and a code for a $20 Amazon gift card as appreciation.

Of 29 prospective participants who expressed interest, 28 were found to be eligible as per the inclusion criteria, and 15 completed the interview process. All interviews were conducted by either the Research Associate or Principal Investigator.

Interview Process

We interviewed participants with a semi-structured interview guide via video-conferencing. To protect participants and make them feel more comfortable, only the audio component was recorded. Face-to-face video allowed the participant to be sure of who they are interviewing with, as well as allow a human connection, allowing the interviewer to further capture nuances of the participant's experience. Interviews lasted between 30 and 45 minutes. Audio recordings were digitally transcribed and manually verified to ensure verbatim transcription.

Data Analysis

We utilized a grounded theory approach, beginning with line-by-line coding. Author RA coded all interviews and Author SC read all interviews and coded four (over 25%). We met to find agreement in our coding. Next, grouping techniques were applied to summarize the codes. Common themes were recorded as they emerged from the analysis, using an inductive method. The research team met several times to discuss our individual observations of the emerging themes, triangulating them, and then finalizing them. This study was approved by the CUNY IRB, approval number 2019-0126.

Results

We had a total of 15 participants; they were between the ages of 21 and 41. Twelve participants identified as female, two identified as male, and one participant identified as non-binary. Additionally, one of our participants identified as transgender. Fourteen participants reported residency in the USA, and one participant reported residency in Canada. Of the 14 who reported the USA, states of residency included New York (4), North Carolina (4), Pennsylvania (2), California (1), Ohio (1), Florida (1) and the District of Columbia (1).

We asked participants to report their ethnicity (with the ability to check all that apply). Options included Asian, Black/African, Caucasian, Hispanic/Latinx, Native American, Pacific Islander, Prefer not to Answer, and Other. The latter allowed the participant to fill in the response of their choice. Twelve participants identified as Caucasian, and one participant each identified as Native American, Asian, and Multiracial, respectively.

Analysis identified six themes, with the fourth theme characterizing the temporal relationship between the first three and the last two: (1) Survivors exhibited both externalized and internalized stigma; (2) Survivors experienced varying levels of professionalism and support from law enforcement and legal professionals; (3) There is a substantial burden on the survivor to educate and explain about cyber sexual abuse; (4) The "Fuck it!" point: The point where there is a noticeable shift in survivors' attitudes and behaviors in their stories; (5) All survivors were forced to become their own advocate; many became an advocate for others; (6) Eventually, survivors embraced an acceptance of a "new normal" (see Figure 1).

Survivors Exhibited Both Externalized and Internalized Stigma

Many participants sought to distance themselves from preconceived notions of who they thought fit the "profile" of a cyber sexual abuse survivor:

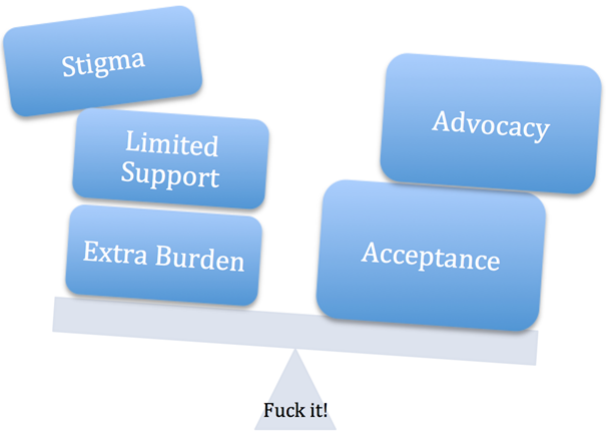

Figure 1. This figure shows the six identified themes, with the fourth theme characterizing the relationship between the first three and the last two.

> I knew about [cyber sexual abuse] from girls that send nudes…I thought you actually had to do something, and then in response, they expose these pictures" (Interview 5, Female)

This participant, who had her photos stolen from her phone, exhibits victim-blaming when describing her shock at becoming involved with NCIS without having sent nude images. Other participants internalized societal gender role perceptions in reconciling their experience as a survivor:

> …as a male, you can't really show vulnerability in these types of situations...you're not going to be taken seriously. Because you're a male, and you're not supposed to be affected or upset" (Interview 2, Male)

Survivors of NCIS who identify as male face additional barriers to reporting, perhaps rooted in societal beliefs associating victimization with weakness.

It appeared to take participants a length of time in their journey to acknowledge the burden of wrongdoing was on the person who shared the images; however, many survivors continued to reconcile with preconceived stigmas which placed blame on the survivor:

> Okay, so I was like, there's no way you could do that. He's not my enemy. Like, I haven't done anything to him" (Interview 7, Female)

These stigmas take on a societal relevance, in which it is not only the survivor's internal perceptions, but also fear of others' perceptions.

Survivors Experienced Varying Levels of Professionalism and Support from Law Enforcement and Legal Professionals

The tone with which participants spoke of their engagement (and often frustration) with laws and the law enforcement system spoke not only to expectations of reception by officers and detectives, but also reflections of their actual experiences.

> But the fact that that [revenge porn] could happen means that we need some laws and law enforcement, and some recourse to protect people from that kind of disaster. We have things to protect people from earthquakes, and tornadoes, right? When a tornado hits someone we have all kinds of things in place to help them, and well, we need the same kind of thing when a tornado hits somebody's life" (Interview 5, Female)

There were both situations in which survivors felt dismissed or blamed as well as those in which they felt supported and validated by the officer(s) with whom they were working.

Speaking to the latter, one participant noted that the officer:

> made me feel like I was being taken seriously…and so I'm grateful to him because he's been extremely supportive throughout the whole process" (Interview 13, Female)

That our participant not only felt "grateful" for what is otherwise a professionally expected reaction from an officer speaks to the inconsistency in reporting expectations that survivors encounter prior to reporting their experience. The participant noting that she felt that her reporting was being taken seriously additionally speaks to an inherent expectation

of victim-blaming and minimizing, particularly in cases of sexual violence.

To that end, underlying feelings of victim blaming on behalf of law enforcement were frequently noted. As one participant stated:

> ...they were pretty accusatory... telling me about how... once you put things online, you can't take them back" (Interview 4, Female)

Interactions with law enforcement at the onset of the experience continued to affect the survivor's ability to cope, long after the initial interaction took place. When asked about the memory of working with law enforcement in the aftermath of her incident, one participant talked about her trauma, noting that she

> ...was really traumatized, and still kind of am, by the treatment... that I received from law enforcement in particular" (Interview 1, Female)

The experience of preparing themselves for interactions with law enforcement spoke to a larger theme that was largely present in the immediate onset of their experience addressing their incident of cyber sexual abuse.

There is a Substantial Burden on the Survivor to Educate and Explain about Cyber Sexual Abuse

Following a perceived lack of support from law enforcement and/or society, many participants felt it was their responsibility to anticipate and intervene in cases where the presence of nonconsensual image sharing would impact their livelihood. Following a period in which a participant was repeatedly absent from class due to the mental health outcomes of her experience, she describes:

> ...frequently sending out emails to my professors... all of them were women, so I was a little more comfortable sharing" (Interview 4, Female)

That the participant noted the gender of her professors speaks to the inherent emotional risk taken in explaining her incident, and why she was missing classes – specifically stating that she was "a little more comfortable." Another participant took it upon herself to address her experience in different professional environment, stating:

> ...and you know, the first thing I did was I went to my boss, terrified. You know, I'm thinking, I'm probably going to lose my job. I gotta tell her what's happening, just in case this comes up" (Interview 9, Female)

This experience of having to relive trauma with multiple individuals – many of whom are not intimate relationships, coupled with ongoing frustrations on the societal level, led to a fourth theme, which facilitated the process of coping and reclamation, otherwise known as "the "Fuck it!" point.

"The "Fuck it!" Point: The Point Where there is a Noticeable Shift in Survivors' Attitudes and Behaviors in their Stories

Participants learned not to rely on external sources for resilience, but to speak up actively against their aforementioned lack of support.

> I got to the point where I was angry and I just said "fuck it." I'm going to do what I want, I don't want this to hold me back. I'm like, okay, if someone came up to me and said "I saw pictures of you naked," or "I saw pictures of you having sex," I'd be like "Okay, congratulations, what are you going to do with the rest of your day?" – like, "Okay, congratulations, I'm gonna do my own thing now" (Interview 7, Female

The point where this occurred was characterized by a sense of exasperation and resignation. Temporally, this point in the survivors' stories was where a shift occurred in their narratives from victim to advocate.

All Survivors Were Forced to Become their own Advocate; Many Became an Advocate for Others

A common theme among participants was taking control of their experience to best of their capacity:

> I was no longer paralyzed by the fear of harm – I was just pissed. I wanted to speak out about my experience on a public platform. Being angry and fighting back was empowering – and talking to other survivors was empowering, as well" (Interview 1, Female)

> It was a very full circle moment. We marched over the Brooklyn Bridge, it was the first day of Sexual Awareness Month. It was an incredibly full-circle moment, like I had taken my life back. And I had taken the power into my own hands to tell my own story" (Interview 10, Nonbinary)

Mobilization of emotions formally acting as a barrier to coping became a mechanism by which the participant was able to own their experience and become proactive in seeking justice against their perpetrators. In one instance, not feeling supported by law enforcement due to an absence of legal protections, a participant and her partner "... were a team in getting [the photographs] off the internet," by directly contacting webmasters and site operators. In addition to taking it

upon themselves to directly advocate, participants appeared to take proactive measures in identifying what emerged as the fifth theme.

Eventually, Survivors Embraced an Acceptance of a "New Normal"

A reflection that came up frequently was the notion that, to "overcome" their experience meant—in part—to understand that parts of their lives may never be the same, and that the threat of emerging photos may always be a distant, yet present fear. Many participants spoke of living in the present and owning their experience:

> One thing I have embraced is trying to accept me as I am at any given moment. . . there is an aspect of fear that you kind of have to overcome. And being scared is such a natural response to invasions of privacy. . . but having to overcome that scared part, I really do think it's just time. If something happens, that's going to trigger you and bring you back to that. But if nothing happens for an extended period of time, then you kind of are more comfortable feeling like, well, everything's OK" (Interview 4, Female)

This acceptance was often accompanied by changes in online habits, which spoke to altered routines to accommodate this concept of a "new normal." Behavior modifications appeared to fall under two categories: monitoring the potential presence of past exposed media and ensuring the minimization of new information/media to be shared. The former was accomplished by, as a participant stated,:

> ...googling myself a lot more, searching myself a lot more. There was a point in time when I would google myself every other day" (Interview 3, Female)

This specific behavior appeared to be inversely related with the amount of time since the initial occurrence of cyber sexual abuse. However, as the participant who spoke of what a "new normal" looked like for her, re-emergence of images can "trigger you and bring you back," which can also see the form of increased vigilance in ensuring the absence of shared images. The latter behavior appeared to be aligned with the concept of a "new normal" and in some cases appeared a permanent behavior modification.

> I started to get a little more concerned about security, I became more aware of my privacy setting. The biggest change I made with Facebook was making my profile more private" (Interview 3, Female)

Efforts toward strengthening privacy extended to sharing locations on media platforms:

> If somebody tagged me in a post that says where we are, I don't approve of it on my timeline to show up. It's, you know, going to be lingering and lasting. So I may just be really squirrely about putting myself out there like for, I don't know, a long time, I think" (Interview 1, Female)

Discussion

Extensive participant interviews revealed coping assets rooted in—simply put—the failure of adequate societal and cultural support toward survivors. Shifting of attitudes appeared to emerge from coping barriers established through interaction with law enforcement, as well as potential re-traumatization through educating and reconciling the experience with individuals at a higher level of authority (such as a professor or job interviewer, as noted throughout the interviews).

The concept of "overcoming" included acknowledgement of a "new normal," which included an acceptance that the threat of emerging images would always be present, and was accompanied by behavior changes that altered social interaction on media platforms, with both friends and strangers alike. These behaviors included setting profiles to a more restrictive setting and not sharing locations as to maintain an increased level of privacy. These behavior modifications mirror survivor reactions to generalized sexual violence. In a dyadic study with adult female survivors of sexual violence, adopted preventive strategies included security measures, protective strategies, and day-to-day routine changes. The latter often resulted in a measure of restriction to the survivor's life and/or "losing prior activities...in the hope of avoiding future assaults" (Ullman, Lorenz, & O'Callaghan, 2018, p. 7). For a survivor of physical sexual violence, this may mean avoiding social engagements or routines which served as a backdrop for the assault in question. Similarly, for survivors of cyber sexual abuse, this may look like ceasing activity on social media platforms, as well as increasing anonymity when engaging virtually (i.e., not wanting to be tagged in photos/have their location shared).

Our study uncovered a parallel in the resilience and healing strategies of cyber sexual abuse survivors to those experiencing other forms of sexual violence. Previously identified strategies include social support, coping strategies, and behavioral modifications to increase perceived control over recovery and reduce perceived risk of re-victimization (Frazier, Tashiro, Berman, Steger, & Long, 2004).

Utilizing preventive strategies appears to denote an internal manifestation of victim-blaming. By restricting or eliminating otherwise enjoyable aspects of life is to place an additional burden on the survivor. Not only are they navigating a traumatic experience, but they must also tailor their lives to feel a perceived measure of protection. In a study of

1,800 women, 71% reported "avoiding things they wanted to do because of their fear of victimization" (Runyan, Casteel, Moracco, & Coyne-Beasley, 2007, p. 272-273). It should be noted that while more than half of participants had reported being subject to a victimization experience, two-thirds of the total study disclosed altering their day-to-day decisions around the fear of being victimized. This onus of perceived safety perpetually resting on the survivor—whether prospective or current—speaks to the internalization of victim-blaming. While our participants exhibited victim-blaming mentalities in rationalizing their experience, it is clear that these stigmas followed—and perhaps defined—their journey of healing.

Limitations

Limitations to this study include recall bias: survivors recounted their past experiences. Additionally, state and country variances in laws criminalizing NCIS may provide inconsistency in themes regarding barriers and assets to coping as related to pressing charges for the assaults.

Implications and Future Recommendations

Given the wide variety in interaction that survivors experienced, further studies focusing on standardized training (or gaps in training) among law enforcement and its effect on survivors would provide a baseline for reforming training manuals on a systemic level. This information may be used to inform detective and police officer training and protocols for working with survivors of cyber sexual abuse. These studies should emphasize the notion of victim-blaming and other gender-based acts of discrimination that may potentially interfere with the ability to work with survivors in an affirming, validating space.

While many states have criminalized NCIS, societal views continue to shape incidents of NCIS within the framework of victim-blaming and risk management; this appears evident specifically through experiences between survivors and high-ranking individuals such as employers, professors, mental health professionals, and law enforcement. Increased research needs to occur to recognize the effects of recounting and working through experiences of cyber sexual abuse in a potentially undertrained environment; alternatively, how structured protocol and training cannot only shape a survivor's experience, but contribute to shifting the burden of blame in cases of cyber sexual abuse from the survivor to the abuser. Survivors of sexual assault face increased risk of revictimization and subsequent negative emotional dysregulation (Walsh, DiLillo, & Scalora, 2011). Long-term effects of experiencing NCIS have been found similar in survivors of child pornography, including "powerlessness, permeance . . . leaving victims engaged in a lifelong battle to control their dignity" (Kamal & Newman, 2016, p.362). In receiving training focused on the complexities surrounding the survivor experience and parallels of mental health effects to other forms of sexual violence, mental health professionals will be able to meet the needs of an increasingly growing population of survivors.

Incidents of NCIS should be considered a form of sexual violence and integrated into campaigns, curriculums, and conversations regarding sexual violence accordingly. As experiences further differ depending on factors like race, ethnicity, and socioeconomic status, aforementioned campaigns should cater to the needs and inequities of its survivor population. Societal adaptation and normalization of NCIS being viewed in the same lens as sexual violence will lead to increased advocacy for support of cyber sexual abuse survivors, as well as shifts in policy and law to criminalize further all forms of cyber sexual abuse.

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Practicalities and Possibilities: PAR Research in Counseling with Sex Workers

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Scholars have increasingly documented that a participatory action research (PAR) paradigm can strengthen learning about sex workers' experiences. Many counseling researchers, however, may not be prepared for various contextual factors and experiences that can occur when doing PAR with sex workers. In addition, sex workers' experiences of oppression and marginalization neces-sitate that counselors adapt their research methods to engage with this community. The author of this article discusses important process elements of PAR research with sex workers to identify methodological practices for counseling researchers engaging in PAR with sex workers. Implications for training with counseling researchers across the professional lifespan are discussed.

Keywords: participatory action research, social justice, research process, sexuality research, community-based research

Introduction

An increasing volume of literature (e.g., Cook, Levy, & Whitehouse, 2020; Shamrova & Cummings, 2017) supports that participatory action research (PAR) is a paradigm of inquiry that is being used with communities, cultures, and systemic social issues that have been noticeably absent from counseling and psychology research. PAR is also a research paradigm that can apply to quantitative, qualitative, and mixed methods research. The process of PAR entails a series of steps that vary slightly across different disciplines and researchers. Some PAR researchers note a four-step process that includes a) initiation of research with participants as co-researchers; (b) identification of a research focus that focuses on positive social change; (c) collaborative data collection and analysis; and (d) evaluation of the research study's impact on positive social change (Canlas & Karpudewan, 2020). Other researchers utilize a slightly varied 4-step model that includes: (1) participatory ethics; (2) from theory to PAR praxis; (3) community-based research and collective inquiry for social mobilization purposes; and (4) enacting action in PAR for social justice (Ritterbusch, 2019, p. 1304). Many current PAR researchers use this slightly revised model widely, and it has become a best practice within the research literature (Burns, Howard, & Ospina, 2021).

Increasingly, scholars in counseling have begun to use PAR with "at-risk" communities. Literature in various mental health disciplines uses the term "high risk" to identify specific groups who have disproportionate rates of mental health symptoms and a theorized lack of resilience, and who need intervention related to their vulnerability (Burnes, 2014; Harpine, 2019). Researchers have begun to use PAR as a way to understand more about what keeps these "at-risk" communities from connecting with their own resilience. In this process, many PAR researchers have noted a need to reframe "at-risk" due to its roots in oppressive and marginalizing language. For example, the term "at-risk" can signify a community's absence of financial resource, its being prone to violence that they themselves do not instigate, and a "resistance" to oppressive ideologies of "reform." These constructions of "at-risk" have roots in classicism and colonization. In contrast, a newer framework increasingly juxtaposes risk with resilience, encouraging more empirical inquiry about resilience in these communities (Hornor, 2017). These shifts exemplify how PAR is a lens that guides ethical and empowering research through its accurate framing of resilience and multicultural humility.

PAR is also a needed research framework for studies within human sexuality in part due to its use of empowerment and collaboration to combat stigma, shame, and erotophobia (Abma et al., 2018). PAR empowers people in many areas of sexuality to co-construct the formation of new knowledge with researchers. Such collaboration provides more accu-

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rate information about stigmatized areas of sexuality and prioritizes spaces for voices of a variety of sexual identities and experiences that are often silenced. Further, although PAR researchers increasingly have documented the content of these collaborative studies in sexuality, they have yet to document the *process* of their research (O'Neill, 2010). Specifically, sexuality researchers have called for writings that highlight the process of research *with*, rather than *on*, communities (Zeglin, Van Dam, & Hergenrather, 2017).

One such sexuality-focused topic where there is a notable absence about the process of PAR research is with participants who are sex workers. Weatherall and Priestley (2001) defined sex work as one or several services in which sex is exchanged for money or goods. In addition, other authors have more recently described sex work distinctly from sexual identities and sexual orientation as jobs including street-based work, camming, sugar relationships, working independently, stripping, massage parlors, burlesque, and phone sex (Burnes & Dawson, 2023). As expression of sexuality often develops within a context of culture and environment (Alexander, 2019), expressions of sex work have evolved in terms of location, social organization, services rendered, and resulting systemic reactions. For example, current definitions often have not included certain types of sex work, including mobile phone app work (e.g., using mobile phone dating applications such as Tindr or Grindr to solicit sex in exchange for money or goods).

Although the prevalence of sex work-related phenomena has increased in interdisciplinary sexuality research (Rule & Twinley, 2020), some researchers in various disciplines continue to view sex work from a narrow, pathology-focused lens (Burnes, Long, & Schept, 2012; Dawson & Burnes, 2018; Nuttbrock, 2018). This lens results in researchers rarely prioritizing sex workers' voices. In addition, researchers rarely collaborate with sex workers to construct a study's design, resulting in faulty methodology. With such a lens, research on experiences of sex workers is often based on samples derived from either incarceration facilities or escorts who are highly resourced (Sawicki, Meffert, Read, & Heinz, 2019), creating an inaccurate lens through which sexologists conceptualize sex work in research and practice. Such methodological bias (e.g., convenience samples, no control groups) in sex work research (Burnes, 2017; Sanders, Scoular, Campbell, Pitcher, & Cunningham, 2018) continually highlights that PAR is a necessary paradigm with which to accurately create knowledge about sex work.

Not only is PAR necessary to help address such methodological concerns in sex work research, but PAR can also further assist researchers in recognizing their own subjectivity in their work. There is a growing need to understand the PAR process and the impact of sex work research on the researchers, the participants, and the relationship between all parties. Although counselors have been trained to engage relationally with participants in traditional research paradigms, many researchers may not understand how to navigate traditional understandings of "relationships with participants" from a PAR framework. How researchers themselves engage with and under-stand multiple levels of oppression (e.g., classism, racism, sexism, erotophobia) is relatively absent from research focusing on sex workers. Further, given the potential for some researchers to hold unchecked power and privilege, researchers need to understand the intricacies of a research frame-work that prioritizes social justice for a PAR study to succeed (Hargons et al., 2021).

Information related to the practicalities of PAR with sex workers is still a nascent topic of scholarship. Not documenting such important process variables may result in further harm of sex workers by researchers when relationship, hierarchy, and oppression are not explicitly prioritized as part of the PAR design (Burnes, Rojas, Delgado, & Watkins, 2017). Not only is there a need to document the PAR process, but there is a specific call to understand how PAR with sex work results in distinct methods, experiences, and actions. The need for writings to understand these various facets of PAR process is critical to ensure that researchers infuse relational and ethical procedures into their scholarship focused on sex work.

Process Themes in PAR Research

In response to the aforementioned needs, this article begins to document specific themes in PAR research with sex workers to understand better the ways in which counseling and psychology researchers can understand and engage with PAR process. The author presents four vignettes from his work with a four-year research program, consisting of two studies using a PAR process that investigated resilience in sex work communities (Burnes, n.d.; Burnes et al., 2017). Accompanying each vignette is a discussion of process themes and recommendations for broadened understandings of counseling research and for the practice of PAR. The author then provides practical strategies for centering process in a PAR paradigm that connect all four vignettes.

Sex Work with PAR Design

As part of our participatory action design that investigated aspects of resilience in communities of North American sex workers, a team of four mental health professionals created a series of five fora for sex workers to come and give feedback about topics that they wanted to study and what was important to them. Each of these fora was in a different city. Sixty-five sex workers participated in these fora and were given food, vouchers for mental health care, and condoms in exchange for participation. "Paula" self-identified as a 28-year-old African American woman who was a sex worker and attended one forum. Throughout the forum process, Paula

appeared skeptical. At one point about halfway through the proceedings, Paula stated:

> *I don't know how this is going to work. I mean, I can just speak for myself. If I join this research, I'm questioning a system that's in place. I could lose my job and my physical safety could be threatened. I don't think you fancy researchers can come in here and say the same thing – all you have to do is to move on to another project, right?*

Upon reflection of Paula's comments, the research team used the forum space to have a conversation with Paula and other sex workers involved in the project about the potential risks involved. For some sex workers, removing themselves from certain parts of the project helped them to feel safer. For others, working with the research team to devise a safety plan helped them to feel more secure about their involvement in the research process. Regular process checks in subsequent parts of the studies helped to maintain these feelings of increased safety for all parties.

Paula's statements highlight a central tension of conducting PAR with sex workers, a community in which risk for physical violence is often present (Logie et al., 2017). Researchers should think about how ethics in the counseling field, such as justice, self-determination, and integrity, can aid in increasing safety for sex workers as research participants (American Counseling Association [ACA], 2014). More specifically, sex workers' participation and collaboration with health care researchers can put them at risk in their own communities. Malcom-Piqueux (2015) noted the importance of PAR's being a catalyst for social change; however, participation in PAR could threaten the safety and well-being of certain participants. Such danger is an important factor that is often left out of discussions of PAR research. Further, an intersectional framework will enable the PAR researcher to understand how sex workers' identities may add additional stressors to their work and may put their safety at increased risk. Researchers should focus on building trust and explicitly naming such risk in their informed consent process (both in writing and verbally when starting the research study), which are hallmark techniques of qualitative research (Ahmed, Vandrevala, Hendy, Kelly, & Ala, 2019; Livingston & Perkins, 2018). Thus, researchers should consider creating safety plans for research participants worried about the logistical and very real consequences of engaging in research outside of their respective communities.

Although traditional research paradigms often have traditional relationships between researcher and participant (Heppner, Wampold, Owen, Thompson, & Wang, 2016), researchers need to understand the complex relationships when working in a PAR paradigm for the effectiveness of the project. Specifically, with-in a PAR paradigm, the need for researchers to collaborate with participants before the research questions of the study are designed insists that the researcher relinquish control of the study's design, goals, and objectives to the participants. Therefore, there is a critical need for the researcher to "let go of their role" that has been traditionally defined as one of power. As sex worker-participants become co-researchers, researchers must share adequate power with them to understand how they can use their work to foster their own resilience, empower their communities, and create social change (Ochocka, Janzen, & Nelson, 2002). Such sharing of power should include a regular "process check" between all co-researchers (including the original researcher) to make sure that all decisions are being made collaboratively.

In addition, like in the case of Paula, the researchers must understand the need to value the unique contexts of their PAR co-researchers that may be dangerous. Some sex workers may feel threatened by members of their community for joining a PAR research team. These fears of participants and their sex work communities—of retaliation, violence, and abuse—may be real and not solved readily. The researcher can see such fear as a coping mechanism and a resilience strategy from a community that may have traditionally been exploited or pathologized by research (Močnik, 2019). Creating information about PAR (e.g., websites with QR codes, pamphlets, FAQ sheets, etc.) for family members, co-workers, and community members of co-researchers is necessary to achieve these goals. For the author of this article, participation in community events, engagement with community centers and spaces, and collaborating in acts of social justice with the communities that are a focus of research helped to ease these coping-focused responses. As these various issues with design allude, PAR requires the need for researchers to conceptualize and implement adequate amounts of time prior to and during the project design and data collection.

Data Collection in PAR with Sex Workers

As part of our participatory action design that investigated aspects of resilience in communities of North American sex workers, a team of co-researchers of academic sexologists and self-identified sex workers began to collect data in four different cities. "Claudia" was a self-identified Mexican American, transgender female, who was the first sex worker that the first author inter-viewed as part of the data collection process. When asked about suggestions for recruitment of participants, Claudia laughed. "Facebook isn't going to work with this crowd. You're going to have to think about hanging outside of the vans." 'The vans', or a series of HIV mobile testing fans that often operated between 11pm-5am nightly, were often parked far from public transportation and in an area of the city to which law enforcement did not routinely respond. The first author reflected on the challenges

of amending the project's application to the Internal Review Board (IRB) and how difficult it might be to have the IRB approve soliciting sex workers to participate in a research study as part of the data collection process.

Claudia participated in the study on a Sunday evening; the following Wednesday, she was found dead in a dumpster in a large Mexican city near her town of residence. For three months after the project ended, multiple members of the research team experienced sadness, grief, and fear for other participants. The first author brought in a consultant with an expertise on grief for the research team, and members were able to pause their work and process their own experiences and emotions. In addition, the first author was able to access his own therapeutic support through both individual and group counseling sessions. He gave referrals to all team members, and referrals for low-cost services were provided to community members. Team members also created a memory circle with community members in which people came together in a community space to stand together, share experiences of Claudia, sing songs, east food, and create a small memory book to give to Claudia's family of choice.

When undergoing data collection process in a PAR paradigm, it is important for the research team to understand the important nuances of collecting data for a project geared toward social change. Specifically, researchers beginning to engage in PAR may not understand the difficulty of collecting data with participants and communities who are systemically, historically, and/or culturally marginalized (Singh, Richmond, & Burnes, 2013). First, many institutional review boards that review research projects may consider certain collection strategies and certain sites for data collection "dangerous" or "at risk" (Levine et al., 2004; United States Department of Health and Human Services, 2015). However, there are problems with avoiding such sites because they are places that are central gathering spaces or sources of resilience and support for sex workers. For example, the author's research team often collected data outside of mobile STI/STD testing vans from 2-4 a.m. in nondescript locations. These working environments allowed the team to meet participants in places where they felt safe and were able to build trust with the team members in order to participate.

As novice researchers begin to co-construct PAR projects with sex work communities, it is important to consider the extreme combination of resilience and vulnerability that occurs when researching marginalized communities (Chughtai et al., 2020). Specifically, the need for researchers to grapple with the practicalities of marginalized communities in which they are conducting research is paramount. Research participants and co-researchers who are sex workers could be survivors of violence, undergo sickness due to lack of access to health care, and/or survive incidents of ongoing, insidious oppression that can occur during the implementation phase of the research project.

When addressing such a theme in PAR research, the research team should implement two concurrent responses: one response to help participants and the other to help themselves. When helping participants, although such incidents of sickness and violence may be common to other members of a particular community, it will probably appear inhumane for the researcher not to respond with care and compassion. As such, researchers should move beyond asking about a specific stage or moment in participants' lives and allow for them to set the agenda for the conversation themselves (Guha, 2019, p. 512). Further, a lack of reaction by a researcher could recapitulate oppressive empirical processes and lead a sex worker to think that a researcher does not care about the community being studied, but rather just sees the community as "work." Providing spaces to address moments of grief, sadness, shock, or fear can help participants to build resilience in the face of violence and oppression. Such spaces can involve research team members and community members engaging in group debriefs, providing referrals to local agencies and organizations for outside support, creating rituals (shrines, memory circles, etc.), and encouraging activities to build resilience.

With such difficult contextual factors impacting research, researchers should also respond by taking care of each other seeking out their own support (e.g., research consultation groups, research supervision, personal therapy). Counseling professionals can encourage students to access resources outside of their immediate work environment to increase resilience against potential vicarious traumatization (e.g., the student counseling center, low-no cost community referrals for mental health support). Having specific debrief conversations with the research team is vital to ensuring the well-being of researchers who have not experienced the result of such difficulties prior to the current moment. As a preventative measure, researchers beginning a PAR research project that utilizes a PAR research paradigm may want to form a research consultation group before the project begins so that they have support for all phases of the project.

Data Analysis in PAR with Sex Workers

As part of our participatory action design, the team of academic sexologist co-researchers and self-identified sex workers also analyzed data. "Nyeema" was a self-identified African American female sex worker, who was a part of the team and who engaged with data analysis. The team engaged in rigorous qualitative analysis with multiple phases. In the first phase, pairs of team members came together to code data. Nyeema struggled with the analysis process in multiple are-nas. She often would question the coding process in terms of the researchers' bias and discomfort related to explicit sexual acts performed by the participants. Nyeema also would bring unique perspectives about the

coding process and challenge the conceptual framework of the project. During one meeting of the entire team, Nyeema announced that she was afraid she would have to leave the project. "I just don't think that I belong on this team," Nyeema reported. "I feel like everything that I say challenges everybody else's viewpoints, so I must not be doing this right. I just feel. . . .kind of like I don't get it even though I keep trying."

The research team members validated and normalized the multiple forces that appeared to be leading Nyeema to leave the project. The team had open discussions about the importance of different perspectives in coding data, and that, "challenging viewpoints" was a good thing in this research space (even if it felt bad or disrespectful in other spaces). Many members of the team who also identified as sex workers reframed some of Nyeema's doubts about her differing view-points as strengths, encouraging her that her experiences in fact added to the rigor of the project. Feeling empowered, Nyeema stayed with the project. The researchers also decided to create pairs (called "pods") in which team members from an academic setting paired with a team member from outside of the academic setting so that each pair could provide support and challenge to each other throughout the remainder of the analysis process.

As part of the PAR process, researchers should understand the difficulty and complexity in sharing the data analysis process with sex workers who may not understand some nuanced processes in counseling research. Counseling professionals should juxtapose the idea that participant-peer researchers learn rigorous data analysis with the idea that they may bring unique and needed ways of deconstructing covert rules and processes of knowledge production from a traditional academic lens (Tanner, 2018). The bringing together of these ideas results in tensions that are not new in the process of deconstructing research paradigms (DeVault, 2017; Olsen, 2017); however, they become a critical element when equalizing power dynamics from a PAR framework. The benefits of including sex workers as peer researchers can result in needed discussions about the erotophobia that may lurk in the academy, as well as about the need to deconstruct traditional ways of making meaning of data that are confined to the ivory tower (Lobo et al., 2020).

To address these tensions, researchers can highlight them early in the analysis process. Scheduled conversations like the one featuring Nyeema above allow all members of the research team to deconstruct such tensions and empower each other to bring up such conflicts between values and process as they occur. Researchers can also encourage impromptu conversations at any point in the research process to enable such collaborative deconstruction. Such conversations may also bring up other research process variables that may feel uncomfortable for co-researchers in other aspects of their lives. For example, some sex worker co-researchers may not feel comfortable disagreeing with specific data interpretations, as providing alternative viewpoints (like in the case of Nyeema shown above) may be seen as disrespectful or like the co-researcher "did something wrong." researchers should reframe these concerns as strengths and resilience of the co-researchers, and that co-researchers should feel comfortable to bring up such issues consistently. Researchers should also validate and discuss such differing experiences with respect and humility as part of research team check-ins. Researchers can also address such tensions with data analysis by pairing non-academic researchers with researchers for the duration of the analysis process. Regardless of what type of analysis is happening in the PAR study (e.g., naming factors in a factor analysis, deciding variables to remove in a stepwise regression, naming codes in qualitative data, synthesizing qualitative and quantitative data in a mixed-methods analysis), having researchers with different relationships to the academy and the community pair with one another can be very helpful in ensuring rigor without silencing the unique voices of co-researchers whose experiences may differ from others on their team. Specifically in qualitative analysis, sharing power as part of the data analysis process (Holloway & Wheeler, 2009; Richards, 2021) through pairing and auditing sections of transcripts can be helpful in ensuring the credibility and trustworthiness of the depth of understanding hallmark to the qualitative paradigm.

Data Sharing in PAR with Sex Workers

At the end of the study's analysis project, the team of co-researchers of academic sexologists and self-identified sex workers also began to ask how we wanted to share the results with the larger professional and personal communities. "Lion" was a self-identified White gay male sex worker, who was a part of the team and who engaged with data collection, analysis, and helped to share findings. Lion listened quietly as other members of the team began to brainstorm ideas about how to share the results with the larger sex work community. Lion noted, "I am worried that sharing this information may put some people who participated at risk." He spoke about how the re-searchers needed to be careful about where we shared results, and how some of these results may speak truth to power. Lion noted that these results may perhaps anger brothel owners and pro-curers, which could in turn result in more violence in sex work communities. During one meeting of the entire team, Lion announced that he did not want to be involved with directly sharing or speaking about the results for fear of his own safety. The team began to recognize both the complexities of openly sharing data in workshops and fliers and also of continuing to protect the safety of participants through constructed safeguards.

Borgman (2012) highlighted the importance of sharing data and findings with participants and concurrently identifies tensions in sharing data with participants. These writings

highlight the difficulty of collecting data within communities but not sharing the product of these data in the communities where the data were originally collected (Borgman, 2012). As noted in the vignettes of Paula and of Lion, such a process can increase fear and can create community-level distrust of social scientists, even when they have social justice-focused interests at heart.

Many individuals may want to engage or have access to knowledge that is created by the study, but due to issues of economic or class disparity lack access to journals or libraries housed within institutions of higher education. Thus, to have an individual take data from a community and not give it back in the form of results or implications of the study can go against the social justice nature of the study or PAR as a research paradigm.

It is important for researchers engaging in PAR to think critically about how to share research with communities in which they are engaged. Specifically, strategies for sharing data and results should not come from research protocols, but instead come from the communities that are being studied (Goldblatt, Karnieli-Miller, & Neumann, 2011). PAR researchers should begin to assess and observe ways in which communities share information generally to figure out how data can inform community norms and values with humility and respect. Providing information in already existing community gathering spaces—fora, town halls, coffee shops—can provide researchers with the space and social capital needed to share this information. If not, researchers should consider making fliers, presentations, or online resources and distributing QR codes, infographics, websites, fliers, or postcards in communities so that individuals may have access to the various information that was constructed with them or in their community.

Implications for Counseling Research Training

The vignettes and corresponding commentary above begin to help counseling researchers using PAR paradigms and methods to think critically about the way that their process engages with sex workers. These various quandaries may also begin to impact how researchers engage in their own reflection and continuing education in their role as researchers. Further, researchers in counseling and counselor education programs (as well as other related social science disciplines) can further educate trainees about the PAR process. The following four strategies can be helpful for research supervisors, mentors, and faculty to consider as they construct learning about PAR.

Learning Outlines that are Intentionally Interdisciplinary

As faculty and applied research supervisors and mentors in counseling are constructing syllabi, instructors should create learning activities about research process. Instructors of research courses at both the master's and doctoral levels should construct course learning objectives that help their students learn about research process. Further, sexuality-focused courses in counseling curricula could also include assignments that focus on research study design to assess students' learning. Licensed counselors and counselor educators can also provide and engage in continuing education seminars to ensure that they learn about and reflect on such research process variables (Burnes, 2017). Faculty who lead research teams and research labs can also use the vignettes in this article (or vignettes with comparable content) to begin to shift how trainees may think about their relation-ships to sex worker communities that they are researching. In these learning spaces, instructors and research team leaders can validate students' uncertainty, as to linger in the fraught spaces of uncertainty and collectivity are some of the most important processes in which researchers-in-training learn PAR work.

Such conversations may naturally gravitate into researchers' exploration of their own identities of privilege. If not, counseling researchers and educators may want to facilitate a conversation about privilege and oppression in the context of a research design class. If the instructor feels that facilitating such a conversation is outside their scope of practice (Lechuga, Clerc, & Howell, 2009) it can be helpful to bring in a guest facilitator or a colleague who can help learners to gain insight into how their own identities may impact their training and professional development (Love, Gaynor, & Blessett, 2016).

Understanding Timing in PAR Research Process

Methodology-oriented PAR curricula and service-learning frameworks run the risk of creating unilateral, semester-long relationships with the participants such as sex workers in which the timing of interactions and contact are dictated by class schedules rather than by the daily and ensuring urgency of injustice (Ritterbusch, 2019, p.1301). As counseling researchers need longer periods of time to construct trust with communities of sex workers, supervisors of counseling students' research should provide these researchers-in-training with accurate timetables about PAR research and how these schedules may contradict traditional academic requirements. Further, researchers at all stages of the professional lifespan—students, early career professionals, and experienced researchers who may be utilizing PAR for the first time—and their supporters should also account for additional time needed to process traumas, resilience, and occurrences for sex workers in dangerous working conditions.

Researchers new to PAR in mental health disciplines may be frustrated by the length of time it takes to complete studies, especially when they have excitement and motivation to learn more about the knowledge base that they are helping to

build. Consultants to the PAR process, such as super-visors of counseling student research and consultants for experience researchers, can help to sculpt these mismatches between perceived and actual timing by continuously amending and updating re-search plans. Likewise, sex worker-participants may also become frustrated with bureaucracy related to academic and institutional requirements associated with knowledge production in counseling research. Researchers can brainstorm talking points to discuss with their research participants about the process. In some cases, role playing these conversations (in which the students are themselves and the counselor educator is a PAR research participant) can be helpful to give the researcher-in-training a chance to practice having conversations about timing.

Support and Community as PAR Researchers in Sexuality

As sexuality researchers may often work alone or in solidarity with their respective PAR projects, it is important to acknowledge that this isolation may have negative impact on the researcher (and the participants and project, by proxy). Engaging with vastly different (and sometimes hostile) environments and communities as research sites can have an impact on counseling researchers, and such emotional taxation may take a distinct toll that has yet to be investigated in the empirical literatures of counseling and related mental health disciplines. Finding a supportive network of col-leagues engaging in PAR-related studies can decrease isolation, provide accountability to the essence of PAR work, and provide consultation for ethics and process-related questions (Gale & Evans, 2007). Further, given the unique stressors that occur within PAR paradigms, researchers may find such a group to be a place where other groups members can normalize and validate their unique questions and experiences.

Some PAR researchers may not be trained or have specific competence in areas related to sexuality. Thus, some PAR researchers focused on sexuality-related phenomena may find peer consultation groups focused on sexuality content using multiple paradigms (not just PAR) to also be helpful in their need for peer support. Such a decision can also help to reduce the incident of the researcher encountering incidents of erotophobia and sex-negativity in the consultation process. Counselor educators' engagement in these types of groups and explicitly referencing them can also be superb modeling for students about the need for continued consultation in later phases in their work as professionals in the field.

PAR Process in Assessment and Evaluation of Research Competence

Competencies as a researcher is paramount to the formation of a strong counselor identity (Council for Accreditation of Counseling and Related Educational Programs [CACREP], 2016). In ensuring these competencies, counselor educators must devise mechanisms to assess researchers' competencies across the professional lifespan (as students, as pre-licensed professionals, as licensed professionals, and as faculty-educators-research supervisors; CACREP, 2016). As such, attention to PAR process should also be a point of evaluation when instructors are evaluating students' learning in research courses and capstone projects related to sex work (e.g., theses, dissertations, etc.). Rubrics that include criteria assessing counseling students' attention to various elements of process in a research project will ensure that PAR with all sexuality phenomena is done benevolently and with the full amount of justice and integrity in which the paradigm was in-tended. Research supervisors should ask open-ended questions in oral hearings and comprehensive examinations of student learning about PAR and how these specific content-focused issues are ad-dressed in order to ensure that they reliably evaluate training in sexuality and social justice.

Counseling professionals should also continue to think about the assessment and evaluation of PAR process in sexuality research that occurs in other domains of their work. Reviewing of manuscripts, proposals for conference presentations, and grant applications may often not have adequate space or structure to account for the difficulty of such PAR process. As sexuality-focused re-searchers have historically been known to critique and question traditional paradigms about social science research (Sakaluk, 2019), the need for sexologists to advocate for the inclusion of such structures is needed. Further, given the need for more intersectional frameworks in sexuality related research (Alexander, 2019), the need for sexologists to continue to advocate for the reshaping of research competency in counseling is vital. Finally, future counseling competencies related to human sexuality (Mollen & Abbott, 2022; Zeglin et al., 2017) could also address the need for PAR as a possible research methodology and the unique processes needed for conducting research in human sexuality (and specifically with people involved with the sex industry).

The writings above help to address ways that counseling researchers and researchers-in-training can specifically begin to think about their own ways of utilizing PAR into their research with sex workers. As researchers continue to co-construct knowledge with communities, attention to the process of such co-construction simultaneously increases in need and value. How researchers attend to these process dynamics—and, in turn, train students, mentees, and supervises to at-tend to such process—should continue to be fundamental points that are brought into research development. With this eventual integration, sex-positive counselors can use the resulting research to advocate for sexual liberation at all ecological levels of various systems while also helping PAR to continue to increase in rigor, outcomes, and impact.

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Sexual Violence Survivors in the Indian Diaspora: The Impact of Acculturation on Support-Seeking Behavior

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Survivors of sexual violence in the United States are provided many more resources than those in Asia. For survivors in the Indian diaspora, this provides a unique perspective when understanding their experience and seeking support. This mixed methods study was an effort to understand the relationship between acculturation and support seeking for these survivors, both from informal and formal supports. This survey research recruited 77 survivors of sexual violence who self-identified as women and within the Indian diaspora in the United States. The participants ranged from 18 to 43 years in age. The Stephenson Multigroup Acculturation Scale, support seeking checklist, and open-ended questions were used to understand the relationship between the variables of acculturation and support seeking within this population of survivors. Analysis showed that differences in support seeking were impacted by immersion in either dominant or ethnic societies, and that more attention might be paid to those with marginalized acculturation identities. Results of hypothesis testing and descriptive statistics are delivered. Implications include particular concern for populations marginalized by their ethnic and dominant societies. Further discussion focuses on understanding cultural norms as opposed to acculturation and integrating informal supports in treatment for survivors.

Keywords: sexual violence, Indian diaspora, support seeking, acculturation

Introduction

Feminist theory discusses sexual violence as an assertion of power (McPhail, 2015), and emphasizes understanding how the survivor would contextualize this experience (Rossetto & Tollison, 2017). Immigrant communities, or diaspora, can frame their experiences of sexual violence and support seeking experiences within acculturation (Agunias & Newland, 2012). Acculturation, or a gradual adaptation of values, beliefs, and behavior in a dominant society, impacts how survivors experience resources and dominant discourses. In turn, this adaptation provides different understandings of how much power a survivor has in their context. Survivors of sexual violence are affected in how their social institutions define their gender and their experience (Rossetto & Tollison, 2017). They are also impacted by the interaction of values modeled in their family/ethnic community and the dominant society (Few-Demo, 2014; Pitre & Kushner, 2015).

Indian diaspora in the United States has the influence of the culture and ideologies that come from India and those cultures and ideologies that exist in the United States (Miller, Yang, Hui, Choi, & Lim, 2011). One researcher asserts members of the diaspora merge the beliefs and attitudes inherent to Indian society with the values demonstrated in American culture and the resources that exist in the dominant, American society (Sharma, Unnikrishnan, & Sharma, 2014). Members of the diaspora, therefore, have some of the sexually conservative attitudes that come from their ethnic society while simultaneously having exposure to more mental health resources in the United States (Sharma et al., 2014).

Sexual Violence in the Indian Diaspora

Sexual violence is a problem within the Indian diaspora, as is evident from headlines regarding rape and sexual assault in India, which impacts recent immigrants (Sharma et al., 2014), and multiple studies discussing the prevalence of sexual violence in the Indian diaspora (Gill, 2004; Murugan, 2017; Pallatino, 2017). The National Family Health Survey in India found that 99% of sexual violence in India is unreported (Murugan, 2017). However, messages around sexual violence in India remain conservative, often using victim blaming and stigmatizing language despite women's rights

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movements that advocate for change (Sullivan, 2015). In the United States, the #MeToo and #TimesUp movements, along with many other recent women's rights movements, have highlighted resources available to survivors and have demonstrated a value towards women's health (PettyJohn, Muzzey, Maas, & McCauley, 2019). This intersection of values and resources provides a unique experience for the members of this diaspora. These interactions inform how survivors will seek support (Few-Demo, 2014; Pitre & Kushner, 2015; Rossetto & Tollison, 2017).

Acculturation

Acculturation, as defined by Berry (2005), is a method of incorporating the values, beliefs, and behaviors of someone's ethnic and dominant societies. This can be applied to new immigrants in understanding the process of cultural identity change that occurs upon arrival in a new society and in interpreting the experiences of second- and third-generation immigrants from communities deeply imbued with cultural values. Indian diaspora in the United States are members of one such community, as they grow up in a third-culture environment where dominant and ethnic communities share continued influence on the individual (Kurien, 2005).

Those who are not first-generation immigrants to the United States often take part in many cultural groups and religious festivals that will provide the unique experience of continuous exposure to their ethnic society while being immersed in a dominant American society (Kurien, 2005). This experience has been interpreted by acculturation scholars as a changing conceptualization of acculturation (Miller, 2007; Miller et al., 2011). Whereas acculturation was often defined as a unidimensional process of assimilation, acculturation is now seen as a bidimensional concept, carrying both the influences of an ethnic society and that of a dominant society (Miller, 2007; Miller et al., 2011). Acculturation in the Indian diaspora would therefore be conceptualized as bidimensional and seen as a unique combination of one's parallel immersion in Indian and Anglo values, beliefs, and attitudes. To conceptualize this combination, Berry's (2005) framework of acculturation (see Figure 1) was used.

Impacts on Support-Seeking

Survivors identify supports based on their understanding of supports throughout childhood and adolescence (Whittaker & Garbarino, 1983). Children, adolescents, and adults who experience sexual violence will seek support from those whom they have already determined are support systems in other aspects of life (O'Connor, Martin, Weeks, & Ong, 2014; Whittaker & Garbarino, 1983). These supports may be informal, such as friends and family, or formal, such as mental health professionals (Orchowski & Gidycz, 2012; Ullman & Filipas, 2001).

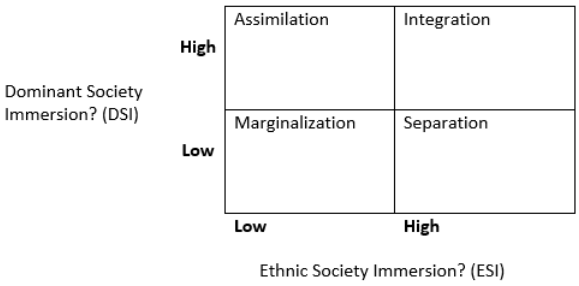

Figure 1. Berry's Model of Acculturation

Many survivors also refrain from seeking support for several different reasons. These concerns include ideas that sexual issues, including assault, are "personal matters," a fear of retaliation, and the survivor's own minimization of the incident (Sinozich & Langton, 2014). Whittaker and Garbarino (1983) further assert that conceptualizing something as a problem is socially constructed. If a person has an experience of sexual violence, but their social network does not define that experience as a problem, this becomes confusing and the survivor may not seek help. There is a need for schema congruence, or understanding of their new experience within their existing constructs of problem identification before a survivor engages in support seeking (Cole et al., 2013; Whittaker & Garbarino, 1983); a survivor will tell supports if it fits a narrative that makes sense for them (Orchowski & Gidycz, 2012).

Support seeking is also influenced by language barriers (Nguyen, 2014; Silove, Steel, Bauman, Chey, & McFarlane, 2007), stigma, and community beliefs towards support seeking. Stigma towards formal mental health services (Miller et al., 2011), combined with a lack of knowledge on how to access mental health supports and what they can provide (Kumar & Nevid, 2010), leads many racially and ethnically minoritized populations to rely on their informal supports (Ullman & Filipas, 2001).

A study conducted by Orchowski and Gidyz (2012) that collected data from college-aged women survivors of sexual violence found that more than 74% of respondents disclosed to someone, most of these being informal supports. Many seek informal support from friends, relatives, romantic partners (Ullman & Filipas, 2001), neighbors, religious figures (Ullman & Filipas, 2001) school figures such as campus authorities (Fisher, Daigle, Cullen, & Turner, 2003; Orchowski & Gidycz, 2012), coworkers, and even acquaintances (Fisher et al., 2003; Gottlieb, 1980; Orchowski & Gidycz, 2012; Whittaker & Garbarino, 1983). The choice of support is influenced by the cultural practices of the immigrant communities and their countries of origin (Montazer & Wheaton, 2011), as well as the resources the survivor has access to

(Shah, Chauhan, Gupta, & Sen, 2016).

Acculturation is one way to conceptualize the gap in affiliation with ethnic culture and understanding of resources in dominant culture (Adam & Schewe, 2007; Vidal & Petrak, 2007). Acculturation impacts how the survivor defines their experience as a problem (Gill, 2004), if they discuss their experience as a problem (Adam & Schewe, 2007), and whether the survivor will seek support for the problem (Shoemaker, 2016). These steps represent many hurdles that impact a survivor's support seeking. Acculturation has also been shown to be a factor in mitigating the effect of sexual violence on the survivor in the sense that people with dominant society immersion (DSI) would be more likely to identify more power in the situation and, therefore, be able to name it (Kumar & Nevid, 2010; McPhail, 2015).

Within Indian culture, there are a few concepts that frame support seeking including beliefs on the origin of struggle, collectivist values, and patriarchal narratives. One belief of the origin of struggle is karma, a central tenet of a few major religions in the Indian diaspora (Padmavati, Thara, & Corin, 2005). Karma says that you have earned what happens to you; sins from past lives manifest in what happens in this life (Kumar & Nevid, 2010; Padmavati et al., 2005). Extant research discusses how this belief is associated with self-blame and belief that a survivor should work through this on their own and a consequent resistance to accessing resources (Aggarwal, Sharma, & Chhabra, 2000; Hoch, 1974; Kakar, 1991; Kaul, 1983; Shoemaker, 2016; Wakil, Siddique, & Wakil, 1981). Specifically, karma translates trauma into a belief that the survivor has done something bad in a past life that warrants this suffering in this current life. Due to this belief, many of those with Indian cultural beliefs decide that they must suffer for those past sins and refuse to seek help (Shoemaker, 2016).

Another central value that affects support seeking is the value of family and collectivism (John & Montgomery, 2012; Pal, 2015). Collectivism is contrary to western individualism and places more importance on the family and community wellbeing than individual wellbeing (Shoemaker, 2016). For Indian diaspora, the "intersection of group expectations creates complex situations producing conflicting forces and behaviors" (Pal, 2015, p. 197). Honor and shame attributed to a female are also reflective on the family, and rape and sexual assault has an additional social stigma attached due to this special nature of the society (Pal, 2015). Scholars assert that the patriarchal community of Indian-Americans denies power to women survivors (Gill, 2004; Sullivan, 2015). This may prevent them from speaking out about their experience (Stanko, 2001).

The Current Study

The patriarchal narratives in Indian culture impact women's sex and sexuality regardless of assault. It is therefore important to consider women's survivor experiences amid these narratives. Acculturation impacts a shift to the values and beliefs of the dominant culture. Though U.S. culture remains patriarchal (McPhail, 2015), its movement towards naming and criminalizing sexual violence is older than that of India's (Sullivan, 2015), and sex education is more prevalent in U.S. culture (Rao, Ismail, Shajahan, & Wylie, 2015). Similarly, mental health is far more stigmatized in Indian diaspora culture than in Western culture (Miller et al., 2011). Thus, acculturation can impact a survivor's understanding of sexual violence and subsequent support seeking. This study was designed to understand the association between acculturation and the support-seeking practices for Indian diaspora sexual violence survivors. As such, the study sought to understand the following research questions:

1. How does acculturation impact the amount of different supports sought by a survivor of sexual violence?

2. How does acculturation impact the type of support (informal or formal) sought by a survivor of sexual violence?

Methods

This mixed methods study focused on the impact of acculturation in the support seeking of women survivors of sexual violence within the Indian diaspora. Feminist theory considers that discourses around sex and sexuality are gendered (McPhail, 2015); therefore, it is critical to consider the gender of the survivor. This study used a cross-sectional survey research design with open-ended questions to access information from a large number of participants and make some generalizable conclusions from the data. This survey research was conducted with a purposive sample (Bhugra, Mehra, de Silva, & Bhintade, 2007). Self-identified women were surveyed across the United States via recruitment on social media and distribution lists. The inclusion criteria were self-identification as a woman, survivor of sexual violence, above the age of 18, and a member of the Indian diaspora. Those who completed the demographic form and did not include an affirmative response to the sexual violence question were excluded. This study was exempted by the relevant institutional review board (IRB), and participants provided informed consent on the online survey.

Participants

Participants were 77 people who self-identified as members of the Indian diaspora and as women. One hundred participants started the survey and 77 participants completed the survey. All missing data were excluded from analyses as missing data were entire sections of the survey. The participants ranged in age from 18 to 43 and represented all

regions of the United States: 20.9% from the South, 16.3% from the West, 10.5% from the Midwest, 50% from the Northeast, and 2.3% from "other." Level of education was also collected. All participants had completed high school; 10.9% had some college, 32% had a bachelor's degree, and 39.3% had a master's degree or more.

Seventy-seven people responded regarding their experiences of sexual violence. Out of these experiences, 72 (93.5%) reported that they had experienced catcalling; 43 (55.8%) shared that they had experienced sexual harassment; 62 (80.5%) shared that they had experienced sexual assault; 22 (28.6%) reported an experience of rape; 16 (20.8%) reported nonconsensual sex; and 3 (3.9%) self-described as having experienced "other." Sixty-five (84.4%) participants shared that they had experienced more than one incidence of sexual violence.

Researcher. The researcher for this study identifies as an Indian American woman. At the time of this study, this researcher was immersed in several Indian American and South Asian American groups for women. The researcher wrote a positionality statement prior to gathering data, which included, "As a member of the Indian community, I have seen people hide their mental and emotional vulnerabilities. I, myself, relied on peers and student affairs professionals for support when I needed it." The researcher, as a member of the community, attempted to mitigate bias; this researcher discussed open-ended analysis with external auditors.

Instruments

Demographics. The survey began with demographic questions to help describe the population. Demographics included age, region of the United States, spirituality, level of education, and gender. The researcher used these demographics to describe the participants because of the current literature on support seeking after experiencing sexual violence. Researchers have shared that faith (Gill, 2004; Pallatino, 2017), level of education (Ullman & Filipas, 2001), and gender (Sullivan, 2015) have impacted the experience of sexual violence in the past. Further, region of the United States and age help to understand generalizability across the Indian diaspora in the United States The demographic questions also asked survivors about the type(s) of sexual violence experienced. This checklist was created based on the definitions of sexual violence from the Rape, Abuse, and Incest National Network (RAINN; 2018).

Stephenson Multigroup Acculturation Scale. The Stephenson Multigroup Acculturation Scale (SMAS; Stephenson, 2000) is a 32-item assessment that approached acculturation from the bidimensional framework of acculturation. The SMAS assesses both the dominant society immersion (DSI) and the ethnic society immersion (ESI) of an individual. This scale was chosen as it is one of the few scales that show norming on South Asian populations and uses a bidimensional framework for acculturation (Celenk & de Vijver, 2011). Also, this scale measures attitudes and behaviors towards dominant and ethnic society. Miller (2007) found that adherence to Asian behaviors explained 30% of adherence to Asian values.

The SMAS is prefaced by instructing respondents how to operationally define "native country" as that from which your family originally came and "native language" as that of the language spoken from where your family originally came. This is contrasted with "Anglo-American" as the dominant society. The assessment consists of statements that respondents must answer as false, partly false, true, or partly true. Such statements include both behavioral and attitudinal questions such as "I regularly read magazines of my ethnic group," "I am informed about current affairs in the United States," and "I feel accepted by (Anglo) Americans" (Stephenson, 2000).

Support Seeking Questionnaire. The support seeking checklist was next in the survey and allowed space for participants to identify the supports or therapeutic activities they sought for their experience with sexual violence. Supports were later dichotomized into groups: informal supports and formal supports. These groups were the categorical dependent variable. The amount of different supports is a dependent variable measured as a count. This counted the number of the total supports sought and was not categorized into formal or informal supports. Thus, the support seeking checklist provided two variables: the categorical variable of "type of support" and the continuous variable of "amount of different supports."

The checklist is an extension of that used by Ullman and Filipas (2001) in their study regarding support seeking behavior of sexual assault survivors. The checklist was formed as a set of yes or no questions so that the survey-taker does not miss one in a list and is, instead, prompted to answer each one. For instance, for the question, "Did you seek support from a parent?" the respondent was able to answer yes or no. This instrument was face-validated by counselor educators, a women's studies and psychology scholar, and an educational psychologist.

Open-ended questions. The open-ended questions at the end of the study were used to help explain results. The researcher used Braun and Clarke's (2006) thematic analysis to understand what may have been relevant to the participants and their experiences of support seeking. This process included the six phases of familiarizing themself with the data, generating initial codes, searching for themes, reviewing the themes, defining and naming the themes, and producing a scholarly report of the analysis (Braun & Clarke, 2006). This latter scholarly report was reviewed by external auditors as an effort towards heightened trustworthiness. As per the use of these questions in Ullman and Filipas's (2001) study, the researcher looked for what themes appeared and

how they connected to support seeking within the theoretical constructs of Feminist Theory. The open-ended questions prompted the participants to expand on their experience of sexual violence, asking "In the time since your experience, what has been the most helpful thing someone has said or done?" "In the time since your experience, what have you wished a particular person had said or done to help you with your experience that they did not do?" and "What coping skills have you used during this process?"

Data Collection and Survey Administration

Data was collected through online surveys to seek a purposive sample of the Indian diaspora in the United States to accommodate for the fact that, regionally, people may have access to different resources. The majority of the Indian-American population resides in the metropolitan areas of New York, NY; Washington, D.C; Chicago, IL; and the Bay Area of California (Skop & Li, 2005). The sample was distributed via social media and, more specifically, Indian cultural organizations across these four areas.

A Power and Sample Size tool was used to gather a sample size needed to conduct the necessary statistical analyses to understand the recruitment needs. To attain a power of .9 with α =.05, at least 68 participants were needed to conduct the necessary data analyses. One hundred respondents started the survey, and a total of 77 participants completed the survey materials.

Data Analysis

Data analysis for the quantitative portions utilized SPSS v25. The main variables researched in this study are acculturation, the independent variable, and support seeking behavior, the dependent variable. Acculturation was a categorical variable and determined by the participants' answers on the demographic survey and by their scores on the SMAS (Stephenson, 2000). Participants were divided into marginalized, separated, assimilated, and integrated acculturation types. These groupings were based on their scores on the ethnic society immersion and dominant society immersion subscales on the SMAS. Assimilation is shown with a high DSI and low ESI. Separation is shown by a high ESI and low DSI. Marginalization is shown as low ESI and DSI, and finally, integration is high ESI and DSI scores. Accordingly, the participant's scores on the SMAS will place them into a category of acculturation.

To understand the amount of support seeking by acculturation type, data were tested for normality assumptions. As the data did not meet the assumptions for homogeneity of variance, a non-parametric Wilcoxon Signed Rank was used to analyze the data and understand the relationship between the mean amount of support seeking for each acculturation type. Between group differences of the type of support seeking and acculturation were then assessed using Chi-Square Test for Independence. The social science standard of α =.05 was used order to determine significance in all analyses.

For the open-ended questions, the researcher coded responses with regard to Braun and Clarke's (2006) thematic analysis. After familiarizing herself with the data, the researcher identified and coded meaning units within participant responses. Then, the researcher compared and grouped codes into themes in accordance to the research questions (Braun & Clarke, 2006), while minding the constructs of power and discourse in feminist theory. The researcher used external auditors to review the themes to mitigate bias.

Results

Acculturation and Support

The hypothesis was that integrated and assimilated acculturation types, with higher DSI, will seek more support. The scores from the SMAS were calculated according to ESI and DSI and the participants were placed in the categories of acculturation types. These can be seen in relation to Berry's (2005) model in Figure 2.

The data failed the homogeneity of variance tests, so I pursued nonparametric testing of the variable of DSI against that amount of support. The Wilcoxon signed rank test delivered Z = -7.631, p < .00, showing a statistically significant difference in the mean amount of support sought as divided by low and high DSI, and also delivered Z = -7.626, p < .00, showing a statistically significant difference in the mean amount of support sought as divided by low and high ESI.

The non-parametric comparison of means also shows that there is a significant difference in amounts of support sought in respect to level of dominant society immersion (see Figure 3). These analyses keep with the hypothesis that acculturation types with greater dominant society immersion—integrated and assimilated—will access more support. It further adds to that hypothesis by showing that those with high ethnic society immersion will also access more support. The nonparametric tests show that those integrated acculturation types, with both high ESI and high DSI, access slightly more support, on average, than those with either high ESI or high DSI.

Type of Acculturation v Type of Support Sought

The original hypothesis was that DSI would interact with the type of support sought and show a difference in those participants with high DSI levels will seek more formal and informal supports, and that those with low DSI will seek only informal supports. To understand this, types of support (Table 1) were divided into informal, including family, teachers, and friends, and formal, including counseling professionals (Table 2). Berry's (2005) acculturation types distinguish between low and high DSI, as the Chi-Square Test resulted in no significant interaction, $\chi^2(1) = 3.055$, p

=.081 found between acculturation by high and low DSI and formal support seeking. There was no difference in formal support seeking between those with low and high DSI.

Open-Ended Questions

Of the participants, 41 completed the open-ended responses. Data analysis of the qualitative data used thematic analysis (Braun & Clarke, 2006). The participant responses fell into themes of patriarchal narratives, control, mental health and collectivist values. These responses help to provide insight into the data.

Table 1
Frequencies of Types of Support Sought

Support Type	n	%
Mother	15	19.5
Father	7	9.1
Sibling	18	23.4
Friend	50	64.9
Grandparent	1	1.3
Professor/Teacher	7	9.1
School Counselor	12	15.6
Mental Health Professional	19	24.7
Family Friend	7	9.1
Cousin	13	16.9
Online Community	14	18.2
Journaling	19	24.7
Art	10	13

Table 2
Frequencies of Categories of Support Sought

Support Category	n	%
Neither	19	24.7
Formal only	1	1.3
Informal only	36	46.8
Both	21	27.2

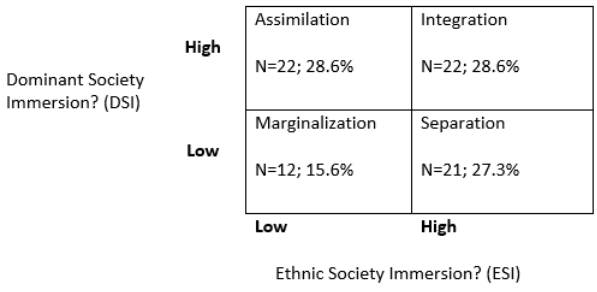

Figure 2. Frequency of Acculturation Types (n = 77)

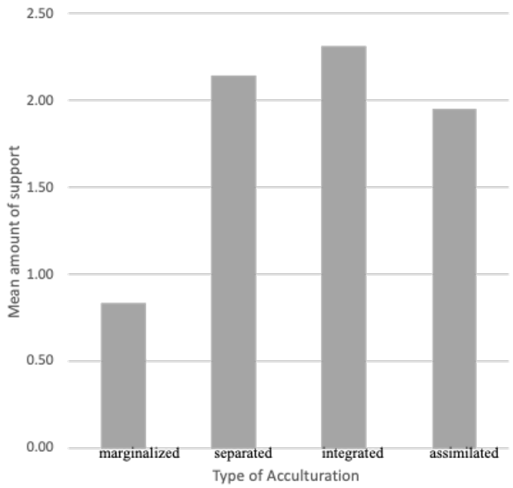

Figure 3. Mean Amount of Supports Sought x Type of Acculturation

Patriarchal narratives. Some respondents reported messages that reflect the patriarchal and rape culture that pervade the United States (Gill, 2004; McPhail, 2015; Sullivan, 2015). Among these messages were reflections that it was "not a big deal," particularly that it was "not severe," or that it "happens a lot." Participant 30 shared "The situation did not make me feel it was a severe or urgent."

One participant shared that her female friend had immediately jumped into what she, the survivor, should have done differently. Participant 13 shared:

> I wish at the moment when I opened up, my friend had just said that it was a horrible thing that person did instead of talking about how I should have handled the situation. It was well-intentioned advice, and advice I needed, just not at that moment.

The supporter was trying to provide the survivor with more power by providing advice on how to proceed with help, but the supporter was inadvertently taking away the survivor's power by saying that she must fulfill certain roles to feel safe in her environment.

Control. A few of the participants discussed their need to control things to be able to feel power within themselves. For example, Participant 34 claimed they tried to "control as many things in my life as possible." Participant 23 shared, "When I reflect on my childhood, because I never discussed what happened in detail with anyone until I got older, I believe I coped through playing competitive soccer." Another way that participants shared attempts to control was by blocking out the experience or trying to compartmentalize. Participant 1 reported, "I block the whole memory out." Similarly, Participant 8 reflected, "I've done a very poor job

coping with these experiences, I guess just avoiding thinking about it." Participant 29, who shared this, also shared that this form of control was not healthy and is often difficult.

Mental health. Some respondents who shared their support seeking experience with their parents reported that their parents blamed them, not unlike the concerns of survivors in India (Sullivan, 2015). Participant 16 shared that she wished her parents "allowed me to fully be open about it and not blamed me." Some parents cited their attire or behavior. Participant 18 shared, "My parents blamed me for how I was dressed as if it was the reason someone was tempted. My mother would reference this incident as a threat thereafter, any time she thought I wasn't dressed 'appropriately.'" Participant 9 reflected on her mother's reaction, sharing, "I wish my mom had told me that it wasn't my fault and that I wasn't bad because of what happened." In this case, the participant's mother suggested that she deserved this incidence of sexual violence.

Some participants shared that their parents might not have had an outwardly negative reaction, but that they wished their parents had done more to find a mental health provider. Participant 23 shared:

> I wish my parents had talked about what happened with me as a child (after the incident, it was never discussed for nearly 20 years until I brought it up around the time of the #metoo movement). Additionally, I wish they had sent me to therapy as a child to help me process what happened.

These behaviors, or lack thereof, are consistent with the stigmatization of mental health services in Indian society.

Some participants shared positive experiences with mental health. Participant 38 shared, "I went to therapy. Through therapy, I learned ways to cope with symptoms of PTSD." Similarly, Participant 7 shared things that helped including, "talking through issues with friends, trusting them. Therapy more recently." Participant 77 shared, "My sister suggested therapy, which has helped a lot in coping with the trauma." This was a unique mention of a family member directing the participant to therapy.

Collectivist values. Participants shared that their experiences transcended into their family, reflecting collectivist values (John & Montgomery, 2012; Pal, 2015) . Participant 34 shared about her disclosure to her mom: "I wish my mother would not continue to make it about her when I bring it up to her." This is consistent with some of the characteristics of collectivist culture.

Multiple respondents reported that their parents could have done more to support them. Some elaborated and shared ways that the collectivist mentality that their parents used had further harmed them. A particularly haunting example of this was a response from Participant 1 who shared, "I wished my parents had done more to keep me away from the pedophile," as the pedophile was in their cultural community. Similarly, Participant 23 shared, "I wish they had chosen to sever ties with the perpetrator's family, they still remain close friends [with the perpetrator's family] to this day." Some shared that their family did not believe that the perpetrator would have done what they did. These actions are detrimental to a survivor's healing process and take away a safe space for the survivor (Relyea & Ullman, 2013).

In a few cases, the collectivist values helped to empower the survivor. Participant 76 shared, "it takes a victim to know a victim," as they shared using their experience to support other survivors. This collectivist value of community uses the survivor experience to help the community.

Discussion

This study worked with a limited final sample of 77 participants which all had higher education and access to the internet for an online survey. The discussion is couched within this context. Suggestions may not be generalized to those members of the diaspora who have not experienced higher education and may be of lower socio-economic status, accordingly. The study also looked at self-identified women, and is not representative of the experiences of men and those who do not identify within the gender binary.

Acculturation and Amount of Supports Sought

The non-parametric Wilcoxon signed rank test that observed amounts of support sought by ESI and DSI showed that there was a significant difference in amounts of support sought when compared across ESI and DSI. Those with low ESI and DSI—marginalized acculturation types—access fewer supports. This may be a result of those in the marginalized categories reporting lower immersion in both their ethnic and dominant societies. The people in this category might therefore have low engagement with the members of these two groups, limiting their access to support overall which, consequently, limits use of support.

Berry (2005) describes those with marginalized acculturation types as "when there is little possibility or interest in heritage cultural maintenance (often for reasons of enforced cultural loss), and little interest in having relations with others (often for reasons of exclusion or discrimination)" (p. 705). Those participants who had marginalized acculturation types, therefore, would have had little involvement with the dominant or ethnic societies. This may have led to a dearth of potential supports available in the event of an experience of sexual violence.

Acculturation and Formal Support Seeking. The analyses showed that there was no interaction between dominant society immersion and the types of support sought. Both those with high and low DSI scores are likely to seek formal and informal supports. This is contrary to previous studies

that report immersion and increase the behaviors that align with the values of the dominant society, and thereby reducing the stigma within the ethnic societies that prevent seeking formal sources of support (Kumar & Nevid, 2010; Miller et al., 2011; Robertson, Nagaraj, & Vyas, 2015).

The study results cannot confirm why this is, but recent literature may provide some clarification. This lack of difference may be due to increased discussions about sexual violence in the media. For example, the discussions with #MeToo and #TimesUp also increased exposure to resources such as RAINN, and the common use of the hashtags on social media may have increased exposure about who might be able to empathize with a survivor's situation (PettyJohn et al., 2019). These movements, as they were on many different social media platforms and news sites, may have exposed these resources to the span of acculturation types, regardless of the person's immersion in the dominant society.

Support Seeking

A percentage of the participants, 24.7%, shared that they did not seek any support for their experiences of sexual violence. This can be compared to Ullman and Filipas's (2001) study in which just 13% of survivors never sought support for their experiences. Their sample consisted of 323 survivors, which is 3.75 times the population observed in this study, with a mean age of 30 and 50.2% being college-educated. The sample in this study was slightly younger (mean age of 28) and more educated (98.8% being college educated), but nearly twice the percentage of participants shared that they never sought support.

In Ullman and Filipas's (2001) sample, only 5.7 percent were described as Asian. "Asian" ethnicities were not delineated; it is unknown if the sample represented any of the Indian diaspora at all. Another notable difference in the sample is that catcalling, and harassment were not included in the descriptors of sexual violence. As rape culture normalizes these two forms of violence (McPhail, 2015), it is possible that this contributed to the marked difference in support seeking.

The findings from the two studies can be contrasted with these differences in mind. This differential is jarring; it shows that survivors in the Indian diaspora are less likely to seek support than those in the general population. The cause of this differential is unknown, but it may be attributed to the type of sexual violence experience. Whereas this study had 27.9% of respondents who disclosed experiencing rape, the rate of rape in Ullman and Filipas' (2001) study was higher at 85.9%. Physical injuries such as contusions, bruising, and bleeding that can occur in rape lead to more emergency room visits, which, in turn, lead to higher support seeking (Ullman & Filipas, 2001). It is possible that the participants in this study did not feel the same severity and therefore did not seek support to the same extent as that in Ullman and Filipas (2001). This may also be a reflection of the underreporting documented in Indian society; support seeking is not a cultural norm and therefore, Indian diaspora in the US may also refrain from reporting and receiving social support (Murugan, 2017).

Another possible explanation is to conjecture, based on the literature, that two main factors might contribute to these differences: sexual taboos and patriarchal messages within the culture. Discussion of sex is taboo in Indian culture (Rao et al., 2015). This taboo affects discussions about relationships, which, in turn, may prevent those that experience sexual violence within intimate partnerships to seek support (Aggarwal et al., 2000; Guilamo-Ramos et al., 2012). Those who experienced sexual violence outside of intimate relationships may still fear repercussions of seeking support because they would have to use words relating to sex, which are still not normalized within Indian culture (Rao et al., 2015).

Patriarchal messages pervade Indian culture (Sullivan, 2015). McPhail (2015) argues that patriarchal messages often blame the survivor when they experience sexual violence. Johnson and Johnson (Johnson & Johnson, 2017) echo this in the messages regarding rape culture and a normalization of sexual violence. Both of these are pervasive in Indian culture (Adam & Schewe, 2007). Indian culture also emphasizes that women's experiences influence the reputation and honor of the family (Wakil et al., 1981). Women in the Indian diaspora, especially, may hear messages of blame in their cultural atmosphere, and then may refrain from seeking support for any experiences of sexual violence.

Gender

The respondents cited both men and women as sources of informal support for their experiences of sexual violence. The men identified were also identified as the survivor's siblings. Seventy-three percent of the gender supports identified were women. This is consistent with Orchowski and Gidyz's (2012) observation that the majority of women who disclosed turned to female supports.

It is powerful to note that many of the survivors (26.5%) identified seeking support from brothers, male friends, and male professors/teachers. The current #MeToo and #TimesUp movements have spurred men-driven movements of their own, including #HowIWillChange and #ImWithHer (PettyJohn et al., 2019). These dialogues have advertised men making an effort to understand the experiences of women in a patriarchal culture. Not all of the responses to these hashtag movements have been positive, but these movements show women how men might make an extra effort to listen to them and believe their experiences (PettyJohn et al., 2019).

Implications and Conclusions

Limitations

The study was impacted by a limited view of acculturation. Literature and instrumentation have focused on attitudes and behaviors and have rarely extended to measure psychological acculturation. These place a limit in using reliable acculturation instruments and may impact how those in counseling and psychology understand acculturation as it pertains to these fields. Thus, the results are not reflective of the nuances of psychological acculturation. Further, the SMAS was created in 2000 and has not been updated. This means that many of the behaviors discussed in the tool are not inclusive of culture after the introduction of social media.

Additionally, the sample size in this study was 77 participants. In the Chi-Square Test to assess differences in support type by acculturation type, the p-value was .081, indicating that a larger sample might provide different results. Another limitation is the sampling, itself. Participants were recruited via email distribution lists and social media, and the survey itself was online. This provides limitations to access for survivors that may not have access to a computer, are not part of any organizations that have distribution lists and lack social media accounts. The participants are likely more internet savvy and therefore have access to more resources.

Implications for Counseling

The open-ended responses shared some explanations for the support seeking behavior as well as methods that survivors accessed for coping. The responses showed themes of power. This power is reflected in system-level issues of patriarchy and rape culture and individual-level issues of their own power and control. The researcher used constructs of feminist theory to reflect upon the responses.

Power was reflected in two ways. Participants reflected power in patriarchal narratives by openly discussing or exhibiting discourse related to rape culture. Others discussed power as something they have attempted to regain since their experience of sexual violence. Power is an underlying aspect of sexual violence (McPhail, 2015) and can impact how a survivor views and copes with their experience (Relyea & Ullman, 2013).

Relationship between types of support. The study asked for referral sources for those that sought mental health resources for support. This was not quantitatively measured and therefore is a suggestion based on the open-ended responses rather than based in the statistical analyses. Most of the responses named informal supports as critical to their accessing mental health providers. One participant specifically cited their sister as bridging her to a crisis center and consequent mental health provider. This bridge is indicative of the impact that informal supports have in a survivor accessing more formal services and shows how informal supports might mitigate some of the rape supportive narratives that come from a patriarchal society (McPhail, 2015). This is also reflected in Ullman and Filipas's (2001) findings.

Suggestions for counseling. It is suggested that mental health clinicians understand their communities and conduct more outreach with communities so that informal supports are better informed of what formal supports exist. This is based on the responses from the open-ended section of the survey. In the situation described above, the survivor's sister was a trained crisis responder. Bystander prevention programs and peer sexual violence advisor programs can be critical to having members of the community understand how to respond to a disclosure of sexual violence and how to refer the clients going forward. This is reinforced in the many women that responded to the open-ended questions that they wished somebody had referred them for counseling services, and many others confessing that they have not been coping in a healthy manner and could benefit from provision of mental health services.

Alternatively, participants also shared negative reactions from parents. This may impact the counseling process in two distinct situations: a) the client is a minor and survivor of sexual violence and b) the client is an adult survivor of sexual violence and part of a collectivist culture. In the first instance, the counselor may prepare the client and family for discussions around the sexual violence. This will include psychoeducation and deconstruction of sexual scripts (Rossetto & Tollison, 2017) with the parents and anxiety management with the child. In the latter instance, counselors may assume that their adult client is not impacted by parental beliefs, however, collectivist cultural values increase the impact of parents' thoughts and worldviews on client's healing (John & Montgomery, 2012; Pal, 2015). Specifically, the language around sexual violence in Indian culture could mean that the client experiences victim-blaming and shaming from their parents that impacts their own self-concept (Gill, 2004; Pal, 2015; Sullivan, 2015). Counselors may want to directly ask the client about their family point of view and work with the client in creating safety plans and healthy boundaries around the discussion of their experience of sexual violence. The counselor may even offer space to conduct sessions for the client to discuss their experience of sexual violence with their parents in the context of the supportive space of a counseling session.

Sexual Education and Wellness. The participants in this study sought supports largely from female friends, not family, possibly due to the taboo in Indian culture around sex and sex education (Rao et al., 2015). This taboo impacts the sexual scripts used by survivors as they describe their experience (Rossetto & Tollison, 2017). Thus, counselors can focus sessions around sex education and discussion around consent, sexual wellbeing, and sexuality. In fact, the counselor may want to practice using words for genitalia, etc,,

that may have been taboo to the client (Rao et al., 2015). Recent movements around #MeToo can also be helpful and integrated into the counseling space. For instance, a counselor might offer clients homework to find social media posts that share their experience and, in turn, supportive people outside of therapy.

Implications for Future Research

The open-ended responses in this study suggested that, rather than acculturation, collectivist values and patriarchal narratives influenced the support sought by survivors within the Indian diaspora. This was observed in the open-ended responses from the survivors. Further research should explore these constructs and how they impact or relate to the support that survivors receive.

This research should not be representative of all minority groups. Cultural values are diverse and unique. The survivors from these groups should be assessed as such and should have the opportunity to share their experience to inform the counseling community about their needs. Similar research can also be repeated with other immigrant or ethnically minoritized communities.

This research was a broad exploration into acculturation and support seeking. The data showed that acculturation has some impact on amount of support sought; however, it did not go in-depth to understand the phenomenon of acculturation in how each survivor understands the supports around them, receives messages regarding their experience, and then seeks support from their community. This research can be better followed up by qualitative phenomenological inquiry into the experience of survivors of sexual violence within the Indian diaspora.

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Disordered Eating and Risky Sexual Behaviors in College Women

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Disordered eating (DE) can negatively impact college students' psychological and physical health; it is crucial to understand DE and its connection to other disruptive and co-occurring disorders. This study investigated if DE behaviors increase the probability of one such issue, risky sexual behaviors (RSB). Participants included 240 single female college students. Multivariable logistic regression analysis indicated a positive correlation between DE and RSB, wherein 44.65% engaged in both DE and RSB ($p \leq 0.001$). Compared to students who did not engage in DE, those who did had 3.42 times higher odds of engaging in RSB. Implications are provided for college campuses.

Keywords: disordered eating, risky sexual behavior, college women, mental health

Introduction

With the prevalence of disordered eating (DE) negatively impacting college women's psychological and physical health, it is crucial to understand DE in relation to other co-occurring mental health disorders. One such example explored in this study are risky sexual behaviors (RSB), as these behaviors are prevalent and inherently threatening to college women's well-being. RSB increases a student's chances of unplanned pregnancy, STIs, and dropping out. To add to the existing literature and build awareness of co-occurring issues that clinicians may encounter when working with college women, this study investigated whether DE behaviors increase college women's probability of engaging in RSB.

Disordered Eating: Prevalence and Health Effects

In 2018, an estimated 16 million people of all ages and genders met clinical criteria for an eating disorder (ED; Our World Data, 2018), and many more cases are unrecorded or sub-clinical. ED's have the highest mortality rate of any mental disorder (Smink, van Hoeken, & Hoek, 2013), are comorbid with mood disorders (Ulfvebrand, Birgegård, Norring, Högdahl, & von Hausswolff-Juhlin, 2015), and severely impact a person's quality of life (Solmi, Hatch, Hotopf, Treasure, & Micali, 2014). ED's are most prevalent in college students (Volpe et al., 2016), making intervention during young adulthood a critical period (Liechty & Lee, 2013).

Eating disorders include, but are not limited to, Anorexia Nervosa, Bulimia Nervosa, and Binge-Eating Disorder. According to the Diagnostic and Statistical Manual of Mental Disorders (DSM; American Psychiatric Association [APA], 2013) Anorexia Nervosa (AN) includes restricting intake resulting in lower body weight, extreme fear of gaining weight, body image disturbances, and denial of seriousness of low body weight (APA, 2013). Bulimia Nervosa (BN) criteria include eating large amounts of food within a short, two-hour period and then participating in compensatory behaviors such as vomiting, laxatives, exercise, or diet pills to expel the food or calories; these behaviors are influenced by body shape and weight (APA, 2013). Binge-Eating Disorder (BED) includes recurring episodes of eating larges quantities of food in a short period of time, often rapidly and in secret; these behaviors are often associated with a lack of self-control and subsequent shame (APA, 2013). It is important to understand eating disorders, as disordered eating behaviors are a sub-clinical version of these disorders.

Disordered eating (DE) is characterized by unhealthy weight control behaviors similar to AN, BN, and BED but the symptoms do not meet full criteria for an ED. DE behaviors can include dieting, using laxatives, diuretics, excessive physical activity, purging after meals, liquid diets,

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fasting, searching weight-loss techniques, and using weight-loss program. In the DSM (APA, 2013), Other Specified Feeding or Eating Disorder may be applied to those who participate in disorder eating behaviors. DE is considered a precursor to ED behaviors and can result in significant mental distress that can negatively impact psychological and physiological well-being, particularly for college students (Galmiche, Déchelotte, Lambert, & Tavolacci, 2019). This study will focus on DE behaviors, as the authors hope to contribute to the prevention and early intervention of those behaviors before they evolve into diagnosable ED's.

It is no secret that college women are susceptible to comparing themselves to the public figures whose presences amass social media outlets (Perloff, 2014) and those who surround them on college campuses. This comparison, namely to the ideal beautiful body, leaves little room for flaws; yet, this expectation of perfection is far from obtainable. This quandary, however, does not keep young women from trying to obtain the perfection that amasses social media (Fardouly & Vartanian, 2015) and whose presence can seem predominant on college campuses. These social comparisons on social media and on college campuses can have a negative impact on women's self-esteem and body image and can influence DE behaviors.

In a 10-year longitudinal study following 2,287 adolescents to college (Neumark-Sztainer, Wall, Larson, Eisenberg, & Loth, 2011) found that over half of the female adolescents who exhibited DE behaviors in adolescence carried them into adulthood. Solmi et al. (2014) also found that people with DE have higher odds of experiencing anxiety, drug-use, alcohol abuse, and suicidal ideation. DE is commonly associated with dysfunctional weight concerns, feelings of weight importance, depressive symptoms, and body dissatisfaction (Loth, MacLehose, Bucchianeri, Crow, & Neumark-Sztainer, 2014). Such symptoms are significantly connected to lower self-esteem and the desire to attain a more aesthetic body shape (Laporta-Herrero, Jáuregui-Lobera, Barajas-Iglesias, & Santed-Germán, 2016). This body surveillance and preoccupation with weight can take time away from life accomplishments, maintaining social relationships, feeling a sense of belonging, and thriving in work and school (Ackard, Richter, Egan, Engel, & Cronemeyer, 2013). Physically, underweight and overweight bodies (a) experience higher strain on cardiovascular, gastrointestinal, neurological, and endocrine systems; (b) report lower health-related quality of life (Ágh et al., 2016); and (c) report lower GPA, energy, and concentration (Maroto, 2013).

DE Behavior: Diet Pills and Liquid Diets. Dieting is a prevalent kind of DE behavior. In a study assessing dieting patterns among adolescents and young adults, Liechty and Lee (2013) found that 27% of women and 11% of men reported dieting to lose weight in young adulthood. Dieting is a broad reaching term that encompasses any behavior used to reduce body weight, including the use of diet pills or maintaining liquid-only diets. Diet pills are associated with increased heart rate, blood pressure, kidney problems (Weissman, 2001), and are considered a form of DE. In a 10-year longitudinal study on DE, Neumark-Sztainer (2011) considered diet pills an extreme form of weight control behavior. Likewise, liquid diets (or substituting with liquid meal replacement) are also categorized as DE.

DE Behavior: Laxatives and Vomiting. Laxatives and vomiting are considered DE purging compensatory behaviors that mimic the psychopathology found in ED. Numerous studies have categorized compensatory behaviors, such as laxative and self-induced vomiting, as a form of DE (Greenleaf, Petrie, Carter, & Reel, 2009; Neumark-Sztainer et al., 2011; Stephen, Rose, Kenney, Rosselli-Navarra, & Weissman, 2014; Kelly-Weeder, 2010). Furthermore, the American College Health Association–National College Health (ACHA) Assessment II (2013), which collected data from 289,024 students across 223 U.S. universities, categorized these behaviors as DE. The official ED Diagnostic Scale (Stice, Fisher, & Martinez, 2004) also includes laxative use and self-induced vomiting as disordered eating behaviors. Finally, Stephen et al. (2014) and Weeder et al. (2010) found that college students who participate in these behaviors perceive themselves as overweight, report higher depression scores, and lower self-esteem.

DE Behavior: Excessive Physical Activity. Compared to other compensatory behaviors, exercise is considered a part of a healthy lifestyle, which complicates the symptom. Exercise becomes disordered when exercise is used with the deliberate intent to lose weight or maintain weight-loss. Among college students, exercise is the most common weight control method, with nearly 73% of students reporting exercising to lose weight (Kelly-Weeder, 2010); this is particularly prevalent among college athletics. Among 204 college athletes, 25.5% showed signs of DE and were more likely to use exercise as a means of controlling body weight over other DE behaviors (e.g., vomiting, dieting, using laxatives, or diuretics; Greenleaf et al., 2009).

DE Behavior: Fasting. Restricting caloric intake to levels below energy requirements through fasting, skipping meals, or reducing portion sizes is a common DE behavior (Schaumberg & Anderson, 2016) prevalent among college students. A study measuring DE among college students (n=526), found that nearly 23% used fasting as a means to lose weight (Kelly-Weeder, 2010). Dietary restrictions such as fasting are considered to be a significant risk factor in the development and maintenance of DE behaviors and associated cognitions (Puccio, Kalathas, Fuller-Tyszkiewicz, & Krug, 2016; Stice, Davis, Miller, & Marti, 2008). Stice et al. (2008) found that fasting is a stronger risk factor for bulimic pathology than self-reported dieting, and Puccio et al. (2016) found fasting behaviors increase disordered binging

behaviors. Fasting, when not associated with cultural norms or traditions, is a form of DE that, if left untreated, may develop into a diagnosable ED (Schaumberg & Anderson, 2016).

DE behaviors such as dieting, purging, excessive exercising, or fasting pose a threat to the well-being of college students. With the prevalence and negative outcomes associated with DE, it is incumbent upon mental and medical health care professionals to assess not only DE among students, but also be mindful of other behaviors and mental health symptoms that might negatively impact well-being. One example that is also prevalent among college students includes Risky Sexual Behaviors (RSB). RSB can increase a student's chances of contracting adverse diseases and negatively impact physical and mental health (Fischer & le Grange, 2007; Ramrakha, 2000). As such, it is important for university health providers to understand, assess, and intervene with students participating in RSB. While there are risks associated with all genders, the primary focus of this study is college women; as such, the associated risks are framed specifically as they relate to women.

Risky Sexual Behaviors: Prevalence and Mental & Physical Health Effects

RSB are prevalent among college women and have the potential to induce unwanted consequences to a student's mental health, physical well-being, and parental status. In 2016, the Centers for Disease Control and Prevention (CDC; 2016) found that nearly half of the 20 million people diagnosed with sexuality transmitted infections (STI) each year are young people aged 15–24 years, many of which come from college students who underestimate the severity of risky sex (CDC, 2016). Additionally, nearly one in 10 dropouts among female students are because of unplanned births (Prentice, Storin, & Robinson, 2012). RSB can include having sex under the influence of drugs or alcohol, exchanging sex for money, participating in sexual acts without contraception or with inconsistent use of contraception, contracting STIs, using the morning-after pill, and abortion. These behaviors and outcomes are shown to have a negative impact on a person's mental and physical well-being and may be more prevalent among those with a previous psychiatric diagnosis (Bennett, 2000).

RSB: Sex Under the Influence of Drugs and Alcohol. Researchers continue to report that adolescents in the U.S. comprise approximately 50% of all new STI cases each year (Shannon & Klausner, 2018; Weinstock, Berman, & Cates Jr, 2004). Substance use has been associated with increased STI risk (Swartzendruber, Sales, Brown, DiClemente, & Rose, 2013), and has been widely correlated to disinhibiting decision making (Yan, Chiu, Stoesen, & Wang, 2007). Bryan et al. (2007) noted that women were more likely to report using alcohol prior to engaging in RSB and Hayaki et al. (2018) found the presence of alcohol and marijuana increased a woman's chance of engaging in condomless sex by 3.39 times. Brown et al. (1997) has long understood that co-occurring clinical disorders (i.e., ED) increase a person's chance of substance use related RSB.

RSB: Sexual Exchange for Money. In addition to drugs and alcohol, sex in exchange for money can also be considered an RSB. There is a historical propensity for sex workers to experience physical violence and unwanted pregnancy. While there has been a considerable shift in culture and stigma surrounding sex in exchange for money, the World Health Organization (WHO) defines violence against sex workers (or people who exchange sex for money) as physical, sexual, and emotional violence. Physical violence can result in death or injury; sexual violence can include degradation, rape, gang rape, or sexual harassment; and emotional violence encompasses humiliation, belittlement, or being threatened (World Health Organization, 2013). Sex work has also been linked to unwanted pregnancy, abortion, and increased risk of contacting human immunodeficiency virus (HIV), STIs (Jewkes, Dunkle, Nduna, & Shai, 2010) as well as depression, anxiety, substance abuse, and PTSD (Golding, 1999), all of which are common co-occurring disorders among ED's (Ulfvebrand et al., 2015). Edwards, Irtani, and Hallfors (2006) reported that 3.5% of young women had exchanged sex for money and that 20% of those women had been diagnosed with an STI. Roberts et al. (2010) added that between 3.5% and 11.1% of participants in their mixed methods study reported likelihood of participating in the sex industry to pay for their college education, if needed.

RSB: Inconsistent or Absent Contraception & STIs. In addition to sex work, inconsistent or absent contraception is also considered RSB. Recent estimates in the U.S. indicate that 51% of all pregnancies are unplanned and are highest among women 18–24 years old (Finer & Zolna, 2014). Only 5% of unplanned pregnancies are due to contraceptive failure, while the remaining 95% occur among women who do not, or inconsistently use contraception (Gold, Sonfield, Frost, & Richards, 2009). Research indicates that attitudes, behaviors, and intentions toward STI testing indicate a favorable and positive shift, with more people indicating social acceptance, self-efficacy, and confidence in being tested (Martin-Smith, Okpo, & Bull, 2018). The CDC urges that consistent and correct use of latex condoms and continued testing can reduce the risk of STIs and HIV (CDC, 2013).

RSB: Morning-After Pill and Abortion. The use of medication designed to prevent pregnancy after unprotected sex is an indicator of RSB. Medications, such as the morning-after pill, have been linked to an increased chance of a woman having STIs (Wood, Drazen, & Greene, 2012). The misuse of medication like the morning-after pill has also been linked to relapse among people who struggle with bulimia, anorexia, and depression (Population Research In-

stitute, 2004). Along this same line, abortion is also considered another indicator of RSB. Research indicates that the majority of abortions are linked to unplanned pregnancies that stem from RSB (Alan Guttmacher Institute, 2006) and that high rates of abortion have been correlated with increased drinking and lower socioeconomic status (Abdala et al., 2011); both increase RSB and lower contraceptive use (Dehlendorf, Rodriguez, Levy, Borrero, & Steinauer, 2010). Statistics remain consistent, as the CDC (2018) reported that women in their twenties account for the majority (57.7%) of abortions in the U.S. and most women who receive abortions (83%) are unmarried and 33% of abortions are performed on college-aged women 20 to 24 years old (Jones, Darroch, & Henshaw, 2002).

With the prevalence of DE and RSB among college women, and the negative impact these behaviors can have on women's physical and mental health, it is necessary to investigate the relationship among these variables in order to provide recommendations and inform best practices for clinicians and campus health professionals.

Purpose and Hypothesis

Disordered eating behaviors (i.e., using diet pills, liquid diets, purging, excessive physical activity, fasting) and risky sexual behaviors (i.e., participating is sex under the influence of drugs or alcohol, exchanging sex for money, inconsistent or absent contraception, use of the morning-after pill or abortion) have the potential to induce unwanted consequences, yet are common behaviors among college women. Such behaviors can impact students' academic success, physical health, and mental well-being. While several studies have independently examined DE and RSB among college students, there are no known studies assessing whether DE behaviors increase co-occurring RSB among college women. To add to the literature and build awareness of the co-occurring issues clinicians may encounter when working with college women, this study investigated whether DE behaviors increase college women's probability of engaging in RSB. Based on the literature, we hypothesized that DE and RSB will be statistically significantly positively correlated among single college women.

Methods

Instrument

Data was used from a comprehensive health behavior survey—Our Campus, Our Health (OCOH)—delivered at a mid-sized university in the Southeast. OCOH is a 92-item instrument modified for the college population from the CDC's Youth Risk Behavioral Surveillance System (YRBSS) for high school students. Given the change in population, efforts were made to ensure validity and reliability by conducting cognitive interviews with college students, pilot testing the instrument, and having a panel of content experts annually review the respective health sections. OCOH measures health behaviors related to mental and emotional health; sexual health; alcohol, drug, and tobacco use; access to healthcare; nutrition and food security; and skin and sun safety.

Procedures

A random sample of undergraduate and graduate students at the institution received an email invitation to participate in the voluntary self-administered survey online over a four-week period during the fall semester. The survey was delivered through Qualtrics Survey Software (Qualtrics, Provo, UT) by the Institutional Research Office as directed by the IRB to protect participant privacy. All responses were de-identified prior to analysis.

Participants

The current study used OCOH data collected in 2014; a total of 770 responses were collected. A total of 79 participants were excluded from the analysis due to missing data. A total of 176 male participants and a total of 275 female participants who were married or in a committed relationship were excluded from the analysis, resulting in a final sample size of 240. The sample size can detect at least a 1% difference in proportions with a power of at least 0.8 using a 2-sided test and a 5% type I error (Hsieh, Bloch, & Larsen, 1998; Katz, 2011).

Measures

The primary independent variable was disordered eating behavior. A total of six items that were previously identified in the literature as being associated with DE were used to develop a composite score. The six items were assessed using the following question: "which of the following methods have you used to lose weight?" Options included: laxatives, diet pills, increased physical activity, vomiting after meals, liquid diets, and fasting. Answer options included "No" and "Yes." Any "Yes" response indicated participants' engagement in DE behavior and all "No" responses indicated a lack of engagement.

The primary outcome variable was risky sexual behavior. A total of nine items that were previously identified in the literature as being associated with RSB were used to develop a composite score where any "Yes" response indicated participants' engagement in RSB and all "No" responses indicated a lack of engagement. One item was reverse scored to be consistent with the negative direction of all other questions. The nine items were assessed using the following questions: "Have you used a preventive method when engaging in any type of sexual behavior?"; "The last time you had sexual intercourse, you or your partner did not use a condom?";

"The last time you had sexual intercourse, were you under the influence of any drugs/alcohol?"; "In the past 3 months, have you had sexual intercourse while under the influence of drugs/alcohol?"; "Have you ever engaged in sexual acts in exchange for money, drugs, alcohol, or other goods?"; "The last time you had sexual intercourse, what type of preventative method did you or your partner use to prevent pregnancy?"; "Have you ever been diagnosed with a sexually transmitted disease/infection?"; "Have you ever taken the morning-after pill?"; and "My pregnancies resulted in?".

Analysis

The findings are summarized using frequencies and percentages. This study examined 240 single female college students who attended a U.S. university in 2014. The data cleaning, merging, and analyses were performed in Stata 14SE. To examine the relationship between DE behavior and RSB, a multivariable logistic regression analysis was used to calculate odds ratios (OR) for the binary risky sexual behaviors variable. The odd is the ratio of the likelihood that an event of interest occurs and the likelihood of that event not occurring (Bland, 2000). Participant age, ethnicity/race, and sexuality were controlled and all variables were tested for multicollinearity. Akaike's and Schwarz's Bayesian information criteria were used to determine model fit. A sensitivity analysis was also conducted on 275 female college students who were either married or in a committed relationship, to examine the relationship between DE behavior and RSB. The sensitivity analysis ensures the impact of the relationship and operationalization of the selected risky behaviors.

Results

Results from both descriptive statistics and multivariable logistic regression analysis are provided. For all single, female college students (n=240), 66.25% (159) reported engaging in DE behaviors. Over 63% used increased physical activity as a way to lose weight. Of the 240 college students, 35.42% (85) reported engaging in RSB; the most common types of RSB reported were not using a condom and taking the morning-after pill. Only one student reported engaging in sexual acts in exchange for money, drugs, alcohol, or other goods and less than 3% reported that their pregnancy resulted in an abortion. Descriptive statistics also indicated that 44.65% of single female college students engaged in both DE behavior and RSB ($p \leq 0.001$). The majority of students who engaged in RSB were students between the age of 18 and 20 (38.10%), non-Hispanic White (78.82%), and heterosexual (90.59%) (See Table 1).

Multivariate Analysis

Table 2 summarizes the findings from the multilevel logistic regression model regarding the influence of DE behaviors on RSB, adjusting for student characteristics. Compared to students who did not engage in DE behaviors, those who did engage in DE behaviors had 3.42 (95% CI:1.68,6.95) times higher odds of reporting engagement in RSB. Additionally, compared to 18-20-year-olds, 21-23-year-olds and 24-26-year-olds had 2.32- and 2.76-times higher odds to also report engagement in RSB, respectively. Lastly, when compared to non-Hispanic Whites, Asians had 73% decreased odds of engagement in RSB.

Results from a sensitivity analysis (see Table 3) highlight the lack of relationship between DE behaviors and RSB among female college students who were either married or in a committed relationship. The sensitivity analysis indicates that our study's logistic regression and two composite measures for risky behaviors are accurately constructed.

Discussion

The purpose of this study was to investigate whether disordered eating behaviors (i.e., using diet pills, liquid diets, purging, excessive physical activity, fasting) increase single college women's probability of engaging in risky sexual behaviors (i.e., participating is sex under the influence of drugs or alcohol, exchanging sex for money, inconsistent or absent contraception, use of the morning-after pill or abortion). Results indicated that DE behavior involvement is significantly correlated with RSB. Initiatives for college counseling centers and student health services are outlined to assist universities in better recognizing, preventing, and addressing DE and RSB concerns.

Implications for College Campuses

A critical component of prevention and tertiary intervention on college campuses is the incorporation of screenings for DE and RSB at student health facilities (SHF). Along with providing critical health services for students who might otherwise lack access, SHF also interface with students struggling with mental and emotional concerns. As such, SHF can screen students and provide appropriate referrals for students struggling with DE or RSB. SHF can implement checklist assessments for all students seeking services that screen for DE and RSB. For example, a brief and inclusive assessment for ED is the Eating Attitudes Test-26 (Garner, Olmsted, Bohr, & Garfinkel, 1982); for RSB, the Sexual Risk Survey is a good option (Turchik & Garske, 2008). It is also important for professionals to look beyond obvious symptoms (e.g., appearing underweight) and be attuned to student's disclosures that might indicate a need for further assessment. For example, tracking student comments about the need to "work-off" or "earn" meals or discussing excessive calorie counting can aid SHF in better assessing and treating the complexities of DE.

These preliminary assessments could indicate if additional DE or RSB assessments and referrals are warranted. Ul-

Table 1
Descriptive Statistics of Single Female College Students Across Disordered Eating Behaviors

	Risky Sexual Behavior			
	No %(n)	Yes %(n)	Total %(n)	Missing %(n)
Disordered eating behaviors				0(0)
No	82.72(67)	55.35(88)	64.58(155)	
Yes	17.28(14)	44.65(71)	35.42(85)	
Age				1.88(10)
18-20 years old	58.82(90)	38.10(32)	51.48(122)	
21-23 years old	23.53(36)	36.90(31)	28.27(67)	
24-26 years old	9.8(15)	15.48(13)	11.81(28)	
27-29 years old	2.61(4)	1.19(1)	2.11(5)	
30-32 years old	3.92(6)	2.38(2)	3.38(8)	
33-25 years old	0.65(1)	2.38(2)	1.27(3)	
36+ years old	0.65(1)	3.57(3)	1.69(4)	
Race/Ethnicity				0.19(1)
Non-Hispanic White	65.81(102)	78.82(67)	70.42(169)	
African American	8.39(13)	9.41(8)	8.75(21)	
Hispanic	7.1(11)	3.53(3)	5.83(14)	
Asian	12.26(19)	4.71(4)	9.58(23)	
Other	6.45(10)	3.53(3)	5.42(13)	
Sexual Orientation				1.32(7)
Heterosexual	98.68(149)	90.59(77)	95.76(226)	
Homosexual	0.66(1)	4.71(4)	2.12(5)	
Other	0.66(1)	4.71(4)	2.12(5)	

timately, integration of health and counseling services on college campuses arguably results in better detection of a wide variety of disorders (Alschuler, Hoodin, & Byrd, 2008); however, students may feel more comfortable or familiar utilizing SHF than counseling centers. Therefore, incorporating mental health screenings in SHF can create a prime opportunity to screen for DE and RSB symptoms that indicate the need for referrals to appropriate services.

In addition to being referred to the counseling center, students who indicate engagement in DE might also benefit from services rendered from a multiple-disciplinary team. Specifically, the American Counseling Association, American Psychological Association, and the Accreditation Council for Education in Nutrition and Dietetics all suggest that treatment for DE should include the integration of a nutritionist during the physical and mental health counseling processes. Given the prevalence of DE developing into a diagnosable ED, incorporating nutritionists in health and counseling centers will engender best-practice interdisciplinary staff teams wherein more robust and evidence-based treatment plans can be executed. In turn, this integration will aid health services and counseling centers in preventing the development of more severe and life-threatening clinical diagnoses among their students.

Lastly, there are several creative interventions that college counseling centers can deploy on campus when treating DE and RSB. Results of this study indicated that college women aged 21-23-year-olds were more likely to demonstrate DE behaviors than any other age group in this study. Traditionally, this age group encompasses third- and fourth-year students who have already established their friend groups, enrolled in extracurricular club activities, or joined Greek organizations. Having these established social networks, coupled with peer pressure and body self-esteem, might increase a young single woman's engagement in RSB (Henry, Schoeny, Deptula, & Slavick, 2007; Lieberman, Gauvin, Bukowski, & White, 2001). Additionally, the increased stress associated with third- and forth-year academics might also increase DE behavior. Costarelli and Patsai (2012) found that DE behaviors among sorority members were highest during academic examination periods. It is critical that university counselors are mindful of the factors that might precipitate DE and RSB and intervene during critical periods. For example, university counselors can attend sorority and extracurricular meetings and provide specific information about self-esteem, body image, body shame, social comparison, reframing, adaptive coping strategies, help seeking behaviors, and prompt important conversation about DE and RSB.

For clinicians working one-on-one with students struggling with DE and RSB, art therapy techniques (e.g., collages, expressive drawing, painting) are proven creative interventions that can address self-esteem and self-worth (Rust,

Table 2
Multivariable Logistic Regression of Single Female College Students

	Risky Sexual Behaviors	
	OR	95% CI
DE behaviors (Ref:No)	3.42***	[1.68, 6.95]
Age (Ref:18-20)		
21-23	2.32*	[1.16, 4.66]
24-26	2.76*	[1.07, 7.16]
27-29	0.81	[0.08, 8.20]
30-32	0.92	[0.17, 5.08]
33-25	4.26	[0.29, 62.61]
36+	9.48	[0.81, 110.51]
Race/Ethnicity (Ref: NHW)		
African American	0.66	[0.23, 1.92]
Hispanic	0.36	[0.09, 1.42]
Asian	0.27*	[0.08, 0.93]
Other	0.63	[0.14, 2.72]
Sexual orientation (Ref: HET)		
Homosexual	3.14	[0.27, 36.15]
Other	2.63	[0.27, 25.26]
Observations (n)	234	
Akaike Information Criterion	293.76	
Bayesian Information Criterion	342.13	

Note: n=240, DE = Disordered eating, HET = Heterosexual, NHW = Non-Hispanic White, OR = Odds ratio, * p<0.05, ** p<0.01, *** p<0.001

Table 3
Multivariable Logistic Regression of Married/Committed Relationship Female College Students

	Risky Sexual Behaviors	
	OR	95% CI
DE behaviors (Ref:No)	1.33	[0.72, 2.43]
Age (Ref:18-20)		
21-23	2.53*	[1.19, 5.35]
24-26	1.98	[0.86, 4.56]
27-29	6.09*	[1.29, 28.73]
30-32	3.57	[0.73, 17.56]
33-25	–	–
36+	6.72*	[1.44, 31.32]
Race/Ethnicity (Ref: NHW)		
African American	3.85	[0.85, 17.41]
Hispanic	1.55	[0.48, 5.02]
Asian	0.94	[0.24, 3.72]
Other	0.89	[0.21, 3.74]
Sexual orientation (Ref: HET)		
Homosexual	1.04	[0.10, 10.55]
Other	1.03	[0.27, 3.93]
Observations (n)	275	
Akaike Information Criterion	294.04	
Bayesian Information Criterion	341.05	

Note: n=240, DE = Disordered eating, HET = Heterosexual, NHW = Non-Hispanic White, OR = Odds ratio, * p<0.05, ** p<0.01, *** p<0.001

2000). Additionally, providing workshops that focus on increasing self-worth, impulse control, assertiveness, and psychoeducation about using substances while participating in sexual activities may prove particularly helpful for students struggling with DE and RSB (Ackard, Henderson, & Wonderlich, 2004; Raykos, McEvoy, Carter, Fursland, & Nathan, 2014; Shea & Pritchard, 2007; Weinhardt, Carey, Carey, & Verdecias, 1998; Winters, Botzet, Fahnhorst, Baumel, & Lee, 2008). Finally, therapeutic referrals including equine-assisted therapy, yoga, and dance therapies have been proven effective when working with DE struggles (Klein & Cook-Cottone, 2013; Krantz, n.d.; Lac, Marble, & Boie, 2013). As such, counseling centers should investigate local referral resources.

Recommendations for Future Research

To address a limitation of the current study, it is recommended that future researchers use specific weight-related and RSB measures in future studies. It would also be worthwhile for future researchers to explore the experiences of young women on campuses and gain insight regarding stressful life events that may contribute to the development of and protection against DE behaviors, this could be done by utilizing qualitative and longitudinal methods. Examining life events can aid practitioners in developing and implementing targeted interventions to increase well-being among vulnerable college populations. It would also be worthwhile to replicate this study and assess and control for impulsivity, as there may be a relationship between impulsivity, DE, and RSB. It would also be helpful for future researchers to collect data about campus culture and practices (e.g., number of counselors on campus, information about mental health programming, implementation of interdisciplinary teams, student health facilities response patterns to students struggling with DE and RSB, community referral practices) that could help identify systemic factors that catalyze or mitigate the risk of DE and RSB among college students. Lastly, exploring the feasibility and effectiveness of implementing specific DE or RSB assessments in student health facilities may expose the realities, benefits, and setbacks of this practice.

Limitations

There are several limitations that exist in this study. Data was gathered from a 2014 survey that collected information about student's global health (i.e., health behaviors related to mental and emotional health; sexual health; alcohol, drug, and tobacco use; access to healthcare; nutrition and food security; and skin and sun safety). The survey was not specifically intended to measure DE or RSB in relation to

one another; as such, the survey did not include all criteria or symptomology related to all ED and RSB. It did, however, include a robust list of DE and RSB that can inform future research and clinical practice. Additionally, the data were collected from people who attended college and therefore might not be representative of all adults. However, the results are generalizable to women on college campuses. Furthermore, although the study was anonymous, self-report bias may impact the results. Also, literature suggests that increased stress during periods of academic testing may increase adverse DE behaviors. The survey was distributed over a four-week period during the fall semester; it is unknown when individual participants completed the survey and what academic stressors they were experiencing at the time of completing the survey. Those stressors may have influenced heightened or lowered DE behaviors. Finally, impulsivity might contribute to DE and RSB; the survey utilized did not assess for or control impulsivity. The results of this study must be interpreted while considering these limitations.

Conclusion

The college years are a critical period for developing and intervening with DE behaviors. To add to the existing literature and build awareness of co-occurring symptomology and challenges faced by college women, this study explored whether or not DE (i.e., using diet pills, liquid diets, purging, excessive physical activity, fasting) is a possible indicator of engagement in RSB (i.e., participating is sex under the influence of drugs or alcohol, exchanging sex for money, inconsistent or absent contraception, use of the morning-after pill or abortion). Results indicated a statistically significant positive correlation between the two. Compared to students who did not engage in DE behaviors, those who did engage in DE behaviors had 3.42 times higher odds of reporting engagement in RSB. Recommendations for student health facilities include implementing screening and assessment tools for DE and RSB and increasing referral practices. For college counseling centers, recommendations include utilizing interdisciplinary teams, outreach programing, and providing creative interventions for students that address self-esteem, body image, body shame, social comparison, adaptive coping strategies, help seeking behaviors, and prompting other important conversation around DE and RSB.

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Counselor Self-Reported Competence for Working with Kink Clients: Clinical Experience Matters

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The experience of counselor stereotyping, bias, and misunderstanding is often very real for those who participate in adult, consensual, non-diagnosable paraphilic sexuality, commonly referred to as kink. A created Counselor Self-Reported Competency Scale, drawn from American Counseling Association competencies, and the Attitudes about Sadomasochism Scale were used to assess counselor knowledge and attitude for working with kink clients. This research suggests competence with kink clients increases as clinical experience working with kink clients increases. The ability to maintain a nonjudgmental attitude and open therapeutic environment seems linked to increased clinical experience with this sexual subculture.

Keywords: counseling, kink clients, bias, competence

Introduction

Depending upon the the historical, socio-political, cultural, or religious contexts, human sexuality can be viewed as either perverse or diverse. There is no consensus on a standard of what is normal versus abnormal sexual expression, or what should or should not be included in sexuality education (Ponzetti Jr., 2015). This lack of consensus adds to the confusion, stigmatization, misunderstanding, and discrimination of sexual subcultures (Moser & Kleinplatz, 2006; Wright, 2006).

Counselor confusion and lack of awareness about what is diagnosable or pathological sexuality is particularly true for the sexual subculture commonly referred to as kink (Hoff & Sprott, 2009; Kolmes, 2003; Pillai-Friedman, Pollitt, & Castaldo, 2014). The terms "kink" and "BDSM" are often used synonymously, and Pollock (2019) states, "kink is shorthand for BDSM" (p. 28). The term "BDSM" reflects three distinct, though sometimes interrelated terms: Bondage and discipline; Dominance and submission (D/s); and Sadism and masochism (SM) (Freeburg & McNaughton, 2017). Other practices included in the kink communities include Master and slave (M/s) (Langdridge, Richards, & Barker, 2007). Put simply, all BDSM is "kink" but not all kink is BDSM. While this distinction is important, for the purpose of this research, kink and kinky are used to define a broad category that includes BDSM but is not limited to BDSM.

Counselors may have conflicting feelings regarding working with clients who self-identify as kinky, due to the very real pathology and victimization that frequently is associated with certain paraphilic sexuality. It is true that some paraphilic sexual behavior is unquestionably pathological, criminal, and diagnosable. This would certainly be true of any sexual behavior that involves victimization of a non-consenting other such as pedophilia, voyeurism, frotteurism, exhibitionism, and in some cases, sadism and masochism.

Some paraphilic sexual behaviors, however, can be viewed as non-pathological, non-criminal, un-diagnosable, adult consensual sexual preferences that are practiced and recognized worldwide (Gross, 2006; Kinsey, Pomeroy, Martin, & Gebhard, 1948; Laska, 2013; Richters, Visser, Rissel, Grulich, & Smith, 2008). The likelihood of a counselor encountering a client who participates in BDSM is as likely as encountering an individual of the LGBTQ+ community (Lawrence & Love-Crowell, 2007; Pillai-Friedman et al., 2014). This paper explores how counselor education and clinical interventions can be enhanced through increased knowledge and understanding of kink culture and practice.

Review of the Literature

Religious, cultural, psychiatric, and educational contexts influence assumptions about kink sexuality (Bhugra, Popelyuk, & McMullen, 2010; Langdridge et al., 2007; Sisson, 2007). Such influences and a lack of graduate school training on the continuum of human sexuality provide a context for

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misunderstanding as well as continued stigmatization and clinical judgment errors of sexual subcultures such as the kink community (Diambra, Pollard, Gamble, & Banks, 2016; First, 2014; P. Kleinplatz & Moser, 2004; Kelsey, Stiles, Spiller, & Diekhoff, 2013; Laska, 2013; Miller & Byers, 2010; Nichols, 2006; Walters & Spengler, 2016).

Consensual, adult paraphilic sexuality has been referenced in ancient texts and sacred writings of Hinduism and Islam (Bhugra et al., 2010), just as other world religions have vilified such practices. While some cultures and religions have embraced paraphilic sexuality, most have established guidelines and sanctions prohibiting unconventional sexual activities (Bhugra et al., 2010; P. Kleinplatz & Moser, 2004; Ponzetti Jr., 2015). The negative and socially punitive effects of religion and social constraints on human sexuality are still largely in place throughout the world.

Esther Perel (2006), observes that "egalitarianism, directness, and pragmatism are entrenched in American culture and inevitably influence the way we think about and experience love and sex" (p. 55). Such influences can paint kink as wild, pleasure-driven, irresponsible, and exploitive sex that gives little regard to the practical needs of a monogamous, child-bearing, marital relationship (Perel, 2006). This attitude is perhaps a vestige of puritanism's roots in the United States.

Viewing sexuality from the lens of pathology and perversity is a common theme. Throughout the 20th century, most non-normative sexual practices were classified as pathological by medical and mental health practitioners, resulting in a variety of theories about the origins and causes of sexual perversions (Freud, 1905; Péloquin, Bigras, Brassard, & Godbout, 2014; Schachner & Shaver, 2004; Keane, 2004; O'Keefe et al., 2009).

Who is the Kink Client?

For the purpose of the research, kink clients are defined as adults who participate in consensual, non-diagnosable, sexual activity which may include any number of sexual fetish behaviors, cross-dressing, bondage, dominance, submission, sadism and masochism. As with all types of sexual behaviors, kink falls on a continuum from cross-dressing, sexual humiliation, mild biting and spanking, to flogging and a wide variety of sadomasochistic eroticism with a consenting adult or group (Pillai-Friedman et al., 2014).

It is estimated that over 14 million individuals in the U.S. currently participate in some type of kink sexuality (approximately 5-10% of the U.S. population), from mild bedroom game participants to membership and full participation in kink community activities (Sisson, 2007). The kink community contrasts with those who occasionally experiment with what Newmahr (2010) calls "kinky bedroom games" (p. 316), made popular by the E.L. James (2012) book *50 Shades of Grey*. The kink community is a subculture with its own norms, beliefs, attitudes, practices, and artifacts. Zambelli (2016) notes that "a member of this subculture feels a certain degree of attachment and commitment to the community, as shown by the time spent in community activities, like greeting new members during events (i.e. munches [*sic*]), moderating online forums and groups" (p. 472).

In a review of five empirical studies of Finnish citizens who self-identified as SM oriented (n = 184), Sandnabba et al. (2002) found that the kinksters in the studies (response rate of 35%) were well-educated, mid-to high income Caucasians. Newmahr's (2010) ethnographic research echoes the middle-to-upper class distinction found by Sheff and Hammers (2011) and Sandnabba et al. (2002), and she defines the kink community as a "social network of people organized around SM [sadomasochism], who practice and observe [others] in particular public spaces and attend informational and educational meetings" (Newmahr, 2010, p. 316).

Kink behavior often meets non-sexual intimacy needs by providing a way for consenting adults to bond with and nurture one another through acts of service (hair brushing, shoe polishing, house cleaning, etc.) and through clear communication and dialog about needs (Connan, 2010; Sandnabba et al., 2002). Perel (2006) suggests that some who participate in kink are inextricably drawn to the power differential—dominant or submissive—to "correct an imbalance... and replenish something vital" (p. 56) in relationships.

Kinksters—those who identify with kink sexuality— are intentionally focused on ensuring consent, safety and risk awareness. A contemporary expression of these attitudes and approaches is found in the 4C's approach, which emphasizes Caring, Communication, Consent, and Caution as a framework for BDSM negotiation (Williams, Thomas, Prior, & Christensen, 2014). This emphasis on clear, spoken agreements between participants of what is allowed and what is out of bounds, is what makes BDSM activity clearly distinquishable from pathological, non-consensual, criminal sexual acts (Balon, 2013; Connan, 2010; Newmahr, 2010; Peoples & Meyer Stewart, 2017).

Counseling Kink Clients

Clients who want to discuss their kink behavior and attitudes are often working with counselors who lack the knowledge and skills required to address sexual issues in general—not to mention kink sexuality. This compromises the therapeutic alliance and creates an uncomfortable situation for both client and counselor (Harris & Hays, 2008; Walters & Spengler, 2016). In spite of this, no training standards exist to address counselor discomfort with sexuality issues, nor counseling competencies for working with the continuum of human sexuality. It would appear that the reluctance to explore and understand sexual behavior is embedded in

counselor training programs, resulting in counselors who are unprepared and resistant to addressing sexual issues in treatment. This is particularly evident in non-normative sexual behavior such as kink. Several studies have reported that kink clients experience bias and pathologizing—even having their sexual practices reported to legal authorities despite the fact that no criminal sexual activity had been disclosed (Harris & Hays, 2008; Kelsey et al., 2013; Yost, 2010).

Kelsey et al., (2013) surveyed 766 psychotherapists in the United States to assess attitude toward and self-reported competence for working with BDSM clients. While 76% of the participants stated they worked with clients who engaged in kink sexuality, only 48% rated themselves as competent to do so. This study also found that therapists who reported competence in working with BDSM sexuality also reported more positive attitudes for working with kink community members, with 67% (n = 513) agreeing with the statement, "BDSM can be part of a healthy, long-term relationship" (Kelsey et al., 2013, p. 259). These findings seem to contradict other qualitative studies that detail client experiences of bias and pathologizing when working with counselors (Hoff & Sprott, 2009; Kolmes, 2003), yet it is unknown if counselor attitude about BDSM influences their level of self-reported competence.

Sexuality in Counselor Education

The Council for Accreditation of Counseling and Related Educational Programs (CACREP; 2016) standards for counselor education provide little recognition of the importance of human sexuality education for working with clients. Research indicates counselors support the inclusion of sexuality education across counselor education tracks. One descriptive study of 243 counselor educators indicated more than half the participants would require a course on human sexuality in all counseling tracks (Gray, House, & Eicken, 1996). Several updates to the CACREP Standards have occurred since the time of their study without an inclusion of a course on human sexuality outside of the marriage, couples, and family track (CACREP, 2016). While counselors-in-training may consider the appropriateness of taking a human sexuality course as an elective based on their state licensing board requirements, not all CACREP programs provide this course as an elective.

A review of the Association for Counselor Education and Supervision (ACES) syllabus clearinghouse revealed "57 of 395 syllabi, or 9.4%, included the word 'sex' in their content, but only four courses—about 1%—focused specifically on sexuality" (Diambra et al., 2016, p. 77). There are established competencies for working with certain sexual subgroups, such as the LGBTQ+ community (ALGBTIC LGBQQIA Competencies Taskforce et al., 2013), and some researchers suggest that similar competencies should be developed for BDSM and used to increase awareness, knowledge, and skills for working with kink community members (Kolmes, 2003; P. Kleinplatz & Moser, 2004; Lawrence & Love-Crowell, 2007).

Some counselors who reported having training on sexuality issues in graduate school expressed neutrality with regard to competence (Ford & Hendrick, 2003), indicating that addressing the topic of sexuality as a way of meeting a specific CACREP standard does not lead to competence. However, when a specific course on human sexuality is required—as it is for marriage and family therapists—researchers have found a positive, linear relationship between sexuality education and supervision on therapist comfort level in working with sexuality issues (Harris & Hays, 2008). These researchers state, "Measuring therapists' sex knowledge as they perceive it proved to be an influential factor of comfort with sexual content and initiating sexuality discussions. These findings may signify the importance of therapists feeling competent, regardless of their actual competency level" (p. 248). The Harris and Hays (2008) study seems to indicate that counselor self-perception of competence is at least as important as actual, measurable competency. It may be that when counselors reported perceived competence, they also reported a comfort level in discussing sexuality issues with clients.

Education is seen as a bridge towards increased ethical practices and social justice for marginalized communities of all kinds (Arredondo et al., 1996; P. J. Kleinplatz & Ménard, 2007). Counselor awareness, knowledge, skills, and action are woven throughout the 2016 Multicultural and Social Justice (MCSJ) and 2013 Association for Lesbian, Gay, Bisexual, and Transgender Issues in Counseling (ALGBTIC) counseling competencies and provide the foundation upon which ethical counselor education programs are developed. Diambra et al., (2016) in their content analysis of 24 master's level counselor-in-training responses to an anonymous survey on sexuality themes, including BDSM, found students lacked factual information and were eager to learn. Diambra et al. (2016) contend that a "parallel process of sorts" may be at work "in that if our students bring with them sexual questions, secrets, and fantasies, their future clients are just as likely to bring them into counseling sessions" (p. 87). To maintain fidelity to the ACA ethics code (2014), increased counselor preparedness on sexuality issues is needed.

Counseling Competencies and Sexuality Issues

Embracing sexuality as a multicultural counseling issue is worth considering in light of the multiplicity of sexual diversity and the differences between sexual expression among various cultures. Distinguishing multiculturalism from diversity is important. Multiculturalism's focus is only on ethnicity, race, and culture, while diversity is all other issues that define the differences between people (Arredondo et al., 1996). However, thoughts, beliefs, and practices related to

sexuality are part of one's cultural landscape, and therefore sexual practices are a part of the multicultural-self.

Consideration of sexuality as a cultural diversity issue is recognized in other helping professions, such as nursing, which works to provide care for the whole of a person, including the person's sexuality and sexual issues (Witte & Zurek, 1995). As Witte and Zurek (1995) observe, "Sexuality is not limited to genitalia or behavior; it is an all-encompassing sense of self-identity, part of a bio-psycho-social-spiritual person...As ethnocentrism in our culturally diverse world is a common problem, so is what we would call 'sexualcentrism'" (p. 10-11). Broadening multicultural courses to include an overview of the continuum of human sexuality seems an appropriate way to increase counselor self-awareness of sexualcentrism, and for building knowledge, skills, and action sets with client sexual identities.

With regard to teaching a multicultural counseling course, Mitcham et al. (2013) believe, "An important aspect of multicultural competence lies in the counselor educators' awareness, knowledge, and skills regarding special populations" (p. 5). As described, the kink community seems to qualify as a special population with a unique culture based on the norms, behaviors, narratives, and artifacts that are unique to this community (Zambelli, 2016). Competency issues, especially when working with the kink community, are a "lingering concern" (Kelsey et al., 2013, p. 264).

Procedure

A stratified, random sample was drawn from a combination of various online counseling Listservs, ACA Division contacts, Licensed Professional Counselor listings on the Psychology Today website, online professional members who self-identified as willing to help with research, and dozens of personal, professional contacts. Emailed invitations to participate and online invitation posts had the potential to reach more than 5,000 counselors, who were invited to take an anonymous, online survey with three parts:demographics, a created Counselor Self-Reported Competence Scale (see Figure 1), and the Attitudes about Sadomasochism Scale (ASMS; Yost, 2010).

From April 2018 through mid-June 2018, a total of 167 surveys were either fully or partially completed, with 97 usable, completed surveys, for a completion rate of 58.08%. All data were entered into the Statistical Package for the Social Science (SPSS) program for use in a predictive model research design. Compliance with the National Institutes of Health, Office of Extramural Research, ethical research guidelines, and the University's Internal Review Board (IRB) was maintained throughout the research.

Predictor variables were used to determine if a correlation existed between each variable and scores on the counselor self-reported competence for working with kink community members and for predicting scores on the ASMS. Predictor variable data gathered in the demographic section is included in Table 1. Information gathered in the demographic section was used to enhance data interpretation for this study. Using the standard ratio of 10-15 participants per variable (8), the minimum number of total participants (80) was met, with 97 useable surveys.

The Counselor Self-Reported Competence Scale

The 10-statement scale was created from wording drawn from the Multicultural and Social Justice Counseling Competencies (American Counseling Association, 2015), and the Association for Lesbian, Gay, Bisexual, and Transgender Issues in Counseling (ALGBTIC) Competencies for Counseling (ALGBTIC LGBQQIA Competencies Taskforce et al., 2013). Participants used a 7-point Likert-scale to respond to the survey statements, with a range from one (disagree strongly) to seven (agree strongly) following the same format and wording as the ASMS scale, thus maintaining consistency between the instruments.

The Attitudes about Sadomasochism Scale

Yost (2010) developed and validated a 23-item scale, designed to measure negative attitudes towards sadomasochists reporting that her scale "demonstrates excellent internal consistency and concurrent validity" (p. 89) and suggesting use of this instrument as a research tool for assessing discriminatory attitudes of therapists working with sexual minorities. She determined discrimination between participant groups by using three variables (Group 1, prior knowledge of SM; Group 2, contact with SM participants; and Group 3, personal SM practices). The ASMS derived four sets of attitudes about SM, including: Socially Wrong (SM is immoral and socially undesirable); Violence (SM activity involves violence against an unwilling partner); Lack of Tolerance (SM is sexually unacceptable); and Real Life (SM practitioners carry their SM interests into the rest of their daily lives).

While Yost (2010) found excellent discrimination between groups, a multiple regression analysis determined that the four sets of attitudes did not account for all variance between groups, with 58% of the variance unexplained by the four sets of attitudes. Yost (2010) determined, "The ASMS captures a set of attitudes specific to SM that do not overlap with already-developed attitudinal scales" (p. 88). Therefore, the ASMS was a useful instrument for this study, as it captures counselors' negative attitudes specific to working with members of the kink community. Example items on the ASMS (Yost, 2010, p. 91) include:

- Sadomasochism is a threat to many of our basic social institutions.
- If I was alone in a room with someone I knew to be a Dominant, I would feel uncomfortable.

Survey of Self-Reported Counseling Competence

This survey is designed to capture your self-assessment of competence for working with a marginalized sexuality. Your honest self-appraisal will help determine initial steps to addressing counselor awareness, knowledge, and skills for working with this population (*must read before ability to continue with survey*).

In responding to the following statements, please use the following definition of competence, taken directly from the article, *"What does it mean to be a culturally-competent counselor?"* by Ahmed, Wilson, Henriksen, Jr., and Jones (2010, p. 18), *(must read before ability to continue with survey).*

> The definition of multicultural competence means, in part, to approach the counseling process from the context of the personal culture of the client (Sue, Arrendondo & McDavis, 1992; Sue & Sue, 2013), *(must read before ability to continue with survey).*

Using the following scale, please respond to the statements below:

1	2	3	4	5	6	7
disagree strongly	disagree moderately	disagree mildly	neither agree nor disagree	agree mildly	agree moderately	agree strongly

1: I have professional competence with regard to appropriate use of language for sexual minorities and how certain labels, such as Poly, Kink, and SM, require contextualization to be utilized in a positive and affirming manner.

2: I acknowledge that cross-cultural communication is key to connecting with privileged and marginalized clients in sexual subcultures, including the kink community, and have professional competence in the area of cross-cultural communication.

3: As either a privileged or marginalized counselor, I have awareness, knowledge, and skills (AKS) for understanding kink clients' worldview, and use the American Counseling Association's competencies to increase my AKS in this area.

4: I am aware of misconceptions and/or myths regarding affectional orientations and the sexual expression of kinksters, and I have professional competence in this regard.

5: I acknowledge that affectional orientations are unique to individuals and they can vary greatly among and across different populations of kink community members, across the lifespan, and I have professional competence in this regard.

6: I recognize and acknowledge my professional competence in understanding that historically, counselors and other helping professionals have compounded the discrimination of kink individuals by being insensitive, inattentive, uninformed, and inadequately trained and supervised to provide culturally proficient services to kink individuals and their loved ones.

7: I utilize an ethical decision-making model that takes into consideration the needs and concerns of the kink community member when facing an ethical dilemma with clients who identify as kink and/or BDSM/SM. I have professional competence in this area.

8: I attend professional development trainings to learn how stereotypes, discrimination, power, privilege, and oppression influence privileged and marginalized clients, ***including*** those who identify as members of a kink community.

9: I assess the degree to which historical events, current issues, and power, privilege and oppression contribute to the presenting problems expressed by privileged and marginalized kink community clients. I have competence with this type of self-assessment.

10: I continue to acquire culturally responsive critical thinking skills to gain insight into how stereotypes, discrimination, power, privilege, and oppression influence privileged and marginalized kink clients. I have competence with such critical thinking skills.

Figure 1. This figure shows the Counselor Self-Reported Competence Scale created for this study

Table 1
Participant Demographics

Characteristic	n	%
Age		
20-29 years old	27	27.8
30-39 years old	35	36.1
40-49 years old	19	19.6
50-59 years old	10	10.3
60-69 years old	4	4.1
70+ years old	2	2.1
Gender		
Female	76	78.4
Male	15	15.5
Transgender	4	4.1
Other*	1	1
Prefer not to disclose	1	1
Sexual Orientation/Identity**		
Exclusively heterosexual	47	48.5
PTOH	17	17.5
PTMH	10	10.3
ETH	6	6.2
PHMT	2	2.1
PHOT	10	10.3
Exclusively homosexual/lesbian	5	5.2
Other**	0	0
Education		
Master's (CACREP Program)	30	30.9
PhD (CACREP Master's)	67	69.1
Experience with Kink Clients		
No experience	56	57.7
Experience with 1-2 kink clients	22	22.7
Experience with 3+ kink clients	19	19.6
Master's Coursework in Sexuality		
Yes	43	44.3
No	54	55.7
Master's Multicultural Course***		
Yes	62	63.9
No	35	36.1
Continuing Ed on Sexual Diversity		
Yes	62	63.9
No	76	78.4

Note: ETH = Equally heterosexual and homosexual/lesbian; PHMT = Predominantly homosexual/lesbian, more than incidentally heterosexual; PHOT = Predominantly homosexual/lesbian, only incidentally heterosexual; PTMH = Predominantly heterosexual, more than incidentally homosexual/lesbian; PTOH = Predominantly heterosexual, only incidentally homosexual/lesbian; *The choice of "other" as an option was included so that those who identify as cisgender male, cisgender female, male transgender or female transgender had a way to acknowledge their personal choice of gender language as different from the other choices; **The Kinsey Scale offers a visual continuum of non-binary sexuality. The use of this scale is justified as a starting point for this research only and the authors acknowledge that it does not represent all sexual behaviors or preferences. The use of "other" was provided for inclusivity not identified on the Kinsey Scale;***Including sexual diversity

- Many sadomasochists are very moral and ethical people

Main Findings

Data analysis using multiple regression predictive design answered the following questions:

- What is the relationship between level of counselor self-reported competence for working with kink clients and counselor attitude towards SM?
- Can scores on the Attitudes about Sadomasochism Scale (ASMS) be predicted by factors such as age, gender, sexual orientation, master's coursework, continuing education, or American Counseling Association Division affiliation?
- Can scores on the Counselor Self-Reported Competence Scale be predicted by age, gender, sexual orientation, master's coursework, continuing education, ACA Division affiliation, and scores on the ASMS?

Research Question 1 and Hypothesis

Question 1 asked *"What is the relationship between level of counselor self-reported competence for working with kink clients and counselor attitude towards SM?"* A Pearson Correlation found a weak, negative relationship between these variables, and although the correlation between the full self-reported competency scores and the full ASMS scores was weak (r = -.260) the result was statistically significant (p = .010). Something other than chance was creating the correlation. Due to the findings, the null hypothesis (H_0 = no relationship between the level of self-reported competence and attitude) was rejected.

Further exploration of the relationship between counselor self-reported competence and the ASMS determined that counselor self-reported competence significantly correlated with three of the ASMS subscales: Socially Wrong (r = -.246; p = .015), Violence (r = -.224; p = .028), and Real Life (r = -.227; p = .025) in a pattern consistent with the overall ASMS. The correlation results indicate that if a counselor is reporting high self-confidence for working with kink clients, the counselor also appears to have a more open attitude towards SM as morally and socially acceptable alternative sexual expression.

The ASMS subscales showed a strong positive correlation between the Violence subscale and the Socially Wrong subscale (r =.782)—that is, those who tended to score high on the Violence subscale (belief that BDSM is associated with violent sexual acts against an unwilling person) also tended to score high on the Socially Wrong subscale (belief that BDSM is morally and socially wrong). This correlation was significant (p = .000). The Socially Wrong subscale had a significant (p = .015) negative correlation (r = -.246) with the

overall self-reported competence scale indicating that those who believe SM is morally and socially wrong tend to rate themselves as less competent for working with clients who participate in some type of kink/SM sexuality. These findings have implications for counselor educators who train students on human sexuality and diversity issues.

The Real Life subscale (the belief that SM practitioners carry their SM interests into the rest of their daily lives) had a significant (p = .025), strong, negative correlation (r = -.227) with counselor self-reported competence indicating that counselors who rate themselves as being less competent for working with kink clients tended to disagree that SM interests are carried into other parts of the client's life. The Lack of Tolerance subscale (a reverse-scored measure of one's belief that SM behavior can be an acceptable form of sexuality among willing partners) had no significant relationship (p = .173) with the overall score for counselor self-reported competence for working with kink clients.

Research Question 2 and Hypothesis

Question 2 asked *"Can scores on the Attitudes about Sadomasochism Scale (ASMS) (Yost, 2010) be predicted by factors such as age, gender, sexual orientation, master's coursework, continuing education, or American Counseling Association Division affiliation?"* Yes. A stepwise multiple regression analysis found several factors able to predict scores on the ASMS and therefore the null hypothesis (H_0 = scores cannot be predicted) was rejected. Data were inspected for analysis assumptions of linearity, homoscedasticity, and normality. All assumptions were met.

The multiple regression analysis produced three prediction models: Model 1, which included the variables of sexual orientation/identity score and age score; Model 2, which added course score and continuing education score to those of Model 1; and Model 3, which added the further variables of experience with kink clients. ACA Division status was reported as a descriptive factor for the sample only.

Regression results indicated that the third model significantly predicted ASMS scores, R^2 = .161, R^2adj = .115, F = 3.502, p = .006. This model accounts for 16.1% of the variance in ASMS (see Table 2). After removing gender and ACA Division, the data were rerun and standardized coefficients revealed several significant findings in the three models that emerged. Per an ANOVA, significance of individual predictors was increased when combined with other predictor variables (significance at ≤ .05), and Model 3 showed significance (p = .005) in predicting 16% of the change in variance of scores on the ASMS (R^2 = .161), due to the addition of experience with kink clients (the 5th predictor variable) to the other four predictor variables. Conversely, Model 1 predicted just 6% of the change in variance of scores on the ASMS (R^2 = .067) and Model 2 just 8% of the change in variance (R^2 = .084).

Table 2
ASMS Prediction Model Coefficients

Predictors	B	T	p
Age	0.252	2.521	.013*
Sexual Orientation/Identity	-0.079	-0.757	0.451
Course Score	-0.153	-1.569	0.12
Continuing Ed Score	0.036	0.351	0.726
Experience w/ Kink Clients	-0.319	-2.891	.005**

Note: *p<.05, **p<.01

Overall, analysis of the data determined that if a counselor has experience working with kink clients, their overall score on the Attitude about Sadomasochism Scale (Yost, 2010) can be predicted at twice the rate than if the counselor's age, sexual identity, courses, and continuing education is known, or that 16% of the change in variance of scores on the ASMS can be predicted based on Model 3. See Table 3.

Table 3
Model Summaries

Model	R^2	SEE
1. Sexual identity & age	.067	.81
2. Sexual identity, age, course score, & continuing ed score	.084	.81
3. Sexual identity, age, course score, continuing ed score, & experience w/ kink clients	.161	.78

Note: SEE = Standard error of the estimate

Research Question 3 and Hypothesis

Question 3 asked *"Can scores on the Counselor Self-Reported Competence Scale be predicted by age, gender, sexual orientation, master's coursework, continuing education, ACA Division affiliation, and scores on the ASMS?"* Yes. A stepwise multiple regression analysis found that 23% of the variance in self-reported competence score can be predicted by combining all of the predictor variables except age and gender. Therefore, the null hypothesis (H_0 = scores cannot be predicted) was rejected. Data was inspected for analysis assumptions of linearity, homoscedasticity, and normality. All assumptions were met.

Regression results indicated that the third model significantly predicted ASMS scores, R^2 = .327, R^2adj = .298, F = 11.191, p = .000. This model accounts for 32.70% of the variance in ASMS. Age and gender were excluded variables due to lack of significance (age: p = .436; gender: p = .792) The residuals for each predictor within this model are presented in Table 4.

Continuing education, surprisingly, did not predict scores

on self-reported competence, nor did continuing education on diversity issues, also an unexpected finding. As with Question 2 outcomes, experience with kink clients had strong significance, at the < .001 level, and experience was able to predict almost 40% of the change in variance in scores on self-reported competence. Participants who worked with even one kink client reported increased competence with this subculture. Results of the ANOVA support Model 3 as significant for predicting outcomes on self-reported competence. The same three models were used to group data for analysis and Model 3 was able to predict 33% of the change in score on self-reported competence (R^2 = .327). Simply by adding experience to the model, there was a 13% increase in predictability of competence scores.

Table 4
Counselor Self-Reported Competency Scale Prediction Model 3 Coefficients

Predictors	B	T	p
Sexual Orientation/Identity	0.23	2.466	.016*
Course Score	-0.17	-1.978	0.051
Continuing Ed Score	0.064	0.712	0.478
Experience w/ Kink Clients	0.394	4.09	.000**

Note: *p<.05, **p<.01

Discussion

The relationship between counselor self-reported competence for working with kink clients and counselor attitude about SM was weak yet correlations became stronger when the four ASMS subscales were applied to the scores. Counselors who viewed SM as socially and morally wrong, per the ASMS subscales, also had less self-reported competence for working with kink clients and were older. This is an important finding of the study as it reflects prior research findings on bias against kink sexuality and has implications for counselors and counselor educators.

The overall findings of the research determined that a single variable, experience working with kink clients, had statistically significant predictive capability for scores on both the ASMS and the counselor self-reported competency scale. In addition, counselors who identified as not exclusively heterosexual, appeared to be more accepting of SM sexuality and report increased levels of self-competence for working with kink clients. Interestingly, having a master's level course on human sexuality or a multicultural counseling course that included sexual diversity topics, had little predictive value for high levels of counselor self-reported competence for working with kink clients or on counselor attitude about SM sexuality. Counselors who self-identified as not exclusively heterosexual and had experience with one or more kink clients seem to have the most self-reported competence and the least restrictive view of SM sexuality.

Kink sexuality may be particularly offensive or off-putting to those counselors who continue to assign stigma and shame to consensual sexual choices with which they are unfamiliar or that are held in contempt for personal reasons. This study seems to indicate lack of experience and exposure to kink culture or working directly with counseling issues rooted in kink behavior as contributors to the lack of self-reported competence among counselors.

Implications for Counselors

This research study gives additional support for counselor increased awareness, knowledge, and skills (competency) for working with SM clients since the overall mean score on counselor self-report of competence was 4.30 reflecting an inability to agree or disagree with the statement. Increasing self-reported competence is correlated with counselors' reported experience working with one or more kink clients. For counselors, then, it is reasonable to say that gaining competence with kink clients requires an ability to maintain a nonjudgmental and open therapeutic environment for the client so that a trusting, therapeutic relationship can be established. Gaining insight into what brings the client into the counseling room and allowing for unconditional positive regard for clients who report kink sexuality practices is a way to refrain from misdiagnosing SM practices as pathologic or ignoring pathology that may be present.

To reduce stigma and bias against kink clients, it appears that personal knowledge of someone who identifies with kink sexuality practices may help in this process. Given the increased negativism and violence in the United States towards anyone who is viewed as other-than, it is important to note that personal contact with someone outside of a socially acceptable group of peers may reduce or eliminate prejudicial attitudes, at least in the short-term. McBride (2015), in a study supported by the Scottish government, recognized "interventions which facilitate positive intergroup contact, or are based on principles of perspective-taking or empathy-induction are considered to be effective," in reducing prejudicial attitudes (p. 5).

Implications for Counselor Educators

The current study seems to indicate that coursework and continuing education on human sexuality and diversity issues has little effect on counselor attitude or perceived self-competence for working with kink clients. This is a surprising find in that multiple studies indicate experiential education helps to increase awareness of hidden bias and address known bias in these areas (Adams, Bell, & Griffin, 2007; McBride, 2015; Ponzetti Jr., 2015). It is noted that experiential education allows for a different level of processing than lectures and power points on sexuality topics. An experiential approach would include taking learning from

the typical classroom environment into the community, thus bridging learning to a real-world environment. In this way, experiential learning "integrates new learning into old constructs" (Eyler, 2009).

Since experiential learning was not clearly defined in the current study, it may have been better to obtain participant data on the actual type of coursework and training received. In addition to type, a question about the perception of the education received as helpful in their overall attitude towards sexually marginalized clients, such as those in the kink community, may have strengthened the results.

Ford and Hendrick (2003)suggest increased opportunities for practicums and internships that expose students to the continuum of human sexuality in ways that will complement their future work and allow for supervision around these topics. They also suggest multiple training modules that create an opportunity for graduate students to fully engage in a discussion of sexuality topics (Ford & Hendrick, 2003). Harris and Hays (2008) view the graduate student supervisor as the initiator of discussions on sexuality in clinical situations and vital to increasing student comfort level with their own awareness of self. They note that increasing comfort in addressing sexuality with their future clients works to facilitate student self-perception of competence (Harris & Hays, 2008). Supervisors might use Yost's (2010) Attitude about Sadomasochism Scale or the survey created for this research as a way to begin a small-group discussion. Recommendations for film studies, both documentary and movie titles, are another way to begin important discussions on sexuality topics that may then allow students to increase their understanding of a variety of issues related to human sexuality.

Limitations

Survey bias creates the halo effect and sexuality surveys are particularly prone to this type of research bias (Dodd-McCue & Tartaglia, 2010; Dunne, 1998), perhaps wanting to view themselves as competent, open-minded counselors. Surveys that use a 7-point Likert scale may also encourage bias since participants might choose the neutral response or simply pick the number that best supports a positive perception of self, as suggested by Cummin and Gullone (2000).

Had the number of useable, completed surveys been higher, age, gender, and ACA Division affiliation may have proved useful as predictors of scores on self-reported competence and attitudes about sadomasochism. The positive linear correlation found between increased tolerance and experience with SM clients may be affected by the counselor's own bias towards a positive SM attitude due to their own participation in kink. Additionally, the Counselor Self-Reported Competence Scale asked about familiarity with using certain labels to affirm non-traditional sexual practices such as "Poly," "Kink," and "SM" but did not provide definitions for these terms, which may have skewed the responses.

Yost's (2010) ASMS is SM specific and does not consider the variety of other sexual behaviors that one might consider kink. Although Yost's (2010) development of the Attitude about Sadomasochism Scale (ASMS) demonstrated validity, her participants were not counselors. Rather, they were a convenience sample of undergraduate students enrolled in an introductory psychology course (n = 471). The subscales she created measured four different levels of sexual conservatism, but the subscales did not explain the variance on the ASMS. Yost (2010, p. 79) noted that "...the ASMS measures a unique attitudinal construct," about SM, unexplained by the variance in score on the ASMS. Since the attitudinal construct is unknown, a guess might be that the ASMS measures a level of discomfort with kink sexuality that cannot be associated with sexual conservatism. Since inflicting pain is one part of the SM dynamic, perhaps the construct is an aversion to pain, which may help explain why so many responses on the ASMS in the current study fell close to the mean of 4 (neither agree nor disagree).

Implications for Further Research

Further research that captures additional participant insight is needed to help determine best practices for increasing counselor competence when working with kink clients, and to increase counselor self-awareness of attitude towards BDSM. This suggests a mixed methods research approach.

The current research was conducted in a time of shifting attitudes toward consensual, adult, non-diagnosable, paraphilic sexuality as a legitimate form of adult sexual expression. Further research is needed on this population that considers if a change in counselor attitude towards kink clients equates to a change in counseling behaviors. Approaching future research with a mixed methods approach is suggested so that deeper meaning can be drawn from participant statements on a questionnaire or survey.

Evolving Norms

Definitive recognition of what is normal versus abnormal sexuality continues to shift and evolve with changes in social and cultural mores. The historical shift in defining sexual pathology highlights the strong influence of psychiatry, religion, and education in shaping heteronormative, monogamous sexuality as the ideal in the United States. If professional counselors want to promote systemic attitudinal change, the ACA competencies serve as a path towards this change (Toporek, Lewis, & Crethar, 2009).

The call for counselor awareness, knowledge, and skills is not a stagnant opportunity one receives in a CACREP program, but one that requires ongoing self-awareness and recognition that conventional sexual and social mores can have negative implications when working with kink clients. Increasing counselor competence in working with kink

clients may increase contact with this sexual subgroup, thereby decreasing stigma and bias. This study supports the idea that counselors who have experience working with at least one kink client seem more willing to view kink sexuality as a creative form of relationship building and self-expression for some consenting adults. It is hoped that this research encourages counselors to set aside any pre-conceived bias against this sexual subculture so that the work of counseling can take place.

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