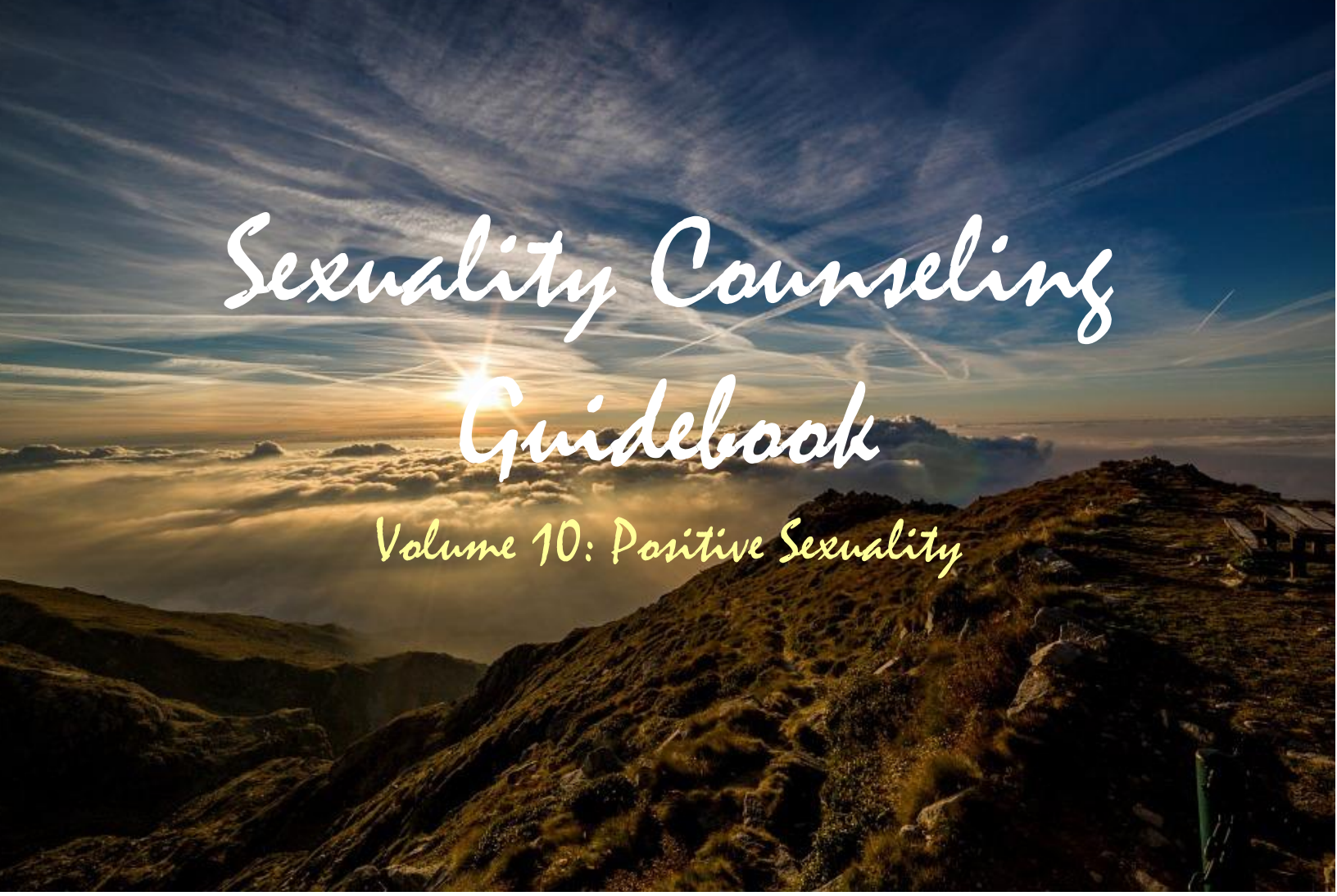

Sexuality Counseling Guidebook

Volume 10: Positive Sexuality

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Introduction

This volume of the *Sexuality Counseling Guidebook* focuses on ways professional counselors can help clients develop a positive sense of sexuality and positive sexual relationships.

Positive Sexuality

Positive sexuality starts with the understanding that sexuality is a normal part of the human experience and develops throughout the lifespan. Positive sexuality is inclusive of all individuals and experiences and recognizes that gender identity, gender expression, sexual orientation, level of sexual desire, and other aspects of sexuality exist on a spectrum. It also promotes being informed about physiological aspects of sexual health and making informed choices that protect the health, safety, and wellbeing of the individual and their partner. Positive sexuality fosters individual sexual exploration and celebrates the experience of desire and pleasure. Within this, it empowers individuals to set and communicate boundaries around when, how, and with whom they desire any sexual experience with. Approaching sexuality from a positive stance also includes reflecting on and establishing one's own values and aligning them with personal sexual beliefs and practices.

Positive Sexual Relationships

While it is important to acknowledge that every sexual relationship involves unique individuals, the following are some foundational principles that are a part of positive sexual relationships. A positive sexual relationship consists of reciprocal consent and a mutual feeling of safety, respect, and trust. Effective communication of expectations and needs are foundational for a healthy relationship. Through nurturing positive sexual interactions, individuals can foster both personal and relational growth. Overall, caring and connection lead to healthy respected boundaries.

Counseling Clients toward Positive Sexuality

Counselors can utilize psychoeducation and bibliotherapy to offer clients accurate and empowering information regarding positive sexuality. Accessing client values is a critical part of counseling and is especially necessary when discussing sexuality. A values sort could be helpful in starting this conversation, and will allow the counselor to show early in treatment that they are willing to move at the client's pace and level of comfort. Counselors have the opportunity to model positive sexuality via language use and word choice. This is a subtle intervention that allows the counselor to help the client create language around their own experience of sexuality and become comfortable using it in session. As always, counselors should take care to identify, acknowledge, and respect the client's cultural context. Counselors doing sexuality counseling may need to broach the topic regularly throughout treatment. Doing so empowers the client and prompts the counselor to examine how their own values are showing up in the room.

Counseling Clients toward Positive Sexual Relationships

Keeping in mind that each individual's experience of a "positive sexual relationship" will be different, one initial approach in working with clients is to facilitate an exploration of the client's sexual relationship to self through identifying individual values, experiences, expectations, and needs. Possible strategies to this end include creating a sexual narrative/timeline, creating a values inventory, and identifying relational patterns. The counselor might also move toward helping the client effectively communicate their needs and values while respecting the needs and values of others. Communication strategies may include counselor-client role-play, exploring and clarifying personal definitions, and psychoeducation about sexual health. In working with couples, systemic therapies (such as EFT) have proven effective in exploring issues of intimacy, attachment styles, and common barriers to positive sexual relationships. No matter one's personal definition of a "positive sexual relationship," it is

important that counselors create a safe and nonjudgmental space for clients to explore their sexuality both as individuals and in relationship with others.

Chapter 1

Effectively Communicating with Clients about Sexuality

By Brian Hollingsworth and Ben Jarvis

Background & Introduction

Human sexuality is a complex topic laden with diverse values, beliefs, practices, and needs. For counselor and client alike, it can be a difficult topic to broach. Acknowledging the pivotal role sexuality plays in each persons' life, this chapter will discuss ways counselors can effectively communicate with their clients about sexuality-related issues. Citing research, we highlight some common barriers to discussing sexuality, and we offer practical tips and guidelines for counselors to incorporate into their practice.

Review of Relevant Research

Counselor knowledge, comfort level, and values around sexuality are all important factors in how (and if) a counselor effectively communicates with clients about sexuality-related issues. In a study conducted by Harris and Hays (2008), researchers found that education is one of the best predictors of whether a therapist will initiate discussions about sexuality with clients. Unfortunately, many graduate programs in counseling and psychology do not require a course in human sexuality (Cruz, Greenwald, & Sandil, 2017; Timm, 2009). Without adequate knowledge and training, counselors often do not feel comfortable broaching the topic of sexuality (Harris & Hays, 2008). In a 2010 survey of 188 clinical psychologists, 50% reported that their lack of training either moderately or very much affected their comfort in addressing the topic of sexuality (Reissing & Giulio, 2010).

Even with adequate knowledge and comfort level, a counselor's own values may influence the ways the communicate about sexuality with clients. For example, McCarthy and Wald Ross (2019) point out that therapists with "traditional" values risk pathologizing nontraditional sexual expressions or assuming that a sexual problem is a symptom of an individual or relational problem. Conversely, therapists whose values align with "nontraditional" expressions of sexuality may become so intent on defending the right of clients to be who they are that they either do not carefully assess the client and their relationship(s), or they risk allowing their own values to override the needs, complexities, and feelings of the client and/or couple.

Finally, culture heavily influences the way we talk about and understand sexuality. Findlay (2012) points out that even *talking* about sex can be understood as a cultural practice; a practice that comes from culture, operates in culture, and makes culture. He points out that for some cultures, talking about *problems*—let alone sex—is not a cultural norm. With this in mind, therapists must be mindful not only of their own values and assumptions, but also the diversity of values and experiences their clients will hold around sexuality and how it is discussed and understood.

Possible Counseling Issues

As the research suggests, knowledge and comfort level of therapists are two possible issues in discussing sexuality with clients. Cultural differences and client hesitancy about sexuality are also important factors to consider.

Lack of knowledge is linked to an increase in counselor anxiety and a decrease in comfort level around sexuality-related issues. Therapists who become anxious in the presence of anxious clients risk losing sight of the relationship process and even perpetuate symptoms of the problem themselves (Harris & Hays, 2008). For the many counselors who did not receive formal

training in sexuality counseling while in graduate school, it is possible that the only sexuality-related message they ever received was the ethical mandate to "not have sex with your clients." While important and necessary, this mandate also risks conveying to prospective counselors a sense of fear and punishment around sexuality within the counseling setting, thereby increasing anxiety even more. It is thus extremely important for counselors to seek out opportunities for ongoing education surrounding sexuality-related topics.

Cultural differences and values may also impact the way sexuality is discussed in counseling. Historically, American culture has often been negative or silent about sexuality (Harris & Hays, 2008). For counselors and clients who have grown up in this environment, discussing sexuality feels like a breach of cultural norms. Even when a counselor has adequate knowledge and comfort, their self-perceived ease with discussing sexuality may be perceived by the client as pressure or even a breach of cultural norms (Findlay, 2012). Counselors must learn to navigate and understand not only their own culture and values, but also be sensitive to the norms and values of their clients, as well as the diversity of sexuality-related concerns that the client may present.

Finally, counselors must be mindful of the hesitancy, and in some cases the dishonesty, of clients in discussing sexuality. Love and Farber (2017) note that clients tend to report that their primary reasons for avoiding the topic of sexuality (or being dishonest about what they share) include shame, a belief that the therapist may not be willing or competent enough to handle disclosure, a fear of jeopardizing the counseling relationship, and the feelings of failure and inadequacy that are often connected to sexual concerns. Dishonesty and hesitancy in matters of sexuality risk dishonesty and hesitancy in other areas, thus weakening the therapeutic relationship and the potential for growth.

Guidelines for Counseling Practice

While research has been consistent in identifying common barriers and issues in discussing sexuality, it has also revealed some fairly consistent guidelines and practices for overcoming these obstacles and communicating effectively about sexuality with clients. What follows is a summary of common considerations and practices for counselors to incorporate into their practice:

1. *Self-Assess*: It is important that counselors commit to ongoing self-assessment of their values, beliefs, and comfort levels around sexuality. This includes awareness of both one's personal and larger cultural norms and values. In their article, Cruz et al. (2017) provide some excellent questions and tools for counselors to use in self-assessment and consideration. In addition, Harris and Hays (2008) suggest that seeking quality supervision may be particularly helpful and effective in this endeavor.
2. *Seek Continuing Education*: In addition to self-assessment, counselors should seek ongoing educational opportunities around sexuality-related topics and issues. This may include workshops, seminars, certifications, and supervision from a counselor experienced in sexuality-related topics.
3. *Consider Culture*: Be mindful of how your own culture as a counselor may be different than that of your client. A broad question to ask a client might be, "How is sex viewed in your culture?" or "How does your sexuality fit or not fit into your culture?" (Cruz et al., 2017). Be mindful that discussing sexuality may not be a cultural norm for your client, and beware of assuming that those who don't want to talk about sex are inhibited or repressed (Findlay, 2012). In addition, be sure to use inclusive language that makes no assumptions about the client (such as monogamy or heterosexuality) (Timm, 2009).

4. *Be Proactive & Directive*: Integrate sexuality into intake paperwork and initial assessments. Consider including it in marketing materials and online professional profiles (Cruz et al., 2017). Use direct language with clients. If you are uncomfortable with certain words or topics, practice saying or discussing them with your supervisor or on your own (Timm, 2009). Don't be afraid to ask direct questions.
5. *Respect Limits*: Be mindful of your own limits and knowledge, and the limits and boundaries set by clients. Consider obtaining consent from your client to discuss sexuality, and always let them know they have the option not to answer or discuss. Be sure to consult (or refer to a trained sex therapist if necessary) when a topic or need exceeds your knowledge or comfort.

Resources

- *The PLISSIT Model* - a simple model with four basic levels of intervention for sexuality-related concerns (Annon, 1976; Timm, 2009)
- *AASECT*: American Association of Sexuality Educators, Counselors, and Therapists https://www.aasect.org/
- *Sexual Attitude Reassessment (SAR)* - Workshop offered by AASECT
- For detailed list of organizations, articles, and references related to a broad range of sexuality-related topics, see https://www.zurinstitute.com/resources/human-sexuality/.

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Chapter 2

Positive Sexuality in Couple Relationships

By Taylor Gabbey and Jena Johnson

Background and Introduction

Sexuality is one of the most maligned topics of conversation in contemporary American culture. However, in couples counseling, sexuality often occupies a prominent role in the therapeutic conversation. Many couples enter counseling due to sexual concerns, whether those concerns be around intimacy, identity, or relationship dynamics. Since positive sexuality places emphasis on sexual pleasure and satisfaction as well as the role of sex in building intimacy between partners, this framework is essential for treating problems between long-term couples. However, this strengths-based approach often goes against the dominant cultural narrative surrounding sex, which can present obstacles for both clients and counselors as they work to recontextualize their own sexual scripts. Therefore, it is important to be able to understand and convey the link between positive sexuality and relationship satisfaction.

Review of Relevant Research

Positive Sexuality approaches sexuality as a fun and pleasurable dimension of the human experience, rather than viewing healthy sexuality as the simple "absence of disease, dysfunction or infirmity" (World Health Organization, 2006). With sex positivity as a goal, clients should come to appreciate and integrate sexual satisfaction as an integral piece of the ever-evolving, lifelong process of pursuing healthy sexuality.

In their framework of positive sexuality, Williams, Thomas, Prior, & Walters (2015) propose that there are 8 key dimensions to positive sexuality. Their framework proposes that positive sexuality is strengths-based, views sexuality as unique and multifaceted, embraces multiples ways of knowing, reflects professional ethics, promotes open and honest communication, is inherently humanizing, encourages peacemaking, and is a systemic approach to sexuality. Anderson (2013) found that sexual satisfaction correlates with increased self-esteem, empathy, and autonomy which indicates that sexuality is an important dimension of the human experience that influences overall mental well-being. In a study by Cooper et al. (2018), researchers looking at long-term relationships found a positive correlation between having an active sex life and overall relationship satisfaction. Overall, the research indicates that counselors working from a sex-positive stance will assist their clients in not only overcoming sexual dysfunctions they may be experiencing, but also to improve their overall wellbeing as well as improve the health of the relationships they are engaged in.

Because so much attention is generally given to the negative aspects of sex and sexuality, there is a lack of research examining the positive elements of intimate partner communication, beliefs about sex, and sexual roles within a relationship. However, communication appears to be an integral piece of any and all long-term intimate relationships, particularly around sexual expectations. In a study conducted by Barnes et al., the attachment styles of various partners were analyzed to find trends in areas like communication, security, and overall relationship satisfaction (2017). Those with insecure attachment styles were found to practice negative or minimal communication around sex, while more secure attachment styles were associated with deeper intimacy and reduced sexual anxiety. These findings illustrate the connection between sexual dialogue and relationship security, showing how a positive sexuality approach can contribute to increased relationship satisfaction through sexual dialogue alone.

Many other researchers have studied the role positive sexual experience plays in overall marital satisfaction. Several studies have found that frequent, pleasurable sex correlates with overall relationship happiness (Schoenfeld, Loving, Pope, Huston, & Stulhofer 2017; Cooper et al 2018; McNulty, Wenner, & Fisher 2016; Fisher et al 2015). For some of these findings, the question has been raised as to whether positive sexual experience leads to healthy relationships or vice versa (McNulty, Wenner, & Fisher 2016; Fisher et al 2015), but given the well-documented impact positive sexuality has on individual health and wellness, it stands to reason these inherent benefits would apply to couples as well. Additionally, Cooper et al. found that a positive sexual relationship between partners helped mitigate the impact of everyday stressors on the relationship (2018), and Schoenfeld et al connected positive sexual behavior to positive behavior across all relationship interactions (2017). All of this empirical evidence speaks to the value of focusing on a couple's sexual relationship in counseling in order to better the relationship as a whole, and positive sexuality serves as an ideal model with which to do this.

Possible Counseling Issues (e.g., Individual, Family, and/or Couple)

As a counselor working with couples, concerns related to sexuality is an important aspect of the relationship that clients may wish to discuss. However, couples often will not broach sexuality-related topics if the onus is on them to bring it up first. For this reason, it is important for counselors to broach a conversation about sexuality starting with the intake session. This communicates to clients that it is okay to talk about the way their sexuality is affecting the different facets of their lives and relationships. In addition to the taboo most people feel around discussing sex, counselors will need to be mindful of other factors that may impact the discussion of sexuality-related concerns. Each client's array of intersecting identities should always be considered when discussing sexuality, as with any topic discussed within the therapeutic relationship.

Working from a sex-positive stance often means starting with psychoeducation for clients who may be unfamiliar with the concept of positive sexuality. Psychoeducation should include an overview of what positive sexuality is, general anatomy and physiology of sexual functioning, general behaviors associated with couples who approach sex from a sex-positive position, and how sexuality is bidirectionally intertwined with the overall quality of the relationship (Fisher, et al. 2015). American society has been described as inherently sex-negative (Williams, Christensen, & Capous-Desyllas, 2016), which means that this information may fly in the face of how clients currently think about their own individual sexuality as well as relational sexuality.

Sexuality is generally considered a private aspect of the human experience, shared only with intimate partners or friends. This can leave many people feeling unsure about how they should be approaching sex within their relationships and wondering if they are sexually "normal." Whether working with individuals, couples, or families, counselors are in a unique position to help clients to critically examine the messages they have received about sex from their families, media, and society at large. Through this process, clients can develop a firmer understanding of their own sexual values and decide to subscribe to or reject the messages they have received throughout their lives. Any concerns and insecurities should be addressed and explored while also affirming to the client that sex can be a satisfying and pleasurable aspect of their relationship.

When working with couples, counselors should facilitate change consistent with the couple's goals in ways that promote all aspects of the relationship, including sexuality. Because the research has shown that sexual satisfaction is intricately tied with overall relationship satisfaction (Fisher et al., 2015; Cooper et al., 2018; Barnes et al., 2017; Schoenfeld et al., 2017;

Mcnulty, Wenner, & Fisher, 2016), it is critical that counselors explore the sexuality alongside any initial concerns a couple presents with. Counselors should explore any problems or blocks that are occurring within the sexual relationship and assist clients with understanding the possible causes and solutions. Because secure attachment within the relationship has been linked to greater intimacy (Schoenfeld et al., 2017), Emotion Focused Therapy (EFT) may be a good option for helping couples to work on improving attachment between partners in order to enhance intimacy and promote relational and sexual satisfaction.

Additional Guidelines for Counseling Practice

Because sexuality is such a personal topic, its discussion requires more nuance than many other counseling topics. For some, sexual practices may be deeply rooted in religious tradition--tradition that may advocate against things like sexual pleasure, contraception, or specific kinds of sexual intimacy. Other couples may come from cultures where male and female sexual roles are rigid and inflexible. In both these cases, the positive sexuality approach is a harder sell and may go directly against the client's worldview. Understanding the potential frames through which a couple is viewing sex and sexuality not only provides insight for the counselor, but also sets parameters around what clients may or may not be ready to explore and experience in therapy. Counselors should take care to learn these frameworks from intake with the client and explore them before diving into the sexual discussion.

Sexual identity, like all aspects of identity, is an ever-evolving, life-long process of discovery which means that long-term partners might also face developmental strain around its role in the relationship. It is important to discuss the many ways sexuality can influence our lives, and to recognize that a couple's sexual relationship is likely to change over the years. This too may be difficult for a couple to talk about. Be prepared to encounter less-publicized situations around relationship sexual development, such as the mid-life coming out of a partner, the disclosure of long-hidden fantasies, or the desire to open a previously monogamous relationship. These situations are part of the natural development of sexual identity across the lifespan, though many clients may struggle to see it that way.

Additional concerns around this topic include matters of sexual immorality between partners. This could take the form of anything from sexual coercion, the use of sex as a leveraging tool for other relationship disputes, or infidelity. When counseling around such potentially traumatic issues, counselors must take care to maintain a sense of objectivity and egalitarian openness towards both partners, while still validating partner insecurities and working to move the couple to a more positive sexual place (if possible). Counselors should keep additional resources about trauma, domestic abuse, sexual orientation, polyamory, and other nuanced sexual topics on hand for both the counselor and clients.

What resources (e.g., books, Internet sites, and journal articles) are available to help professionals learn more about this topic?

- *Sexuality Counseling Theory, Research, and Practice* by Christine Murray, Amber Pope, and Ben Willis
- The Sexplainations Youtube Channel: https://www.youtube.com/user/sexplanations
- The World Health Organization: https://www.who.int/topics/sexual_health/en/
- Where Should We Begin? With Esther Perel - A podcast that follows Esther Perel through single-session couples counseling that explores problems couples are experiencing, including sexuality-related concerns.
- The Guttmacher Institute: https://www.guttmacher.org/

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Chapter 3

Positive Parent-Child Communication About Sexuality

Adrienne Loffredo and Liz Mecham

Background and Introduction

Talking to kids about sexuality can feel like a taboo subject, and for good reason - it's a culturally pervasive message! In this section, we'll explore the history of 'the talk' and look into what schools are (and aren't!) teaching kids about human sexuality. Next, we'll take a look at the effects of effectively educating kids and then dive into what kids are exposed to in absence of effective sex ed.

The History of 'The Talk'

The phrase "the birds and the bees" has been part of American lexicon for some time, as has the similar concept of "the talk". Attached to these ideas can also be an almost archetypal reaction of discomfort. But, where did these cultural ideas come from? According to Wikipedia, "The "Birds and the Bees talk" (sometimes known simply as 'The Talk') is generally the event in most children's lives in which the parents explain what sexual relationships are." Interestingly, the page citations contain references to Google groups and Yahoo! Answers, suggesting a lack of stronger sources for the background and history of this culturally pervasive idea. A 2000 LA Times article, *Birds Do It, Bees Do It, But Why'd We Say That?,* does a slightly better job explaining the history of the phrase, crediting Samuel Coleridge Taylor's 1825 *Work Without Hope* as the origin of the concept. However, neither source explores the idea of why we need euphemisms to explain human sexuality. What's apparent is that culturally, we aren't very comfortable talking about sex, and we seem to also be uncomfortable talking about talking about sex, too. Euphemisms like 'birds and bees' and the common reaction of discomfort surrounding the idea of 'the talk' point to a need for resources and support for parents discussing sexuality with their children.

What Schools Are (and Aren't!) Teaching

Schools began taking on sexual education in the 1920s, following suit with the US military's sex ed programs born out of a need to address rampant sexually transmitted infections occurring during WWI. By the 1930s, the US government, in conjunction with the US Hygiene Society, was creating resources for educators. Ironically, resistance to sex ed didn't emerge as a political agenda until the 1960s, a response to the sexual revolution. By the 1980s, abstinence-only sex education emerged as a reaction to the HIV-AIDS epidemic (Cornblatt, 2009). The debate on comprehensive versus abstinence-only sex education is ongoing. Though there is no federal mandate for sex education, all fifty states and the District of Columbia have passed some form of legislation mandating sex education for public school students. What is covered varies by state.

Review of Relevant Research

Having The Talk can occur in as many different ways as there are families. Below, we explore considerations for parents, emerging adolescents (ages 10-12) and older adolescents (ages 13-15), as well as provide of review of some relevant research.

Parents and The Talk

Many parents profess to be open about talking with their children about sex. But what does that really mean? And if parents feel their child was taught at school, how specific do they think their message should be? "The majority of parents professed to being open about sexuality with their children, only a minority reportedly conveyed direct messages". (Hyde et al., 2013) Hyde calls what most parents share with their children to be "surface level" using "innuendo and

intimation". When asked about what the parents specifically shared with their children, they "expressed surprise at how little they had actually said" (Hyde et al., 2013)

How can parents communicate with their children in order to pass along information on biology as well as values, emotional aspects of sexuality and safe sex practices? The first step is to build a supportive and trusting relationship with the child. Parents must create opportunities to talk with their children about sensitive subjects, many children, especially during adolescence are more likely to withhold information about their lives from parents. Parents should talk early and often with their children about sexuality, which may be difficult to initiate. During conversations, it is important to listen, ask open ended questions and answer questions with a calm response. The conversation should include all participants, it should not be a lecture. While studying parents' experiences communicating with their children found that "Situations of genuinely relaxed, two-way dialogue about sexual issues between parents and teenagers were almost never described by participants" (Hyde et al., 2010)

Parents should be prepared for adolescents to be uncomfortable. They may also be unwilling to listen or talk, and they may become angry or laugh in discomfort. Adolescents may also claim to already know everything. Parents should remain calm and be prepared for resistance. Parents should know that these are normal reactions. Parents need knowledge, skills and confidence. Parents may want to prepare with books, websites or pamphlets to learn from and share with adolescents. They may want to prepare open ended questions and practice their listening skills in less stressful situations.

Parents should know that augmenting the information learned in schools has shown to affect sexual behavior of adolescents and young adults. "Adolescents not communicating with parents on four topics (pregnancy, the menstrual cycle, STDs and methods of birth control) were nearly five times more likely to report having multiple sex partners in the past three months". (Crosby et al., 2009). A study involving parents in school administered programs found that boys delayed becoming sexually active when the family activities were completed. Showing that family support and communication were critical to boy's sexual health (Grossman, 2014)

Emerging Adolescents and The Talk

A search on the topic of child-initiated conversations about sex or sexuality yields staggeringly fewer results than a search on parent-initiated conversations about sex and sexuality. However, given the advice of open and ongoing conversations about sex and sexuality within families, conversations will often be generated by children. What insight can counselors give children about beginning conversations with their parents? Planned Parenthood is one of the few sites that offers some suggestions for children. They include considering a variety of communication channels - are you more comfortable on the phone than face-to-face? Does texting your parents feel most comfortable? Also, it may help to simply help children be aware that parents feel awkward, too!

Between the ages of 10 - 12, kids may have questions about the changes they are seeing in their bodies. Hearing about puberty in school may have been too removed for kids to relate it to themselves, and it can be scary to start seeing these changes actually happen. Often, kids may think something is wrong - the growth of pubic hair, vaginal discharge or nocturnal emissions are all new. As some girls get their periods and others don't, or as some boys begin to experience erections and others don't, it's easy for kids to feel like something is wrong with the way they are developing. Equipping children at this stage with the vocabulary and the confidence to initiate discussions can benefit the family.

Older Adolescents and The Talk

As children become teens, their sexuality-related concerns can change. This may be when first relationships begin and decisions about sex present themselves. This can also be when developmental abnormalities emerge (for example, absence of a period related to diet and exercise habits). Teens in this stage also need the vocabulary and confidence to initiate discussions with their parents.

Further, teens need to understand what kinds of support may be available to them within the family(For example, Would my mom help me get on birth control if i think I need it?), and where they might turn for supports that aren't available in the family. The nature of the conversation at the stage may be shifting from what's going on with their bodies to what's going on with their own values about sex, if they want to have it, and who they want to have it with.

Counseling Issues for Positive Sex Communication in the Family

How can counselors help families have positive communication about sex and sexuality? What skills to counselors need, what questions should they ask and how are counselors viewing families? These topics are explored below.

Family Counseling from a Developmental Perspective

Using a developmental approach can help counselors understand the impact of a family's constellation of life stages - each person is a different stage in development, those stages interact with one another, and the family itself also has a developmental stage. Being able to identify these stages and how they are interacting helps a counselor understand a family system more deeply and provides opportunity for psychoeducation. Understanding the biology of how children and teenagers are growing isn't enough. As Liddle, et al note, "Puberty's observable manifestations signal impending changes in the adolescent's potential for greater responsibility, autonomy, adult reproductive capacity, and sexuality to parents and others in the teenager's social world" (2000).

The whole family will experience changes as children and teens age and go through puberty. As counselors, the skills to think about how these changes can affect the family unit become important for family counseling. Helping families identify their goals for their children as they grow can impact how these stages are experienced. What family values do they hope to instill? How might families navigate value differences, especially about sex and sexuality? What do conversations about sex and sexuality look like in the family? In what other ways are messages about sex and sexuality conveyed (for instance, through other systems the family interacts with - church, school, youth programs, extended family, caregivers)?

Additional Guidelines for Counseling Practice

One challenging topic for families can be how they are acknowledging (or not acknowledging) their children's and teens' emerging autonomy. Specifically, parents' ability to see their children as individuals versus extensions of self is a shift from infant and early childhood conceptualizations. According to Kagitcibasi, "adolescence is the period where autonomy and relatedness dynamics assume special significance. 'Emotional autonomy' from parents is an important aspect of individuation" (2005). Some developmental psychologists view autonomy as the distancing of adolescents from their parents, emphasizing the importance of this part of the process as a part of healthy development. Other developmental perspectives, however, note the importance of a close and nurturing relationship with parents as critical to the development of healthy autonomy (Kagitsibasi, 2005). Acknowledging a teen's growing separateness and agency as an individual can be hard to balance with a close nurturing relationship with parents, who's own feelings about the growing separateness are often overlooked in developmental conversations.

Resources

Websites:

www.hhs.gov/ash/oah/adolescent-development/index.html
www.talkwithyourkids.org,
www.plannedparenthood.org/learn/teens/sex/all-about-sex/how-do-i-talk-my-parents-about-sex

Books:

It's Perfectly Normal Changing Bodies, Growing Up, Sex, and Sexual Health by Robie H. Harris and Michael Emberley

Sex and Sensibility: The Thinking Parent's Guide to Talking Sense About Sex by Deborah M. Roffman

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Chapter 4

Supporting Teens in Healthy Sexual Decision Making

By Macy Nesom, Nicole Osborne, and Rocio Perez

Background and Introduction

By the end of high school in the U.S., about 70-93% of teens are sexually active, with the age of first sexual interaction beginning in the early teenage years (Guttmacher Institute, 2011). Adolescents who engage in sexual behaviors before the age of 15 have noted riskier sexual behaviors, such as lack of contraceptive use and larger numbers of sexual partners (Hoffman, 2009). Risky sexual behavior can result in various consequences, such as STIs and unintentional pregnancy (Centers for Disease Control and Prevention [CDC], 2009). "Casual" relationships and "hookup" culture among adolescents leads to new risks such as unknown past sexual partners, limited planning prior to sexual intercourse, and feelings of comfortability resisting sexual activity or insisting on contraceptives (Manning, Flanigan, Giorano, & Longmore, 2009).

Parental support during early adolescence can significantly predict stable and quality adolescent peer and romantic relationships. Parental support and healthy parental relationships are also protective factors again risky sexual behaviors (Kerpelman et al., 2013). Since relationship dynamics and delayed first intercourse is more consistent with the use of contraception, how can parents support teens in healthy sexual decision-making practices?

Review of Relevant Research

In order to support teens in making healthy sexual decisions, parental relationships have proven most successful, followed by education institutions, and community-based resources. Research has found that parental support positively predicted self-esteem and dating identity exploration. Parental support during early adolescence can significantly predict stable and quality adolescent peer and romantic relationships. Strong parental support with warm, nurturing, and communicative relationships was a protective factor that deterred adolescents from having sex at earlier ages. This linked to higher levels of adolescent self-esteem and lower engagement in risky sexual behaviors (Kerpelman et al., 2013).

While most of the research has been done on Caucasian and African American adolescents, it should be noted that Latinas have the highest teen pregnancy rate across all ethnic groups in the U.S. Latinos and other ethnic groups such as African Americans have a greater risk of HIV than Euromericans. Sexual behavior among adolescents is influenced by the family members and peers with whom they interact. Most parents first talk about sex to their children when they are between the ages of 10 and 13 years, with mothers being the main educator. Adolescents who talk frequently about sex with their parents are less likely to be sexually active, have fewer sexual partners, and have a higher likelihood of using contraception (Guzman et al, 2003). Successful parental monitoring strategies are asking questions about dating/sex, rule setting (e.g. a condom must always be used), acknowledgement of teens as sexual beings, and openness to adolescent's questions (Feinstein et al, 2018).

While close parental relationships can reduce risky sexual behavior in heterosexual adolescents, little is known about gay and bisexual male youth - even though they have an increased risk of HIV. Often, gay/bisexual males reported that coming out strained their relationship with their parents, which can be a risk factor for risky sexual behaviors. Thus, online community outreach programs have proven success in teaching against HIV/STI protections and healthy relationships (Feinstein et al, 2018).

Intimate partner violence (IPV) and sexual violence in adolescents place them on a route to violence, which can be either as a victim or perpetrator. Of the few studies done on IPV,

school-based dating education has been most successful (although, such programs have only been implemented in high-income countries). With the right resources and parental permission, such education has been successful (Irimia & Cottschling. 2016). Risk factors for IPV include gender inequality, relationship conflict, and tolerance of sexual violence. Research shows success with education adolescents as early as age ten. The parental relationship is yet again, a protective factor for youths.

Possible Counseling Issues

There are various factors that impact teens sexual decision making and their general knowledge about sex. Lack of sex education or noncomprehensive sex education programing in schools can have an impact on teen sexual decision making (Kirby, 2002). Coupled with a lack of communication from parents about sex, teens may be misinformed and lack adequate knowledge. Additionally, some religious communities subscribe to abstinence only education, which can leave some teens fearful to ask questions about sex and skew their perception of sex. With this being said, our goal as counselors should be to promote healthy and effective communication between parents and teens in order to increase healthy sexual decision making. As counselors, we can support both parents and teens by providing psychoeducation and additional resources while also addressing personal beliefs and various cultural values about sex.

Additionally, we can help parents begin to have conversations about sex with their teens and discuss some of their anxiety or embarrassment around having the conversation, identify any barriers to communication and discuss their own personal views about sex. With adolescent clients, some may be hesitant to have a conversation about sex with their parents or choose not to disclose their sexual activity with parents. As counselors, we can discuss their general feelings about having sex and process some of the messages they have received about sex from their family, friends, and society. Furthermore, it is important that we as counselors ensure that our adolescent clients are practicing safe sex, obtaining consent, maintaining healthy relational and sexual boundaries, in addition to understanding any potential risks.

Additional Guidelines for Counseling Practice

There are some additional guidelines for counselors and parents of adolescents. As counselors, it is important that we recognize sexuality as a cultural element and strive to be culturally competent (Zeglin, Dorothy & Hergenrather, 2018). Counselors should have basic knowledge about sexual anatomy and develop the communication skills necessary to discuss sexuality with their adolescent clients (Zeglin et al, 2018). It can also be helpful to provide adolescents with accurate information regarding intimate partner violence (Committee on Psychosocial Aspects, 2016). Moreover, counselors should educate parents about the ineffectiveness of abstinence only education in schools and emphasize the importance of teaching adolescents about STIs, human sexuality, and contraception (Committee on Psychosocial Aspects, 2016).

Media can also influence adolescent's perceptions of sex and sexuality and most often provides inaccurate and unhealthy representations of sex. In order to reduce the effects of media on adolescent sexuality, communication between parents and adolescents is important (Ballam & Granello, 2011). Research has found that observing relationships in the media can be a good way for parents to start conversations with adolescents about sex and that adolescents often have a desire to talk about this topic (Ballam et al, 2011). Parents should also help their adolescents develop media literacy skills so that teenagers can critically analyze the information they are receiving from media about sex (Ballam et al, 2011). A good resource for helping adolescents and children develop media literacy is https://www.medialit.org.

Resources

- Parent Involvement in Sex Education
- This is What Sex Positive Parenting Looks Like
- Planned Parenthood - For Teens
- Talking with Your Teens About Sex
- Making Healthy Decisions About Sex
- Making Healthy Sexual Decisions - Young Women
- Making Healthy Sexual Decisions - Young Men

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Chapter 5

Healthy Sexuality in Older Adulthood

By Vernika Jain, Eleanor Beeslaar, and Jessica Leistikow

Background and Introduction

Sexuality is complex and multi-faceted, and it includes an individual's gender identity and expression, sexual orientation, sexual desire and expression, feelings of intimacy and connection, and beliefs, values, and cultural identities (Henry & McNab, 2003; Rheaume & Mitty, 2008; Skalacka & Gerymski, 2019). Sexuality is a core part of an individual's identity and well-being at all life stages, including older adulthood. Although older adults are sexual beings and view sex as an important part of life, the dominant discourses of sexuality often exclude this population (Gott, Hinchliff, & Galena, 2004). Cultural myths and stereotypes about sexuality in older adulthood view older adults as incapable of experiencing sexual desire and disinterested in sex (Gott et al., 2004; Langer, 2009).

Despite these misconceptions, many older adults view sex as an important aspect of quality of life (as cited in Gott & Hinchliff, 2003) (Gott et al., 2004). In fact, according to the AARP's 2009 survey on sex, romance, and relationships in midlife and older adults, 85 percent of men and 61 percent of women agreed that sex is "important to quality of life" and 67 percent of men and 50 percent of women agreed that "sexual activity is critical to a good relationship (Fisher, 2010, p. 5). Not only is sexuality a topic of concern for older adults, but sex in older adulthood is also associated with a wide range of benefits including neurological and hormonal benefits, behavioral benefits, emotional benefits, cognitive benefits, interpersonal benefits, and spiritual benefits (Tower, 2017). It is evident that sexuality is an important issue that persists throughout the lifespan and must be addressed by counselors and other mental health professionals when working with older adults.

Review of Relevant Research

Research suggests that many older adults are or desire to be sexually active and that sexual interest and activity can lead to therapeutic effects in this population, dispelling the myth that older adults are not sexual beings (Willert & Semans, 2000). Older men and women are able to experience pleasurable sexual activity well into later life and engage in a range of sexual and intimate behaviors including: sexual intercourse, oral sex, touching, masturbation, hugging, and kissing (Willert & Semans, 2000; Muzacz & Akinsulure-Smith, 2013). Expression of sexuality may also look different during later life and include more non-intercourse activities, such as caressing, embracing, or kissing (Henry & McNab, 2003). These activities enable older adults to experience warmth, caring, intimacy, and connection, while expressing affection and loyalty (Langer, 2009; Muzacz & Akinsulure-Smith, 2013).

Expression of sexuality in older adulthood also leads to a variety of psychological and emotional benefits. A research study examining the correlation between happiness and sex in partnered older adults found that higher levels of sexual behavior were associated with greater positive psychological well-being and fewer symptoms of depression in participants (Freak-Poli et al., 2017). Additionally, according to Langer (2009), physical intimacy and connection positively contribute to older adults' self-esteem.

Though many older adults show interest in engaging in sexual activity, research indicates that sexual interest and activity can gradually decline due to the physiological changes that occur with aging (Willert & Semans, 2000; Zeiss & Kasl-Godley, 2001; Henry & McNab, 2003). For males, these physiological changes include: lower testosterone levels, decline of sperm production, seminal fluid changes, slower development of excitement of erections (Willert &

Semans, 2000; Zeiss & Kasl-Godley, 2001; Henry & McNab, 2003). Females also experience changes, which include: decreased levels of estrogen and progesterone, thinning of the vaginal walls, delayed or decreased vaginal lubrication (Willert & Semans, 2000; Zeiss & Kasl-Godley, 2001; Henry & McNab, 2003). Additionally, for some older adults, illness, pain, or medications and treatments for health issues may also be barriers to sexual activity (Willerat & Semans, 2000). It is important for counselors and other mental health professionals to be aware of age-related physiological changes, while also considering the possibility of sexual dysfunctions in older adults, as to not assume that presenting concerns related to sexual activity are due to age (Willert & Semans, 2000).

According to Langer (2009), some older adults may lack accurate information about sexual health. An increasing number of older adults are contracting sexually transmitted diseases (STDs), which often go undetected because doctors are less likely to ask older adults about sexual activity or may misdiagnose symptoms of STDs for normal signs of aging (Langer, 2009). Additionally, older adults may also be less willing to bring up their sexual activity to their doctors (Langer, 2009). Education about sexuality during older adulthood, including information about sexual health can help promote the health and wellbeing of older adults (Henry & McNab, 2003).

Despite older adults' desire to engage in sexual activity, many clinicians, other mental health professionals, and health care professionals, are not adequately prepared to address sexuality-related concerns with individuals in this population (Willert & Semans, 2000). Sexual health in older adults is often overlooked, as evidenced by research findings, which indicate that staff members in residential facilities display minimal knowledge and recognition about sexuality issues, particularly when dealing with older adults (Bauer, McAuliffe, Nay, & Chenco, 2013). Additionally, Haboubi and Lincoln (2003) found that health professionals are poorly trained, ill-prepared and rarely practiced talking to older adults about sexuality issues even though they agreed that sexuality is an important topic when working with this population. These findings indicate a need for increased education related to sexuality concerns in older adulthood among professionals in the mental health and health fields. A study done by Bauer, McAuliffe, Nay, & Chenco (2013), evaluated the effects of an educational intervention on the attitudes and beliefs of residential staff working with older adults. They found that the educational intervention increased the staff's understanding of sexuality in older adulthood and decreased their negative views toward sexuality in older adults, improving their responses to the residents' sexual behaviors (Bauer, McAuliffe, Nay, & Chenco, 2013). This study highlights the importance of education and how it can change the beliefs of healthcare and mental health-care providers, as well as society at large.

Possible Counseling Issues

It is common for individuals in older adulthood to encounter sexual problems. In a study by Lindau et al. (2007), half of the participants between age 57 and 85 reported having at least one sexual problem that was concerning to them. For men, the most prevalent sexual problems were related to getting and keeping an erection, low sexual desire, anxiety about performance, and difficulty reaching orgasm (Lindau et al., 2007). For women, low sexual desire, lubrication difficulties, and difficulty reaching orgasm were most common (Lindau et al., 2007). According to Lindau et al. (2007), only 58 percent of participants from age 57 to 65 and 31 percent of participants from age 75 to 85 reported engaging in oral sex. Therefore, it may be helpful for counselors to empower older adult clients to explore pleasurable sexual activities, besides penetration, individually and with partners.

Although sexual problems can be common in older adulthood, counselors must also be careful not to make assumptions or apply biases based on aging. Sex is often perceived as an activity for young people that will naturally decline with age, but this is not the case for all older adults (Langer, 2009). Despite their lack of basis in reality, myths about aging are often internalized by older adults, causing them to prematurely withdraw from sexual expression and behavior (Langer, 2009). Since myths about aging are often at the root of sexual problems that older adults experience, it is important for counselors to normalize sexual expression and behavior across the lifespan. Younger counselors may also find it helpful to broach age differences in order to create a safe space for conversations about sexuality with older adults.

Additional Guidelines for Counseling Practice

As mentioned in the relevant research section, education and training in sexuality issues related to older adulthood are very important. Counselors should stay up to date with new information regarding sexuality in older adults and be trained in how to approach and talk about sexuality issues in older adulthood. Additionally, counselors need to be willing to open discussions about sexuality with older adults, as many older adults may be initially hesitant to share sexuality concerns. According to a study by Lindau et al. (2007), 73 percent of 57 to 64-year-olds, 53 percent of 65 to 74-year-olds, and 26 percent of 75 to 85-year-olds are sexually active. Therefore, sexuality is a relevant aspect of many older adults' lives, and it is important to address it in counseling.

When counseling older adults, it is also important for counselors to consider cultural factors related to attitudes about sexuality in older adulthood. As previously mentioned, myths about aging that exist in U.S. culture may affect older adults' self-image and comfort with bringing up the topic of sexuality in counseling (Muzacz & Akinsulure-Smith, 2013). In order to avoid reinforcing the cultural taboo that surrounds sexuality in older adulthood, it is necessary for counselors to broach the topic of sexuality (Muzacz & Akinsulure-Smith, 2013).

Counselors should also be prepared to help older adult clients advocate for themselves. Many older adults encounter decreased agency due to moving into a residential facility, developing a disability, or struggling with illness. Additionally, medical care providers and family caregivers may disregard these older adults as sexual beings (Langer, 2009). If appropriate, counselors should empower older adult clients to reclaim their agency by exploring ways that they can obtain privacy to engage in sexual behaviors.

Counselors and other mental health care providers can also empower older adult clients to make informed decisions related to their sexuality by engaging in psychoeducation about different aspects of sexuality, including sexual health (Willert & Semans, 2000; Huffstetler, 2006). This is especially important as some older adults may lack accurate information about sexually transmitted infections and the need for protection, such as condoms when engaging in sex during older adulthood (Langer, 2009).

When providing sexuality counseling to older adults, there are some particularly relevant components of the ACA Code of Ethics to be considered. Code A.4.b. instructs counselors to avoid imposing personal values, so counselors should examine their beliefs about sexuality in older adulthood and be careful not to apply biases when counseling older adults. Additionally, Code A.11.a. requires counselors to acknowledge the limitations of their practice and provide referrals accordingly. Therefore, if a counselor is not knowledgeable about providing sexuality counseling to older adults, they should seek out providers who have this within the scope of their practice. However, as previously mentioned, it is important to be prepared to provide sexuality

counseling to the older adult population, as this is likely to be encountered in your counseling practice.

Resources for Professionals

- American Psychological Association. Aging and Human Sexuality Resource Guide: https://www.apa.org/pi/aging/resources/guides/sexuality
    - This website provides journal articles, books, websites, and organizations to help mental health professionals address sexuality related concerns with older adults.
- Sage-Advocacy and services for LGBT elders (https://www.sageusa.org/)
- Sex, Romance, and Relationships: AARP Survey of Midlife and Older Adults: https://www.aarp.org/research/topics/life/info-2014/srr_09.html
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Chapter 6

Spirituality and Sexuality

By Ansley Hayes and Lauren Shriver

Background and Introduction

In 2009 the Association for Spiritual, Ethical and Religious Values in Counseling (ASERVIC) released new guidelines for practitioners to use when addressing religious and/or spiritual issues in professional counseling relationships (Cashwell & Watts, 2010). Though these guidelines do not include a specific mandate for addressing the intersection between client spirituality and client sexuality, their overarching theme is that spiritual/religious beliefs (or lack thereof) can influence the psychosocial functioning of individuals. Counselors may be tasked with the difficulty of assisting clients in navigating their relationship to both spirituality and sexuality in a culture that often suppresses frank discussions of these topics. Definitions of religious and spirituality vary widely, but religion generally refers to the adherence to/participation in spaces which adhere to a specific set of dogmatic beliefs while spirituality is a more abstract reaching for connection to something divine that is greater than the self (Killian, Peters, & Brottem, 2019). Counselors are advised to take an interdisciplinary approach when seeking research to inform the practice of integrating spiritual/religious concerns into sex and marital therapy as counseling specific research on this topic is still in its adolescence.

Review of Relevant Research

Pondering the intersection of marriage and family counseling and spirituality has been a part of the field since its inception due in part to the fact that many early practitioners were also religious leaders (Helmeke & Bischof, 2011). Despite these roots, research that specifically addresses the impact of client spiritual/religious beliefs on sexual and intimate relationship concerns emerged more recently, primarily during the last two decades (Helmeke & Bischof, 2011). The earliest research, conducted between 1990-1999, examined the impact of religious and spiritual beliefs on family and marital functioning while exploring potential benefits, consequences, and ethical guidelines for integrating client spiritual beliefs into counseling (Helmeke & Bischof, 2011). The bulk of that early research primarily sought to address two questions; how to integrate spirituality into counseling when working with individual and couple clients and identifying the impact of spiritual/religious beliefs or practices on marital functioning.

Following what Helmeke and Bischof termed “the first and second wave” of research, sex therapists began to take interest in exploring how spirituality might impact sexuality in long-term, monogamous, heterosexual marriages. One of the first explicit links between sexuality, couples counseling, and spirituality occurred in 1997 when David Schnarch described the fulfillment of human sexual potential as a developmental task that can be a pathway to the sacred (Helmeke & Bischof, 2011). Schnarch argues that differentiation, the lifelong work of developing the ability to balance the innate human need for togetherness with the need for individual identity development, can be conceptualized as a spiritual process where an individual seeks to transcend the self (Schnarch, 2012). In the final chapter of his book *The Passionate Marriage,* Schnarch attributes the relative dearth of counseling specific research examining the spiritual within the sexual to the difficulty of creating a satisfactory scientific construct for spirituality. He goes on to draw from Ken Wilbur’s work *Sex, Ecology, and Spirituality: The Spirit of Evolution* in an attempt to connect the developmental process of differentiation in a romantic relationship to models of spiritual development (Schnarch, 2012). By including

Wilbur's writing in the pivotal chapter of a book about sex and marriage counseling, Schnarch illustrates the importance (perhaps even necessity) of interdisciplinary study that incorporates the voices of counselors, sociologists, sexologists, religious scholars, and other academics and practitioners. Research investigating how the relationship between the sacred and the sexual impacts individual experiences of intimate relationships is still in its adolescence.

Much of the research seeking to link sexuality and spirituality is investigated from a Western Christian framework which has a history of strict separation between mind and body. Many scholars have struggled to map the implications of the mind/body binary present in Christian perspectives on sexuality. The central question in much of this research is whether or not the body, which is often viewed as an imperfect vessel for the soul rather than integral to the soul, can be the primary site of spiritual experiences (Ullery, 2004). Drawing from both global biblical, philosophical, and counseling texts, researchers began to identify clinical considerations for using spirituality in sex and couples counseling and hinted at introducing integrated, holistic Eastern perspectives of sexuality to Western Christian clients (Ullery, 2004). The term "sacred sexuality" has been used to describe the experience of openness and connectedness with God during sexual encounters where participants may ascribe sacred or transpersonal qualities to the encounter (Carlisle, 2018). Counselors will likely encounter Christian and other religiously identified clients who believe that one's sexual identity and spiritual identity are in opposition to one another. However, research indicates that persons can move through stages of sexual and spiritual development toward an understanding that these identities can exist in harmony (Carlisle, 2018). Moving toward a "spirit-centered level of awareness" during sex allows one to appreciate the physical and personal aspects of sex without trading in their belief in God (Carlisle, 2018).

The number of people who practice Eastern religions, such as Buddhism and Hinduism, have grown over the last two decades in Western society (Turner, Fox, Center, & Kiser, 2006). Couple and family counselors should also note that many American partners do not share similar religious beliefs with one another and differences in belief systems within the same couple or family system are increasingly common. Counselors are bound by ethics to practice unconditional positive regard for all clients and should seek research regarding clients' religious beliefs that might be unfamiliar or prompt discomfort for the practitioner (Turner et al., 2006). Taoism, Hinduism, and Buddhism each value the integration of spirituality and sexuality in their own way. Taoism encourages sexual expression as a way of developing one's spiritual purpose (Turner et al., 2006). The harmony of sexuality and spirituality is considered healthy and allows a person to come closer to unity with the divine. Hinduism and Buddhism connect sexuality and spirituality through two main philosophies: Kama Sutra and Tantrism (Turner et al., 2006). Kama, meaning sexual love, exists "when the five senses, along with the intellect and the spirit, consciously and intentionally explore the full and complete pleasure of bodily contact (Turner et al., 2006)." On the other hand, Tantric sexuality has the goal of promoting energy channels between partners and uniting all the forces of the universe in the relationship (Turner et al., 2006).

Possible Counseling Issues (e.g., Individual, Family, and/or Couple)

Before addressing any issues that may have a spiritual and sexual component in counseling, practitioners must possess the skills to assess the degree to which spiritual or religious beliefs and practices influence clients' experience of themselves, others, and the world. In order to do this, counselors can look to the ASERVIC competencies for guidance and as always, consult with more experienced practitioners. Assessment of religiosity/spirituality should

be a component of any intake interview and counselor broaching process and may need to be revisited regularly. For Christian clients, additional assessment may be helpful in determining the client or client systems' beliefs regarding connections between the body and the spirit (Ullery, 2004). For all clients, regardless of religious identification, it may be helpful to have a frank discussion about early messages received from the family and larger social system about the body and sexuality. However, counselors should be prepared for messages from religious leaders to potentially have an outsized impact than messages received from other sources when working with clients for whom religion/spirituality is particularly important (Turner, Center, & Kiser, 2004).

Because many religious teachings issue strict guidelines for specific sexual behaviors and in which contexts they many occur, clients who identify closeness with a specific dogma may enter into counseling with the belief that sex is synonymous with shame and sin (Timmerman, 2001). Clients may struggle to view themselves as sexual beings without feeling guilt, shame, or other negative emotions. Counselors may need to move slowly during this phase of therapy, taking care to include grounding practices and work around self-compassion. Counselors may need to assist clients in examining their perception of what sexuality means; is it viewed as more behavioral?; is it a pathway to greater connection to self, the other, and the spirit? (Ullery, 2004). One intervention that may be helpful is an adapted Genogram designed to uncover messages a client has received from family, significant others, and religious leaders, with the invitation to gently interrogate those messages for their current helpfulness to the client. Rather than mapping interpersonal relationships, this adapted Genogram maps implicit and explicit messages received over a lifetime and provides a graphic representation of those messages that may be revisited in ongoing sessions.

For people who identify as both religious/spiritual and LGBTQIA+, identity formation can be particularly difficult because these identities are often culturally considered to be at odds with one another (Killian et al., 2019). A client might feel forced to choose one identity over the other depending upon their social context or other pressures. LGBTQIA+ individuals have often faced the possibility of rejection for coming out in religious communities, but there has not been much attention given to those individuals who might come out as religious/spiritual in queer communities (Killian et al., 2019). Counselors can allow space in session for clients to work on the effective integration of these, and other, identities to empower individuals and help foster self-efficacy. Research has shown that empowerment and the affirmation of one's spiritual identity can assist in the development of a positive sexual identity, particularly for queer women (Hagen, Arczynski, Morrow, & Hawxhurst, 2011). When working with this population, counselors must consider the intersectionality of identities and oppressions clients face and interventions should be catered to the needs of the client accordingly.

Practitioners may encounter clients who express their sexuality in ways that may be considered deviant by the larger culture yet contain a spiritual component for the client. People who practice kink or BDSM (bondage & discipline, dominance & submission, sadism & masochism) often report a spiritual element to their sexuality that is often overlooked in popular representations of the practice (Fennell, 2018). Counselors working with individuals who are a part of the BDSM subculture and experience a spiritual connection to the practice can offer a safe, nonjudgmental space to allow room for the client to hold these identities simultaneously. There is a small, but growing, desire for kink-aware professionals including mental healthcare providers (Carlson, 2017).

Additional Guidelines for Counseling Practice

Given the fact that both sexuality and spirituality can be relatively taboo topics, counselors should take care to create an open and welcoming environment in which the client feels comfortable discussing their beliefs and practices. Normalizing both the counseling process and their personal struggles or presenting concerns will also help to build rapport and create a solid working relationship. It is important that counselors are willing and able to explore the individual's and/or couple's identities, beliefs, and experiences regarding their spirituality and sexuality (Killian et al., 2019). Outside of the counseling space, clinicians must also know their own beliefs and reflect on how they might come into the room with clients (Ullery, 2004). Counselors who have reflected upon their own understanding of the intersection of sexuality and spirituality are "best equipped to provide effective mental health services to religious and spiritual LGB clients. (Sherry, Adelman, Whilde, & Quick, 2010). On the whole, counselors must not exceed the limitations of their competencies and hold the client's best interest at hand at all times.

Counselors will also benefit from staying up to date with ongoing research into sexuality and spirituality in counseling practice, particularly into issues of gender and sexual identity exploration and its relation to spirituality. In addition, counselors may want to explore, through reading or experiential practice, other philosophies and spiritual disciplines with which they are unfamiliar. Clinicians can expect to encounter clients with different levels of commitment and exposure to Eastern religions and further research into these areas will allow the counselor to better serve these clients and/or recognize when a referral is in the best interest of the client. As clients bring in certain issues, the counselor can also reach out for additional resources to best meet the client where they are and understand their perspective as much as possible (Turner et al, 2006). Practicing non-judgment in these scenarios is key to ethical counseling work and will aid in building the therapeutic relationship.

What resources are available to help professionals learn more about this topic?

a. https://www.aasect.org/
b. http://expandingsextherapy.com/
c. Journal of LGBT Issues in Counseling
d. Journal of GLBT Family Studies
e. Sexualities, Journal by Sage Publications
f. *Expanding the Practice of Sex Therapy: An Integrative Model for Exploring Desire and Intimacy* by Gina Odgen
g. *Mating in Captivity: Unlocking Erotic Intelligence* by Esther Perel

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Chapter 7

Healthy Sexuality Following Sexual Trauma

By Katie James, Jennifer Shafer, and Kailei Trippi

Background and Introduction

According to the Center for Disease Control (CDC), sexual violence (or sexual trauma) is defined as a "sexual activity when consent is not obtained or freely given," and unfortunately is a very serious problem in the United States. Sexual assault, rape, sex trafficking, and genital mutilation are just a few of the terrible acts that are considered a sexual trauma and they can be perpetrated by a stranger, but more often the perpetrator is someone the victim knows and has an interpersonal relationship with. The statistics for sexual trauma are growing more alarming by the day – 1 in 3 women, and 1 in 4 men experience sexual violence that includes physical contact at some time throughout their lifetime (Sexual Violence). Not only is sexual trauma common, but it starts early in childhood as well: The CDC found that 1 in 8 women and 1 in 4 men reported their rape occurred before the age of 10. Even though women are more likely to be exposed to a sex-related trauma while men are more likely to be exposed to violence and physical assault traumas according to an article published by Clifford Broman, sexual trauma can happen to anyone. These heinous acts do not discriminate based on age, sex, gender, race, ethnicity, religion, or any other identity - they can happen to anyone – and anyone can be a perpetrator. So, the question becomes: "As counselors, how can help foster healthy sexuality following sexual trauma?

Relevant Research

It has been found that, "sexuality attitudes are linked to the experience of trauma" but the "experience of sexual abuse does not always lead to sexual symptoms" (Broman, 356; Bornefeld-Ettmann, 536). These findings indicate that one's view of sexuality can be influenced by an experienced sexual trauma, but that a sexual trauma does not always lead to negative symptoms of sexuality. Some of the negative symptoms can include but are not limited to, physical injuries (bruising, broken bones, genital injuries), psychological (guilt, depression, anxiety, PTSD, suicidal thoughts), sleep disturbances, poor appetite, obsessive thoughts about the victimization experience, or other problems pertaining to gynecological, gastrointestinal, cardiovascular (including palpitations) and sexual health (Sexual Violence; Broman, 351). Furthermore, "the assumption that PTSD rather than the experience of sexual violence is crucial for impairments in sexual functioning is supported by a high prevalence of sexual dysfunctions in PTSD [post-traumatic stress disorder] patients who experienced other forms of traumatic events, such as war-related trauma" (Bornefeld-Ettmann, 530). This finding implies that sexual dysfunctions stem from the presence of PTSD and post-traumatic stress symptoms rather than the sexual trauma itself.

A study conducted by Pia Bornefeld-Ettmann and colleagues compared three groups of women: those that suffered from PSTD after childhood sexual abuse, those that experienced childhood sexual abuse but did not have PTSD, and healthy women. The study found that the women who had experienced childhood sexual abuse and were diagnosed with PTSD had more problems with sexual aversion, sexual pain, and sexual satisfaction. However, the women with a childhood sexual abuse and PTSD showed no differences in sexual arousal or orgasm compared to the other two groups of women. Continually, Bornefeld-Ettmann found that sexual dysfunctions were prevalent in about 59% of victims of childhood sexual abuse compared to a

40-45% prevalence rate of sexual dysfunctions in the general population, and about 45-55% of victims of childhood sexual abuse develop PTSD as a result.

Another study, conducted by Clifford Broman, examined attitudes toward sexuality following a sexual trauma – the study found a strong attitudinal link between this event and its consequences. Even though this study asked very few questions regarding sexuality, the results are still important because it conveys the link between sexual trauma and sexual attitudes. Broman's study examined gendered differences regarding pornography and homosexuality. Typically, women have more negative views pornography and men have more negative views of homosexuality. However, this study found that after suffering a sexually traumatic event women's views on sexuality related topics were more likely to be changed – women's views were now more accepting of pornography and having a homosexual friend or family after a traumatic event of a sexual nature. Additionally, those that are highly education and nonreligious also tended to be more accepting of pornography and homosexuality regardless of experienced sexual trauma or not. Another interesting point that Broman noted was that, "before the victimization experience, people likely have a basic understanding about how and why people become victimized. This set of beliefs aids in understanding why some people become victims while others do not" (352). This statement indicates that one's view on what being a victim means affects if one views themselves as a victim after a sexual trauma.

Possible Counseling Issues

It is important for counselors to remember there is a great deal of loss and grief associated with surviving a sexual trauma. The predominant primary loss identified in the literature is the loss of one's life and worldview prior to the trauma. Additionally, a plethora of secondary losses may be present, such as loss of trust in others as well as one's self, loss of freedom and independence, loss of a sense of safety, and loss of positive self-concept or self-esteem. A survivor of sexual trauma may also experience a diminished desire for sex or the loss of interest in sex altogether. It is possible for this sense of loss to feel ongoing and never-ending and may intensify the stress associated with uncertainty. Additionally, the losses associated with sexual assault are regarded as "uncommon," or losses that are high in prevalence but not experienced by most of the population, resulting less recognition and opportunities for support. Grief associated with such a loss has been termed "disenfranchised grief" (Bordere, 2017). Survivors of sexual trauma are frequently attempting to cope with grief that is not recognized interpersonally or culturally and has no ritual or transitional markers despite the corresponding loss and grief reaction. This disenfranchisement can keep survivors from benefiting from grief-support interventions and connecting with others who also relate to being a sexual trauma survivor through the language of loss and grief (Shakespeare-Finch & Armstrong, 2010).

Individuals who are racially minoritized may be affected by the losses associated with sexual assault differently. The legal system can impede a survivor's recovery by limiting their autonomy, the control of their narrative, and feelings of safety. For those who have multiple marginalized identities, namely African American women, police protection and accessibility to legal services before and after an assault may be limited or counterproductive in some cases. Religious institutions have been found to be a helpful means of coping with the inadequacies of the legal system and injustice of sexual assault, especially for African American women (Bryant-Davis, Ullman, Tsong, & Gobin, 2011). On the other hand, individuals who herald from a place of privilege may be less familiar with injustices of the world - injustices many of minoritized identities face regularly - and thus may find additional challenges in coping with the injustice forced upon them (Bordere, 2017).

Additional Guidelines for Counseling Practice

Grief work takes time to process and heal from, thus it is recommended counselors provide the time and space for survivors to establish new norms for their lives following a sexual assault. Oppression and negative social messaging about sexual assault can complicate the healing process and may cause survivors to feel as though they must mask or conceal their grief. It may be helpful for counselors to address the "myths" associated with rape and assist clients in crafting their own messages about sexual assault. Additionally, it is important for counselors to be an advocate for their clients as misdiagnosis of depression and the subsequent prescription for antidepressants is associated with sexual trauma. Normalization of feelings of grief, psychoeducation around how lack of sexual interest is normal following an assault, and empowering clients to craft their own narrative and be their own advocate are all considerations for mental health professionals (Bordere, 2017).

To meet the aforementioned considerations, clinicians should utilize a client-centered, trauma-informed approach in an intentional, safe environment in which the survivor feels empowered (Ullman & Townsend, 2008). Research suggests women feel empowered when they can control their behaviors, feelings, and thoughts (Ullman & Townsend, 2008). Cognitive Behavioral Therapy emphasizes identifying maladaptive thoughts and behaviors, then replacing them with positive alternatives; thus, Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) has been shown to effectively treat the post-traumatic stress symptoms of trauma survivors ages 2-18 (Deblinger, Mannarina, Cohen, Steer, 2006). By embracing an empowerment approach, counselors help clients regain control that is often taken from them through the trauma itself and the responses to the trauma from various systems such as the medical and legal system (Ullman & Townsend, 2008). The empowerment approach emphasizes empathy, honesty and non-directive counseling techniques (Ullman & Townsend, 2008). Furthermore, safety planning is a specific way counselors can empower clients by collaborating on strengths-based goals that a client can action toward and regain feelings of control over one's life.

Counseling survivors of sexual trauma can be an emotionally taxing undertaking; thus, helping professionals must consider taking care of themselves in order to prevent burnout and compassion fatigue. A study by Killian (2008) involving 104 clinicians who work in high-stress, trauma-related settings were given questionnaires about their caseload, work stress, burnout, compassion fatigue, and coping strategies. Results indicated that engaging with social supports had the greatest positive impact on compassion satisfaction. Findings also indicated that those who set time boundaries on their workload experienced less compassion fatigue. In fact, these components along with possessing an internal locus of control accounted for 41% of the variance in compassion satisfaction scores. Thus, research supports that taking time for yourself, asking for what you need from your supervisor and social support system, as well as believing you have the ability to control your response to stress are all beneficial ways to reduce the fatigue associated with providing services to survivors of sexual assault.

What resources (e.g., books, Internet sites, and journal articles) are available to help professionals learn more about this topic?

The following list includes some additional resources that clinicians, professionals, survivors and supporters may consider useful when exploring healthy sexuality following sexual trauma. This is not an exhaustive list but includes national and local resources that can connect users to more specific information as desired.

https://centers.rainn.org – Rape, Abuse & Incest National Network
https://www.nsvrc.org – National Sexual Violence Resource Center

http://www.nccasa.org/cms/ - North Carolina Coalition Against Sexual Assault
https://www.plannedparenthood.org Planned Parenthood
https://www.fspcares.org/domestic-violence-sexual-assault/ - Family Services of the Piedmont
http://www.christinemurray.info/sexuality-counseling-resources.html - Sexuality Counseling Resources

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Chapter 8

Healthy Sexuality and Body Changes from Medical Treatments and Procedures for Cancer

By Betsey Davis and Bernard Shalvey

Background and Introduction

Individuals who have undergone medical interventions for cancer in the form of surgical procedures, such as a mastectomy (surgical operation to remove a breast) or orchiectomy (surgical operation to remove a testicle), and treatments such as radiation and chemotherapy, may experience a variety of difficulties with body image and sexuality. As counselors, mental health practitioners, and as individuals in community, it is important to understand the impact that these procedures (as well as other procedures and treatments resulting in potentially "compromised sexuality") have on an individual's sexual functioning/comfortability, body image and identity, and sexually intimate relationships. This chapter will primarily focus on the presenting concerns associated with people's experiences after undergoing these interventions that may result in challenges related to sexuality. While this chapter focuses on the impact of cancer interventions, these presenting concerns and a direction for treatment may be relevant to persons navigating other experiences of medical necessity resulting in changes one's sexual life.

Review of Relevant Research

Medically indicated surgical interventions related to sex characteristics that have been traditionally termed "primary sex characteristics" (vagina, penis, ovaries, testicles) or "secondary sexual characteristics" (breasts) may impact self-image and sexual functioning/comfortability. A retrospective study by Incrocci, Hop, Wijnmaalen and Slob (2001) explored the outcome for individuals who experienced an orchiectomy for testicular seminoma (malignant tumor of the testicles). Their study found that orchiectomy procedures negatively impacted sexual life as reported by a third of the participants (52 out of 157). At a mean of 51 months after treatment, this data was gathered by the administration of a questionnaire that asked participants questions about body image and current sexual functioning. The questionnaire gathered information about frequency and quality of erections, sexual activities, significance of sex as well as changes in sexuality (Incrocci, Hop, Wijnmaalen, & Slob, 2001).

In a study titled: "Perceptions of masculinity and self-image in adolescent and young adult testicular cancer survivors: implications for romantic and sexual relationships" researchers Carpentier, Fortenberry, Ott, Brames and Einhorn (2011) asked participants questions about their romantic and sexual relationships. The questions were validated through multidisciplinary expert review. The participants underwent a number of procedures/therapeutic approaches including orchiectomy, RPLND, radiotherapy, chemotherapy (low and high dose), and peripheral blood stem cell transplant. The result of the 18-minute interviews with the aforementioned individuals resulted in the following four common themes: "Embarrassment leads to delays in care-seeking...Testicular cancer makes you feel different from others...Being different from others makes you damaged goods...Cancer disclosure is difficult" (Carpentier, Fortenberry, Ott, Brames, & Einhorn, 2011). These results (themes) yield important considerations for medical providers, mental health practitioners, and the general public.

Possible Counseling Issues

When considering possible counseling issues, it is important to consider information supplied by research. Some commonalities in the results of research around Healthy Sexuality and Body Changes from Medical Treatments and Procedures for Cancer acknowledged as

counseling considerations, include: embarrassment delaying care seeking, feeling different from others, thinking of one's self as "damaged goods", difficulty with disclosure, a sense of sexual loss, a high likelihood of a different level of sexual satisfaction, body image concerns, changes in sexual self-schema, and relational coping challenges (Carpentier, Fortenberry, Ott, Brames, & Einhorn, 2011; Pillai-Friedman & Ashline, 2014; Williams, 1996; Loaring, Larkin, Shaw, & Flowers, 2015). Sex therapists and researchers Pillai-Friedman and Ashline (2014) suggest a grief model of treatment for cancer survivors facing challenges in their relationship with their sexuality.

In their study, Pillai-Freidman and Ashline (2014) propose that due to physical repercussions and psychosocial impacts, a sense of sexual loss and sexual dissatisfaction is often experienced by survivors. Their treatment model follows similar protocol as Annon's (1975, 1976) PLISSIT: "permission giving, limited information, specific suggestions, and intensive therapy" to address the often times unacknowledged grief, and ultimately, to pursue the objective of re-embodying and "eroticizing the altered body" (Pillai-Friedman & Ashline, 2014, p. 437). Permission giving allows the survivor safe, welcoming space to discuss their feelings, information provides psychoeducation regarding challenges the survivor may encounter individually and/or in a relational context, and specific suggestions entails offering practical help related to sexual adjustment (Pillai-Friedman & Ashline, 2014). The intensive therapy component allows for more complex psychological issues related to sexual self-schema to be explored, and in particular, for the grief work that may be helpful to this end (Pillai-Friedman & Ashline, 2014).

The Pillai-Friedman and Ashline treatment model incorporates medical, family, relationship and sexual histories (Buehlar, 2014; Downey & Friedman, 2009; Nusbaum & Hamilton, 2002) with assessments such as the Body Image Scale (BIS) designed specifically for cancer survivors (Hopwood, Fletcher, Lee, & Al Ghazal, 2001; Pillai-Friedman & Ashline, 2014). Alternative therapies such as "mindfulness, guided imagery, EMDR, directed journaling, and rituals [are recommended] to deepen the healing and alleviate the survivor's grief" (Pillai-Freidman & Ashline, 2014, p.446). Changes in sexual self-schema may also benefit from re-embodiment work through narrative interventions (Williams, 1996). Relational coping techniques are helpful in promoting a supportive atmosphere for survivors who are coupled (Zunkel, 2003). Pillai-Friedman and Ashline (2014) also refer to research on sexual trauma healing, such as the "healing with your own hands" technique (Ogden, 2008, p.164), and a version of sensate focus presented by Katz (2009) as examples of possible accompanying interventions of benefit, to be practiced with or without one's partner.

Loaring, Larkin, Shaw and Flowers' (2015) study specifically addresses the relational aspect to cancer recovery and healthy sexuality. This study outlines a methodology for attending to a couple's concerns and provides a helpful recommendation for "the importance of clear and reciprocal communication" not only between partners, but between patients (and their loved ones) and medical providers (Loaring, Larkin, Shaw, & Flowers, 2015). Likewise, support through supplemental therapy is considered to be of significant help (Loaring, Larkin, Shaw, & Flowers, 2015). This study lends support to couples counseling directions for therapy.

Additional Guidelines for Counseling Practice

As is always essential, counselors would need to consider a client facing recovery from cancer holistically and to build an accurate understanding of the individual's strengths, protective factors, and contextual factors, especially in assessing for trauma, safety or any barriers (such as financial needs) that might affect an individual's optimal healing and wellness. For instance, it is

important to not assume that a client has a support system, or reliable one, or is not facing additional experiences of adversity or marginalization. Appropriate resource guidance and coordinated care may be critical in many instances. Understanding an individual's relationship to their sexuality and their view of what sexual health means from their cultural perspective and/or religion/spirituality is also of the utmost importance.

Also, it is important to understand an individual's sexual development independent of any surgical procedures a person has experienced in order to effectively and accurately provide treatment. Although the presenting concerns of one of the previously mentioned procedures may vary among people in a similar stage of sexual development, there are similarities that, when considered, could assist in an accurate treatment approach. These stages could parallel certain developmental models of counseling such as Erik Erikson's psychosocial stages of development. Social pressures and internalized messages around sexual issues and healing should be considered. Feminist theory could be beneficial in developing an individualized treatment plan as well as other theories focusing on gender roles.

Resources

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Local (Greensboro, NC)

https://www.conehealthmedicalgroup.com/chmg/practice-locations/profile/cone-health-cancer-center-at-wesley-long/ (cancer center offering free recovery programming and a support group network for cancer patients/survivors and their loved ones & caregivers)

https://www.hirschwellnessnetwork.org/ (free healing arts workshops for cancer patients/survivors and their loved ones & caregivers)

www.triadyoga.com (free yoga for cancer survivors and their loved ones & caregivers on Tuesday nights)

https://www.ymcagreensboro.org/programs/specialty-programs/livestrong-ymca%C2%AE (free exercise program for cancer survivors and their loved ones & caregivers)

Internet Resources

www.livestrong.org

www.breastcancer.org

www.cancersupportcommunity.org/living-cancer/living-cancer-topics/quality-life-cancer-patients/improving-sexual-intimacy-after-cancer

https://www.curetoday.com/publications/cure/2010/summer2010/sex-and-intimacy-after-cancer

https://www.oncolink.org/support/sexuality-fertility/sexuality/women-s-guide-to-sexuality-during-after-cancer-treatment

https://www.oncolink.org/support/sexuality-fertility/sexuality/men-s-guide-to-sexuality-during-after-cancer-treatment

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Chapter 9

Kink Culture and the BDSM Community

By Edie Allen and Elana Baumann-Carbrey

Background and Introduction

When contemplating what constitutes a 'healthy' portrayal of human sexuality, it is important to recognize the variety of diverse behaviors and choices that are present in humanity. BDSM falls within this spectrum and is used as an umbrella category to encompass a vast range of activities, desires, fantasies, communities, identities and meanings related to Bondage/Discipline, Dominance/ Submission, and/or Sadism/Masochism. BDSM is often used synonymously with the term Kink, a more general term for non-normative sexuality including an extremely diverse range of interests such as fetishes, cross-dressing, strap-on sex, voyeurism and exhibitionism. However, there is no agreement on what specific behaviors denote Kink or BDSM activity (DeNeef, Coppens, Hays & Morrens, 2019). This makes it challenging to specify what classifies as a kinky practice and what does not. The practice of BDSM is complex and controversial because emotions and behaviors that are more widely perceived as undesirable (shame, powerlessness, pain, control) are normalized through eroticization.

One of the most salient features of BDSM culture is the heavy reliance on formal consent contracts that represent the commitment to "Safe, Sane, Consensual" sex (SSC) and the more recent shift to "Risk-Aware Consensual Kink" (RACK) (Simula, 2019). BDSM culture is founded on consensual interactions and that separates it from pathological or abusive behaviors. Participants plan, negotiate, and set limits and rules of play prior to engaging. Consent is framed as an ongoing process. Kink communities often create evolving understandings of consent that shift responsibility for safety from an individualist to community model. In this way, the community is accountable for acting on consent violations and imposing sanctions on perpetrators.

Stigma and misconstrued media messages concerning BDSM/Kink have led to common misconceptions that practices perpetuate violence, inequality, pain, and abuse. Put simply, BDSM/Kink is consensual, abuse is not. Regardless of the behavior's subjective appeal, it is the duty of a professional to be able to differentiate between the two. The act of choosing to participate in a safe, consensual, and desired experience for the sake of erotic arousal or personal growth is an empowering element of kink culture. In reference, Gayle S. Rubins, a pro-feminist, queer, and BDSM-activist states, "Most people mistake their sexual preferences for a universal system that will or should work for everyone. If we decide to judge or police other people's consensual sex lives, we aren't being feminist. We're being patriarchal," (Rubin, 2011). Deconstructing the binary of what is 'deviant' as opposed to 'normal' precipitates necessary conceptual shifts in exploring BDSM as a "complex social phenomenon," (Simula, 2019).

It is difficult to accurately gauge the size of the U.S. BDSM population. Estimates from the 1990s to the present range from 2% to 25% of the population (Simula, 2019). Explanations for the divergent results of studies include differing time ranges (behavior in the past year vs. across a person's life) and differing definitions of what constitutes BDSM behavior (fantasy, sexual interest and/or sexual behavior and which behaviors). There are also other known challenges in researching sexual behavior in a stigmatized population (DeNeef, Coppens, Hays & Morrens, 2019).

Review of Relevant Research

Some scholars argue that BDSM "seeks to expose and investigate the ways in which sexual desire and experience reflect and construct systems of power" (Harvard Law Review, 2014, p. 713). By role-playing scenes of power imbalance, BDSMers reject normative standards surrounding equality as the basis for sex. However, sexual encounters often contain power differentials and the accompanying risks, despite what society purports to be true, and exaggerating these inequalities for pleasure and personal exploration may lend a transgressive quality to the excitement. This acknowledgement of a hidden dynamic is considered by practitioners to be "radical honesty about sexual power" (Harvard Law Review, 2014, p. 716).

In recent years, the development of BDSM studies as a field has resulted in important research that illuminates the complexity of BDSM culture. Studies suggest that due to the scope and range of fantasies and activities, as well as the various levels of interest and practice, BDSM/Kink are part of a larger spectrum of human sexuality reflecting more of a continuum than a categorical definition. The question of whether to understand BDSM/Kink as an activity, interest, orientation, identity, or a combination has largely been focused on its intersection with gender and sexuality. However, BDSM provides a space where gender becomes less important and traditional gendered hierarchies are subverted or experimented with. In fact, many BDSMers have stable identities (dom, sub, switch) which take on a more salient role for them than gender. Consequently, BDSM does not always have a sexual meaning or the sexual meaning may come secondary to other meanings for participants, because the attraction is mainly to dominance versus submission (vs. both or neither) (Simula, 2019).

BDSM remains a diagnostic category in DSM-5 for individuals who experience distress related to their activity but a pathological perspective is increasingly unwarranted due to research showing little or no difference in psychological functioning and attachment styles of kink practitioners as well as limited associations to a history of sexual abuse, violence, sexual difficulty, or mental illness (Joyal, 2017). In fact, some kink practitioners describe BDSM experiences as being therapeutic and healing. BDSM can be a way to navigate and work through feelings of powerlessness, embarrassment, discomfort, and stress on a level participants describe as similar to types of talk therapy. Aspects can also involve feelings of deep connection with others through ritualistic activities and transcendent or spiritual components of fulfillment (Simula, 2019). Across studies, an underlying theme is the importance of connection with others - both to specific individuals and to a broader community. The collaboration and connection, also sought within the greater context of human sexuality, are key to enacting mutual erotic fantasies among BDSM participants.

Possible Counseling Issues (e.g., Individual, Family, and/or Couple)

Due to the mainstream misconception that BDSM equates to violence, often the challenges kinky clients bring to therapy involve navigating stigma: discrimination in professional, medical, familial, and social settings, coming out (who to tell, how to disclose, processing responses, associated feelings), and internalized kink phobia - giving reassurance that it can be a healthy part of sexuality. Counselors may also encounter clients who are trying to be an ally to a friend in the BDSM community and need support. Finally, the broader humanity of a kink practitioner is important to consider - a client may be seeking your services for therapeutic support outside of their identity as a kink practitioner and may be experiencing no distress or desire to therapeutically explore around their BDSM lifestyle.

The level of self-reflection and education therapists invite around kink culture will determine their ability to create an unbiased and nonjudgmental space for their clients. Therapists can become Kink-Friendly (accepting but limited) or aspire to be a Kink-Aware therapist who

can assist clients in navigating more specific issues. These topics may include awakening interest, navigating sexuality with partner(s), communication about BDSM proclivities with a non-kink-inclined partner, negotiating boundaries, distinguishing BDSM from abuse, facilitating the creation of consent contracts, and exploring desire in the face of cultural messages.

Additional Guidelines for Counseling Practice

Mental health professionals must confront mainstream values and their own subjective biases about aspects of BDSM in order to promote well-being in BDSM clients. Counselors can promote concepts of positive sexuality by understanding and questioning the social contexts and biases that surround BDSM. Although sexual health is defined as "a state of physical, emotional, mental and social well-being in relation to sexuality" in which sexual rights are "respected, protected and fulfilled" (WHO, 2010 as cited in Murray, Pope & Willis, 2017, p. 272), there are also prescriptive cultural ideas about the *kinds* of sexual behaviors that can one can engage in to attain that sexual health.

A fundamentally pathological bias has been created by a society and medical culture which historically has defined 'normal healthy' sexuality as penile/vaginal intercourse for the sole purpose of reproduction despite the body of research detailing the broad range and purposes of human sexual practices (Rehor, 2015). Sexual satisfaction and fulfillment, other components of positive sexuality, are similarly framed as within reach only of those engaging in mainstream practices. This narrow perception of the human sexual experience lands heavily on the kink community and has resulted in common misconceptions, fears, and even disgust about kink that perpetuate misguided shame for the BDSM community. Kink practitioners share many of the stressors of sexual minorities, such as distress from stigma, fear of encountering stigma and discrimination. They often fear disclosure and encounter prejudice due to a lack of training among medical professionals (Sprott & Randall, 2017).

Terminology/Glossary

Research has established the necessity of learning to talk intelligently to kink practitioners and understanding the language used by them to describe their community. These considerations are imperative in creating positive impacts as a mental health professional:

- *Aftercare* involves post scene activities or processing. Styles vary.
- *Bondage* and *discipline* (BD), *sadism* and *masochism* (SM) or *dominance* and *submission* (D/s) are all aspects of kink known as *BDSM*. While not always overtly sexual in nature, the activities and relationships within a BDSM context are almost always eroticized by the participants in some fashion. Many fall outside of social norms regarding sexuality.
- *Bondage/Discipline* is the practice of restraining individuals using tools, punishment, and/or rules to assert control and may be intended to cause humiliation.
- *Bottom* is used to describe the submissive, slave, subordinate, animal, and/or someone being taken care of.
- *Consent Contracts* are formal agreements to plan, negotiate, and set limits and rules of play prior to engaging.
- *Domination and Submission* is when someone is granted control or when someone grants control or authority in a scene, situation, or relationship.
- *Drop* describes physical or emotional exhaustion after a scene that can be experienced by all players. Common after intense scenes (even if enjoyed). Characterized by feelings of sadness, remorse or guilt, physical shaking or chills, crying and simple but profound exhaustion.

- *Dungeon* refers to a public or semipublic BDSM community space where BDSM play, scenes, or interactions take place and is usually equipped with BDSM furniture and toys
- *Edge play* is a type of play that pushes personal boundaries and involves greater risk. Approach with care and experience.
- *Exhibitionistic* behaviors involve arousal by being observed by others
- *Fetishistic* behaviors involve eroticization of and/or arousal by objects
- *Impact play* is any practice that involves striking the body (hands, belts, canes, paddles whips).
- *Kink* is a general term for unconventional sensual, erotic, and sexual behavior.
- *Kink Practitioner/Kinkster/Kinky* is a person who participates in at least one kink behavior
- *Leather* refers to a subset of BDSM originating in gay communities in the 1960s and spreading to lesbian communities in the 1970s.
- *Munch* is an informal gathering of individuals interested in BDSM for the purposes of socialization in a safe, generally non-sexualized environment.
- *Risk-Aware Consensual Kink (RACK)* is a newer consent model emphasizing potential harm due to the subjective definitions of what is 'sane.'
- *Sadism/Masochism (S/M or S&M)* is play which involves seeking or giving pain or humiliation.
- *Safe, Sane, and Consensual (SSC)* is a model affirming all activities taking place are physically and emotionally consensual.
- *Safe word* is a preselected word that players use to stop a scene in progress.
- *Scenes* or *Play* define BDSM interactions within a specific time period.
- *Sensation play* describes activities that focus on physical or sensory interactions.
- *Switch* refers to a participant who enjoys being a top and a bottom.
- *Top* is used to describe the Dominant, Master, someone in charge, trainer, caretaker.
- *Vanilla* is slang for non-kink identified people, things, or activities.
- *Voyeuristic* behaviors involve arousal by observing others.

For a more extensive resource of terms:
https://ncsfreedom.org/images/stories/pdfs/Activist/BDSM_Pamphlet-Glossary_of_BDSM_Terms.pdf

What resources are available to help professionals learn more about this topic?

Websites

- The National Coalition for Sexual Freedom (NCSF) https://ncsfreedom.org
- The Eulenspiegel Society's Orientation Booklet (Oldest and Largest BDSM Group in the U.S.) http://www.tes.org/wp-content/uploads/2015/07/CherryBooklet2015.pdf
- An Introduction to BDSM for Psychotherapists https://societyforpsychotherapy.org/an-introduction-to-bdsm-for-psychotherapists/

Books

- Easton, D., & Liszt, C., (2013). *When someone you love is kinky*. San Francisco: Greenery Press.
- Ortmann, D., & Sprott, R. (2015). *Sexual outsiders: understanding BDSM sexualities and communities*. Lanham, Maryland: Rowman & Littlefield Publishers.
- Shahbaz, C., & Chirinos, P., (2016). *Becoming a Kink Aware Therapist*. New York: Routledge Taylor & Francis Group.

Articles

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