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Using Surrogate Partner Therapy in Counseling: Treatment Considerations

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

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

Introduction

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

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

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

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

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

Surrogate Partner Therapy

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

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

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

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

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

emotionally, and sexually.

Surrogate Partner Therapy vs. Sexological Bodyworkers

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

Surrogate Partners vs. Sex Workers

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

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

Challenges

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

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

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

Professional Associations

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

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

Legal Concerns

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

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

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

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

Ethical Concerns

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

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

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

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

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

Benefits

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

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

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

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

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

Considerations

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

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

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

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

Recommendations for Best Practices

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

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

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

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