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Zachary D. Bloom
Northeastern Illinois University

Ashley J. Blount
University of Nebraska at Omaha

Dalena L. Dillman Taylor
University of Central Florida

Galina Lipkin

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The Sexual Values and Behaviors Discrepancy Model

Zachary D. Bloom

Northeastern Illinois University

Ashley J. Blount

University of Nebraska at Omaha

Dalena L. Dillman Taylor

University of Central Florida

Galina Lipkin

Northeastern Illinois University

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

Keywords: sexuality, wellness, theory, supervision, relationships

Introduction

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

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

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

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

Corresponding Author

Zachary D. Bloom
Northeastern Illinois University
5500 North St. Louis Avenue
Chicago, IL 60625-4699
E: Z-Bloom@neiu.edu
P: (773)442-5553

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

Sexuality and the Counseling Field

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

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

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

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

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

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

Theoretical Foundations

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

Therapeutic Relationships and Differentiation

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

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

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

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

Wellness-Informed Counseling & Wellness Discrepancies

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

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

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

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

The Sexual Values and Behaviors Discrepancy Model

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

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

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

Step 1: Identification and Operationalization of Potential Sexual Issues

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

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

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

Sexual Values and Behaviors Discrepancy Model

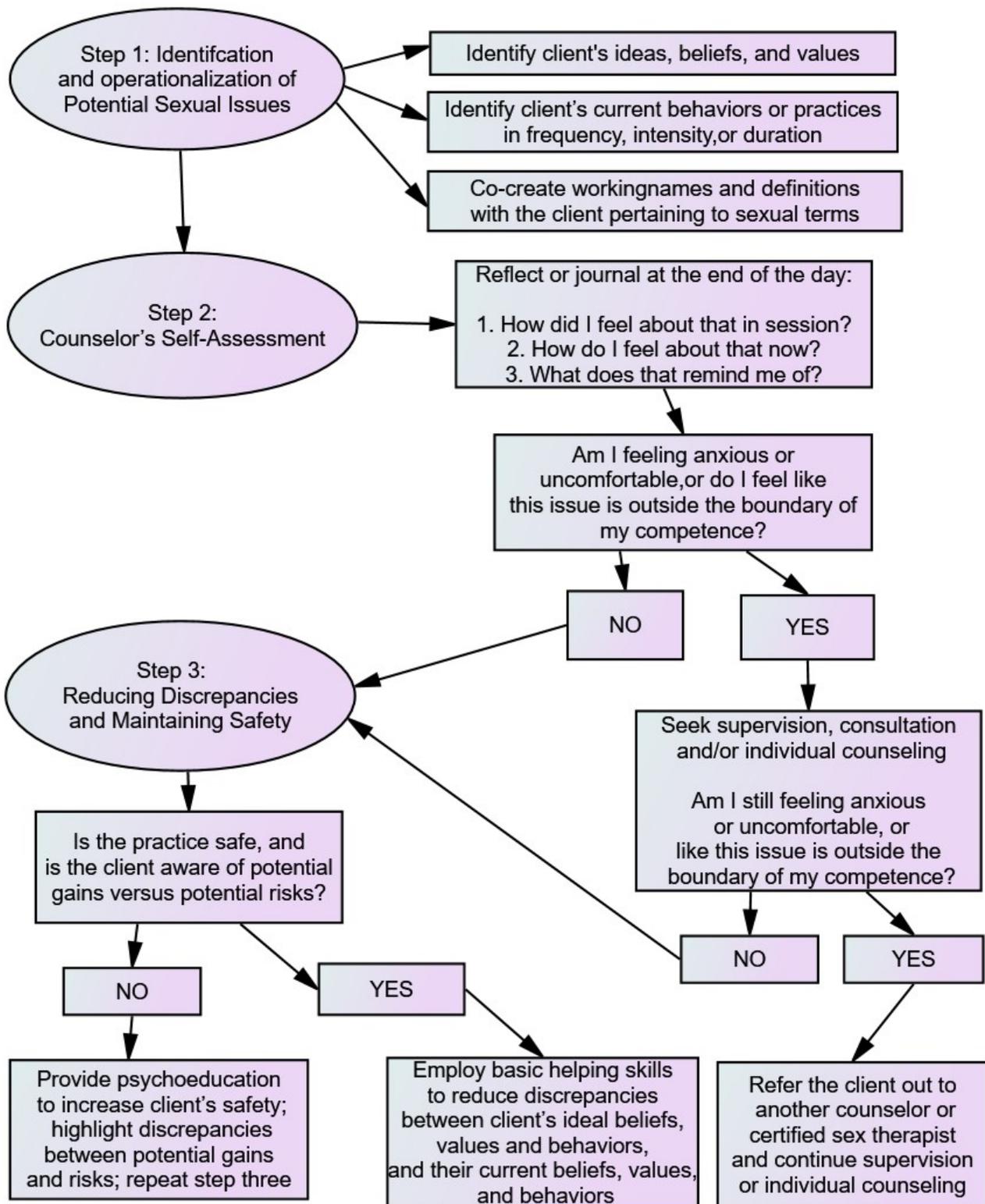


Figure 1. Sexual Values and Behaviors Discrepancy Model

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

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

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

Step 2: Counselor's Self-Assessment

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

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

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

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

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

Furthermore, we suggest that counselors also explore how

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

Step 3: Reducing Discrepancies and Maintaining Safety

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

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

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

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

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

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

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

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

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

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

Conclusion

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

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

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

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

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

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

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