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CME Information: Surrogate Partner Therapy: Ethical Considerations in Sexual Medicine

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- Review the history and evidence-based literature regarding SPT
- Describe and provide a model for ethical SPT practice, and
- Present two case examples illustrating ethical concerns.

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CME

Surrogate Partner Therapy: Ethical Considerations in Sexual Medicine

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ABSTRACT

Introduction. Surrogate partner therapy (SPT) is a controversial and often misunderstood practice.
Aim. The aim of this study was to review the history and evidence-based literature regarding SPT, describe and provide a model for ethical SPT practice, and present two case examples illustrating ethical concerns.
Methods. Literature review and report of clinical experience were the methods used.
Main Outcome Measure. Results of literature review and clinical experience were assessed for this study.
Results. Sex therapy pioneers Masters and Johnson introduced surrogacy in sex therapy; however, there is a lack of published evidence supporting treatment efficacy and ethico-legal questions have limited the practice from becoming a common intervention. SPT can be an effective intervention that may enhance sexual medicine practice. However, SPT must be offered according to legal, professional, and ethical standards.
Conclusions. Sexual medicine practitioners should consider SPT based on the ethical paradigms offered, and sex therapy practices utilizing SPT should collect and publish outcome data. **Rosenbaum T, Aloni R, and Heruti R. Surrogate partner therapy: Ethical considerations in sexual medicine. J Sex Med 2014;11:321–329.**

Key Words. Surrogate Partner Therapy; Sex Therapy; Ethics

Introduction

Recognizing the biopsychosocial context of sexual problems, sexual medicine values the role of sex therapy in the treatment of individuals and couples presenting with sexual dysfunction. Sex therapy with couples most often follows a behavioral model that includes psycho-education, improving couple communication, breaking down activities, and focusing on sensations rather than performance. For an individual who is un-partnered, sexual problems may be a preventative factor in forming a meaningful relationship. Yet, effective therapy, according to early sex therapy pioneers, requires a cooperative partner with whom to undergo the therapeutic process [1]. Surrogate partner therapy (SPT) is designed to provide the individual in sex therapy with a proxy partner with whom to experience this process.

As a result of the recent film *The Sessions*, SPT may have gained sympathy for providing the disabled with the opportunity for sexual expression. However, the goal of SPT is not simply to provide a sexual experience but to empower clients to be able to engage in meaningful and satisfying relationships. Moreover, sexual problems are common in all age groups and are not solely the domain of the sick or aged [2]. Surrogacy, therefore, offers benefits to able-bodied as well as disabled clients with sexual dysfunction.

While sex therapy is a well-established intervention, the use of surrogates remains a controversial and fairly misunderstood practice, which has professional, legal, ethical, and financial considerations. The exact prevalence of surrogate use worldwide is not known and appears to vary with geographical location, partially because of legal ambiguities. In Israel, sexual surrogacy is a legal

and accepted practice, and the information and treatment model provided in this review article are based partially on the experience and expertise of the authors, and in particular, the second author (R. Aloni), who trains and provides sexual surrogates in her Tel Aviv sex therapy clinic. The purposes of this continuing medical education (CME) activity are to describe the currently accepted practice methods of SPT, review the evidence-based literature available, discuss the ethical implications, and provide two case examples that illustrate and elucidate ethical considerations.

Treatment Methods

Masters and Johnson [3] introduced the concept of surrogate partners and defined their role as partners for the duration of therapy that put the therapist's instructions into practice and act to model sexual comfort and confidence for the client. As such, surrogacy was never intended to replace but rather to assist the sex therapist. Cole [4] endorsed an interdisciplinary method that began with a medical workup and diagnosis. SPT is part of a "therapy triangle" and consists of sessions between the therapist and client, the surrogate and the client, and the therapist and surrogate, at which the therapist provides guidance to the surrogate. The conclusion of the therapy also signifies the end of the relationship between the client and the surrogate.

The surrogate, therefore, is not a therapist but acts as a mentor with whom the client experiences a social and intimate connection, improved relationship forming behaviors, reduced anxiety, and increased self-confidence about sexual functioning [5]. The surrogate–client sessions include exercises in communication, relaxation, sensual and sexual touching, and social skills training [6].

Surrogate therapy uses a graduated approach—beginning with casual contact, progressing to sexual contact, and often involving sexual intercourse. There remains full client awareness of the surrogate's intention to aid and improve his or her self-esteem through this therapeutic construct. The experience of achieving a successful and meaningful sexual relationship acts to instill confidence in the client [5,7].

SPT is a recognized behavioral intervention within sex therapy and assists, but does not replace, sex therapy, which is essentially a psychotherapeutic modality. Critical to the surrogacy treatment paradigm is training. In the (R. Aloni) sex therapy clinic, sex therapists working with surrogates receive specialized training and surrogates receive specialized training as well. Surrogates undergo a careful screening process before selection. They are expected to display confidence, positive self and body image, warmth, the ability to connect easily as well as to have well-developed social skills. They undergo an initial interview in order to be accepted to the training course and must also pass several psychological screening tests. The goals of the screening are to determine the candidate's integrity, trustworthiness, discretion, and ability to receive guidance and feedback and to follow up accordingly. The screening also rules out psychopathology or inappropriate personality traits or motivations.

Surrogates are not expected to be particularly attractive but rather to look like regular people. Surrogates are matched to clients based on their personalities, age, and scheduling availability. Recognizing that clients typically fail to function sexually with partners to whom they report sexual attraction, they are not necessarily matched with surrogates to whom they might be attracted, but to whom they would feel most comfortable and secure. When clients report wishing to switch surrogates due to lack of attraction, we view this with them as a possible defense mechanism and use this as therapeutic material to process with, or even challenge the client. Having said that, we will avoid partnering a client with a surrogate who he or she finds repulsive.

The surrogacy training program consists of 40 hours as recommended by the International Professional Surrogates Association (IPSA) that includes a sexual attitudes reassessment (SAR), a sensate focus workshop, information on sexual anatomy and physiology, sexual dysfunction, and the basics of human sexuality, including sexual and reproductive rights, sexual development, birth control, and human sexual behavior.

The surrogate is utilized as a model with whom the client practices, role-plays, and rehearses skills taught by the therapist during their sessions. The surrogate provides feedback to the client on their behaviors while the session is in progress. Tasks are broken down into stages that are limited and tailored to the client's needs. Initial sessions may begin with getting acquainted and building

rapport and trust. Concepts such as safety and boundaries are discussed, and when touching begins, mutual, pleasure-oriented, and nondemanding activities such as sensate focus are practiced together. Eventually, clothes are removed, allowing the client to confront his or her own issues of comfort and body image in a containing atmosphere. Excessive demands and high expectations are initially avoided in order to decrease the possibility of performance anxiety in the client. The therapist guides the client in avoiding zones of low confidence as the surrogate, in practice, rehearses the rules of caution and boundaries. Ineffective behaviors are replaced with effective ones in a process referred to as "behavior shaping" [8].

Efficacy of SPT Trials

There are only minimal data examining the efficacy of SPT retrospectively, but to date, there are no published controlled trials. Masters and Johnson [3] reported on 28 men who worked with surrogate partners and found that SPT was successful for 63% of men presenting with primary erectile dysfunction (ED) and 78% of men presenting with secondary ED. Sommers studied 12 male subjects who underwent 10 sessions of SPT and reported marked improvement in 8 men, improvement in 3 men, and equivocal improvement in 1 of the subjects [9]. A retrospective study of 150 participants (133 male and 17 female) involved in surrogate therapy found that 6 months after concluding therapy, 73% of the respondents had maintained the improvements achieved during therapy and had succeeded in applying the practiced sexual skills with new partners [4]. There were several limitations in these studies including the variable number of sessions, lack of conformity in the treatment interventions, and very low response rate in follow-up. Another study that tracked 501 participants reported that 89% of clients in surrogate therapy resolved their sexual problems. A further 5% were partially satisfied and only 6% terminated therapy [7]. Yet another study involving 407 participants reported that 69% of participants experienced complete success, 21% partial success, 7% saw no change, and 1% experienced a worsening of their situation [10].

The most recent study assessing SPT was published in 2007 and was based on data from the (R. Aloni) Tel Aviv clinic [11]. Sixteen vaginismus patients who were treated with a male surrogate partner were compared with 16 vaginismus patients who were treated with their own partners. The clients were all women presenting with vaginismus, half of whom worked therapeutically with a primary partner, and half whom were un-partnered and worked with male surrogates. One hundred percent of the women working with surrogates achieved pain-free intercourse compared with 74% of the women working with their partners. Nineteen percent of the couples' terminated therapy was due to separation. Both groups reported similar levels of satisfaction with the process and the outcome, although women working with surrogates ended therapy about 2 months earlier than those going through the program with a partner. This was likely to be due to the lack of necessity to address complex dynamic and partner sexual issues with a surrogate partner [11].

Ethical Considerations: The Israeli Experience

Israel's population is nearing 8 million people and contains a diverse melting pot of cultures, religions, and ethnicities where marriage and family stand at the center of society [12]. The State of Israel, established on the heels of the Holocaust, values large families and liberally provides procreation and birth opportunities. As rehabilitation of disabled war veterans is also a valued and state-supported service, sexual rehabilitation became a recognized need. This led to surrogacy use becoming fairly mainstream in the field of sexual rehabilitation in Israel [13,14] The ethical guidelines in place in Israel follow those of the IPSA.

The IPSA exists to ensure professional and ethical standard in the practice of surrogacy. According to the IPSA code of ethics, surrogacy may only be practiced within the context of the therapeutic triangle. The clients' relationship with the surrogate is limited to the context of the therapy. Surrogates are committed to acting within the boundaries and limitations of their competence, respect confidentiality, and maintain all precautions against pregnancy and disease [15].

In the (R. Aloni) Tel Aviv clinic, surrogates undergo a physical examination and laboratory tests for detection of sexually transmitted diseases (STD) every 6 months. Surrogates are required to be vaccinated against hepatitis B. Clients are tested 3 months after last sexual activity (even if it

was safe) to make sure the potential incubation period for an STD is completed. Condoms are used in every encounter, including in cases of psychogenic ED. Surrogates also sign a contract committing them to engaging in safe sexual practice in their personal encounters as well. Aside from the initial visits in a coffee shop and other social activities that resemble dating, the SPT treatments occur in specialized rooms within the clinic. This arrangement provides an additional measure of professionalism.

In our (R. Aloni) clinic, we follow the ethical guidelines of the IPSA and when faced with ethical challenges, they are raised, processed, and resolved in joint surrogate and therapists staff meetings generally attended by 15–20 staff members.

Surrogacy is legal in Israel, but Jewish law, which views sexual relationships as exclusive to matrimony, does not sanction the practice [13,16]. Nonetheless, when surrogacy was introduced, the clinic received recognition by the Rabbinate of the Religious Kibbutz movement provided that the female surrogates were unmarried. The clinic has since applied this rule to both male and female surrogates. There is no recognition from Muslim or Christian religious leaders.

The argument that surrogacy is not unlike prostitution represents an insufficient understanding of the surrogacy relationship. Data by Noonan [6], who interviewed 54 sex surrogates, found that 87% of the time spent with clients was spent in nonsexual activities, which included providing education, relaxation, emotional support, and coaching. The activity breakdown demonstrated that 48–55% of the time was devoted to nonerotic exercises, 34% focused on sexual education, 5% was designated for the practice of social skills in a social framework, and only 13% devoted to actual practice of sexual activities. The idea of using of surrogates as escorts or people with whom patients indulge sexual fantasies or paraphilia had been summarily rejected by early pioneers Masters and Johnson who claimed that this arrangement would damage the self-image of clients who may attain the social stigma of being a person who paid for the services of an escort. Additionally, while the goal of the prostitute is to gratify specific sexual desires in exchange for monetary reward, surrogates take an active role in a therapeutic process. Surrogates, in contrast, use therapeutic techniques and consistently report back to the sex therapist on the therapy's progress, acting to prevent failure at critical junctures. Escorts act according to the demands of the client, whereas surrogates act in accordance with the demands of therapeutic goals under professional guidance of a therapist. A surrogate's motivation differs from that of an escort in that they see themselves as part of a therapeutic process rather than a participant in an isolated sexual experience. Furthermore, surrogates are invested in the therapy's success. Surrogates, as opposed to sex workers who generally provide sexual gratification in exchange for financial gain, are required have an external source of steady employment and income earning ability [14]. Surrogates have been reported to demonstrate pride in their work, a positive and professional role identity, self-confidence, and the ability to cope with complex issues that therapy is liable to present [15]. Regarding the position that surrogacy involves "payment for sex," our recommendation, as practiced in the (R. Aloni) clinic, is that payment be arranged through the clinic and that money not change hands between the client and the surrogate.

In the (R. Aloni) clinic, surrogates are paid approximately the amount that sex therapists and physiotherapists earn, yet a surrogate visit costs about double the amount of a sex therapy session. This is because there is a great deal of overhead costs involved in maintaining an ethical surrogacy practice. These costs include maintenance of sanitary and esthetic treatment rooms well stocked with clean linens, condoms, lubricants, oils, showers, and toiletries. The clinic also covers medical exams, laboratory tests, and high malpractice insurance fees and provides surrogate mentors and therapist supervisors.

Additional ethical considerations have been addressed in the course of the development of surrogacy as a legitimate profession. The early sex therapy literature raised concerns regarding the emotional experience of the surrogate partner. Masters and Johnson endorsed limited use of surrogacy because of the stress of "playing a role in which the surrogate's needs were left unmet and no emotional bonds were formed" [10]. This was of particular concern for female surrogates, of which there were far fewer in their practice. Cole [4], however, argued that the absence of emotional intimacy was actually a therapeutic advantage in strengthening the clients' sexual responses as "performance failure" would not be associated with self-esteem loss.

The model of the surrogate as an individual capable of containing the client unilaterally, without needs or demands of his or her own, was challenged by Apfelbaum [10], who proposed that a more realistic paradigm be offered, which includes devoting attention to the subjective experiences of both the client and the surrogate. Today, SPT is conducted in a manner that enables the therapist to address the needs of both the client and the surrogate. The surrogate is not expected to be devoid of emotion or attachment. Separation from the therapy may be emotionally challenging for both the client and the surrogate, and both receive emotional support at the time of the inevitable separation. However, as separation is a part of life, learning to deal with it effectively is considered to be a positive learning experience.

An additional ethical concern includes the utilization of surrogacy services by clients already involved in partnered relationships. Masters and Johnson's as well as Cole's data [4] indicated that a portion of the clientele utilizing surrogates was married. In both investigations, a portion of the married clients' spouses were not aware of the treatment arrangement. Currently, the option of SPT is generally not suggested for clients who are already in a committed relationship, and if a married client would benefit from treatment, it takes place with the full knowledge and agreement of the spouse. This situation is illustrated in the following case example. In both cases presented, identifying characteristics have been altered to assure the anonymity of the subjects.

Case Study 1

Shimon, a 50-year-old independent contractor is in his second marriage and has three children. As a child, he underwent facial surgery, experienced delayed physical maturity, and experienced limited sexual interactions. His parents divorced when he was a child, and his father raised him. He and his first wife only engaged in sexual intercourse a few times, and the experiences were anxiety provoking, unsatisfying for him, and painful for her. This brief marriage ended in divorce. In his second marriage, he reported that he experienced erotic sex in a threesome with his wife and another woman whom his wife had convinced him to include. Today, he suffers from ED with his wife and with other women. He was referred to surrogate therapy by a family therapist, who has been treating them both for a long period of time. His wife, who was engaged in a lesbian relationship, refused to participate in sex therapy. SPT was indicated for Shimon to gain sufficient confidence in his sexual functioning to decide whether to remain in the marriage or not. After a total of 18 sessions, he was able to demonstrate the ability to achieve a full erection and engage in sexual intercourse with the surrogate partner. This provided him with the self-confidence to explore the option of ending his marriage.

While SPT therapy is generally not indicated for married clients, because his wife was unwilling to participate in sex therapy and was aware of the SPT process, SPT therapy was initiated.

An additional argument against SPT is the high cost involved. However, ethical arguments in support of SPT claim that while application of a psychotherapeutic process may help or not, exposure and functional treatment may solve the problem in a relatively short time. This argument is illustrated in the following example.

Case Study 2

Yael, 35 years of age, is a pleasant and popular professional who has never experienced a romantic relationship except for a number of isolated dates. When conducting a conversation, however, she creates the impression that she is sexually experienced. Throughout the years, she has convinced herself that when she meets "the right man," she will overcome her anxieties and allow herself to be swept up in the sexual experience. Of late, with her 35th birthday coming up, she has begun to doubt that this will occur and has decided to pursue treatment. Clinical assessment revealed that Yael has never had sexual relations, had never inserted a tampon nor had a gynecological examination. After meeting with our clinic gynecologist, she was diagnosed with vaginismus. When dating and reaching the stage where sexual contact is anticipated to occur, she disconnects from the relationship. She never got very far with any man for fear that intercourse would be the expectation. On a certain point, she became embarrassed that a man would discover the "shameful secret" of her virginity. On her 35th birthday, Yael turned to SPT in order to break this vicious cycle. Sex therapy with Yael followed a behavioral model that included psycho-education, gradual exposure, and instruction in the use of vaginal inserts, which Yael did herself at home. After she was able to insert the dilators, she began meetings with the surrogate

partner. In addition to working with Yael on overcoming her aversions and fear of touch, he became her partner in working together with her on inserting vaginal inserts.

After a total of 15 sessions with the surrogate, which ultimately included engaging in sexual intercourse, Yael felt confident that she could begin to date seriously without fears of her potential partner revealing her sexual inexperience.

Vaginismus is a common condition and various behavioral and psychotherapeutic modalities have been studied and found effective. However, complete avoidance of intimate or romantic experiences suggests years of avoidance and repression of her sexual self. While it is difficult to know how long a traditional therapeutic process would be, it appeared that a process of insight-oriented psychotherapy would likely not be short term. Furthermore, Yael was anxious to find a solution and she was not particularly insight oriented. Nor was she seeking a psychotherapeutic process. Surrogate therapy was proposed in order to help change Yael's reality by addressing the vaginismus and demonstrating that she was capable of having sex. This allowed her the confidence to begin dating without embarrassment and fear of her virginal status being discovered.

While the cost of a therapeutic session in surrogate therapy is more expensive than that under psychological therapy, the short-term, behavioral, and focused treatment provided results in a relatively short period of time. This case exemplifies the clinic's data on the relatively short-termed vaginismus treatment that SPT demonstrates [11]. This provides an ethical argument in favor of surrogacy in these situations.

Conclusion

SPT is not a common therapeutic intervention in most countries and appears to be not well understood by many sexual health professionals. We have shared the Israeli experience and demonstrated indicated SPT case studies. We acknowledge as well that there are contraindications for SPT. We do not recommend SPT for individuals who appear easily capable of establishing relationships, individuals already in committed partner relationships, individuals who have a history or suspected history of psychiatric instability, or those who believe that SPT is an opportunity to experience sex in a risk-free environment. We have provided a model for ethical practice of SPT and recognize the need for controlled trials establishing the efficacy of this intervention. While we provide ethical and professional guidelines, we recognize the need to establish clarity regarding the relevant local legalities of this practice.

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Statement of Authorship

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References

1 Wolfe L. The question of surrogates in sex therapy. In: LoPiccolo J, LoPiccolo L, eds. Handbook of sex therapy. New York: Plenum Press; 1978:491–7.
2 Heruti R, Shochat T, Tekes-Manova D, Ashkenazi I, Justo D. Prevalence of erectile dysfunction among young adults: Results of a large-scale survey. J Sex Med 2004;1:284–91.
3 Masters WH, Johnson VE. Human sexual inadequacy. Boston: Little, Brown & Co; 1970.
4 Cole MJ. The use of surrogate sex partners in the treatment of sexual dysfunction. Br J Sex Med 1982;9:13–20.
5 Roberts B. Surrogate partners and their use in sex therapy. In: Brown DA, Chary C, eds. Sexuality in America. Ann Arbor, MI: Greenfield Books; 1981:283–300.
6 Noonan RJ. Sex Surrogates: A Clarification of Their Functions (Master's thesis), SexQuest/The Sex Institute. 1984.
7 Dauw DC. Evaluating the effectiveness of the SECS surrogate-assisted sex therapy model. J Sex Res 1988;24:269–75.
8 Lezak MD, O'Brien KP. Longitudinal study of emotional, social, and physical changes after traumatic brain injury. J Learn Disabil 1988;21:456–63.

9 Sommers FG. Treatment of Male Dysfunction Medical Sexology. Littleton, Mass; 1978.
10 Apfelbaum B. The ego-analytic approach to individual body work sex therapy: Five case examples. J Sex Res 1984;20:44–70.
11 Ben Zion I, Rothschild S, Chudakov B, Aloni R. Surrogate versus couple therapy in vaginismus. J Sex Med 2007;4:728–33.
12 Ekert-Jaffe O, Stier H. Normative or economic behavior fertility and women's employment in Israel. Soc Sci Res 2009;38:644–55.
13 Aloni R, De Paauw E, Heruti R. Israeli sexuality at the intersection of tradition and modernism. In: Hall KSK, Graham CA, eds. The cultural context of sexual pleasure and problems. New York: Routhledge, Taylor & Francis; 2013:334–54.
14 Aloni R, Dangur N, Ulman Y, Lior N, Chigier E. A model for surrogate therapy in a rehabilitation center. Int J Adolesc Med Health 1994;7:141–51.
15 Johnson W, Kempton W. Sex education and counseling of special groups. Springfield, IL: Thomas Publishing; 1981.
16 Ribner DS, Rosenbaum TY. Classical Jewish perspectiveson sex. In: Kuriansky J (series ed.) and Tepper MS and Owens AF (vol eds.). Sex, love and psychology: Sexual health, Vol III. Moral and cultural foundations. Westport, CT: Praeger; 2007: 23–41.

CME Multiple Choice Questions

1. SPT program began?
   a. As a theoretical experiment by H.S. Kaplan
   b. As a need to provide a partner for sex therapy for single men with sexual dysfunction
   c. As an ethical need to provide sex therapy to all applicants
   d. As a theoretical experiment by Masters and Johnson
   e. As a method to provide sexual experiences to men with difficulty finding sexual partners

2. Surrogate partner therapy uses therapeutic modalities from the field of?
   a. Psychotherapy, psychoanalysis
   b. Behavioral, rehabilitation, and education
   c. Drama and art therapy
   d. Eye movement desensitization and reprocessing
   e. None of the above

3. Common ethical concerns regarding surrogacy include?
   a. Lack of clarity regarding differences between surrogates and sex workers
   b. Surrogates working independently without therapists
   c. Surrogates continuing to meet clients after therapy has concluded
   d. Surrogates working with married clients without the partners' knowledge
   e. All of the above

4. Research shows that surrogate partner therapy is?
   a. At the least as efficient as other modes of sex therapy
   b. Less efficient than other modes of sex therapy
   c. Usually more efficient and shorter than other modes of sex therapy
   d. There is not enough evidence-based research about the efficacy.
   e. None of the above

5. Ethical practice is ensured by?
   a. Frequent communication between the surrogate and the therapist
   b. Sufficient training of the surrogate
   c. The understanding that surrogacy is not intended for people in partnered relationships
   d. Adherence to termination of relationship between surrogate and client at completion of therapy
   e. All of the above

6. Surrogacy may be preferable to psychotherapy for the treatment of vaginismus because?
   a. The treatment is behavioral and may achieve results in less time.
   b. Vaginismus never require psychotherapy.
   c. Women with vaginismus may have homosexual tendencies, and intercourse with a surrogate resolves this.
   d. A surrogate can achieve penetration with a woman with vaginismus easily because of his experience.
   e. All of the above

7. Surrogates are expected to display the following characteristics:
   a. Confidence, beauty, integrity, warmth
   b. Positive self-image, confidence, integrity
   c. Integrity, beauty, warmth
   d. Warmth, integrity, psychotherapeutic skills
   e. Beauty, good social skills

8. The educational curriculum of surrogate training includes all but the following:
   a. SAR
   b. Basics of human sexuality
   c. Counseling skills
   d. Sensate focus workshop
   e. Basics of sexual dysfunction

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