

Article 12

Sexuality Is Universal: Implications for Using a Constructivist Approach to Sexuality Training in Counselor Education Programs

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Sexuality is unrivaled as the most basic and yet most controversial experience throughout history. Sexuality crosses culture, gender, age, and even species. It permeates pop culture and mass media. In spite of significant research by Kinsey, Masters and Johnson, and Money at varying points in the young history of psychology, sexuality continues to incite discomfort and difference. Perspectives and interventions regarding sexuality are as varied as snowflakes and are often permeated with contradiction.

Understanding typical sexual behavior helps define the often blurred line between normal and pathological sexual practices, aiding counselors as they help clients navigate through the complexities of their sexual experiences, behaviors, and values. The current article offers counselor educators an opportunity to explore the relevance of sexuality in mental health, examine the significance of modifying sexuality training in counselor education programs, and entertain the use of a constructivist approach to educate while respecting cultural diversity.

Disordered Sexuality in Mental Illness

There is an ongoing debate about what sexual behaviors constitute normal and abnormal sexuality, with definitions within the counseling field relying heavily on social and cultural influences. The modifications in the American Psychiatric Association’s *Diagnostic and Statistical Manual of Mental Disorders (DSM)* across editions reflect the development of the perception of sexual behavior and emphasize the significance of sexual issues within the field. To understand how to address sexuality training and sexuality counseling, it is important to examine the presentation of sexual symptoms in mental illness, as well as physiological and psychosocial factors that contribute to the presentation of sexual issues in counseling.

Sexual Symptoms in the *DSM-IV*

The prevalence of disordered sexuality in mental illness is undeniable. In the *DSM-IV-TR* (2000), sexual disorders and symptoms account for 28.9% of all diagnoses. In addition to diagnoses that specifically identify sexual symptoms, extensive research documents problematic sexual behaviors in many other diagnoses as well (4th ed., text rev.; *DSM-IV-TR*; American Psychiatric Association, 2000, p. 857). Indeed, mental illness has a significant impact on a person's sexual behavior and functioning.

The intrapersonal and interpersonal ramifications of mental disorders with sexual symptoms are significant. This can be seen in the following examples of mood disorders, bipolar disorder, and depression. In bipolar disorder, promiscuous sexual behaviors common during manic episodes can lead to health and relationship complications. Although these behaviors decrease significantly when the individual's mood is treated, individuals with bipolar disorder may experience feelings of shame and embarrassment, and damage to relationships (Highfield, Markham, Skinner, & Neal, 2010). Depressive episodes can involve other sexual symptoms, such as difficulty achieving climax, pain during sexual intercourse, and lack of satisfaction with their sexual lives for women (Frohlich & Meston, 2002). Unfortunately, the treatment of mood disorders does not necessarily improve these symptoms and can often exacerbate sexual difficulties.

Dyl, Kittler, Phillips, and Hunt (2006) found that individuals with body image issues scored much higher on the sexual preoccupation/distress scale in the Trauma Symptom Checklist for Children (TSCC) than did their peers without body image issues. In addition to anxiety related to body image, anxiety due to fear of contamination also impacts sexual functioning. Individuals with Obsessive-Compulsive Disorder (OCD) experience a negative impact on their romantic functioning as the severity of OCD symptoms increase, while both intimacy and relationship satisfaction decrease (Abbey, Clopton, & Humphreys, 2007).

Although Post-Traumatic Stress Disorder (PTSD) has received extensive attention in research that examines the impact of traumatic responses on sexual health and well-being, particularly as a result of childhood sexual abuse (CSA), not all individuals who have experienced CSA meet the diagnostic criteria for PTSD. However, Chen et al. (2010) found that the most commonly documented mental health issues in participants with a history of CSA were: anxiety, depression, eating disorders, PTSD, sleep disorders, suicide attempts, and somatic disorders. Borderline personality disorder (BPD) has also been cited as correlating strongly with CSA. Indeed as much as 91% of individuals with a diagnosis of BPD have experienced abuse as children ("Treating Borderline," 2010). These disorders are correlated with issues related to sexual functioning (Brennan, Hellderstedt, Ross, & Welles, 2007; Chen et al., 2010; Johnson, Rew, & Sternglanz, 2006; Lemieux & Byers, 2008; Putnam, 2009).

Although the *DSM-IV-TR* (2000) does not focus on disordered sexuality in children and adolescents, research has indicated significant findings in this area. Externalizing disorders, such as conduct disorder, Attention-Deficit/Hyperactivity Disorder (ADHD), mania, and oppositional defiant disorder, correlate with an increase in reports of engaging in high risk sexual activities (Brown et al., 2010). These results parallel with previous findings with young adults that substance abuse disorders, conduct disorders, and antisocial personality disorders strongly correlate with engaging in high risk sexual behaviors (Tubman, Gil, Wagner, & Antiques, 2003). Consistency between

adolescents and adults with particular diagnoses and sexual behavior problems is also found in ADHD. Flory, Molina, Pelham, Gnagy, and Smith (2006) found that childhood ADHD correlated with earlier sexual behaviors, an elevation in the number of sexual partners, participation in casual sex, and partner pregnancies. In a study with adults by Blankenship and Laaser (2004), 67% of the patients participating in the sexual addiction program met the criteria for ADHD, and extensive parallels between sexual addiction and ADHD symptoms were noted.

Physiological Factors

Sexual difficulties may not meet the criteria for a specific medical or psychiatric disorder but still cause significant distress to the client. Physiological factors can significantly impact a person's sexual behavior, whether due to natural changes or physiological impairment. A transition that is connected with changes in sexual behavior is giving birth. New mothers express distress about their bodies and a disconnection from their partners regarding sexual desires (Olsson, Lundqvist, Faxelid, & Nissen, 2005). As a result, new fathers are impacted by this transition as well, in addition to adjusting to viewing their wives as a spouse and a mother. Women also experience shifts in their sexual functioning during menopause, when hormonal fluctuations lead to physiological changes in the female reproductive system, impacting women's sexual behaviors and satisfaction.

Sexual dissonance experienced by individuals with physical disabilities or medical illnesses can be debilitating. Stroke victims experience a significant difference in sexual functioning before and after their stroke. Women experience a decrease in vaginal lubrication and ability to reach orgasm, and men experience difficulties in erection and ejaculation following a stroke (Tamam, Tamam, Akil, Yasan, & Tamam, 2008). Kanayama et al. (2010) found that after having surgical correction for lumbar disk herniation, patients experienced a 50% decrease in sexual desire, with 31% of women reporting permanent decrease. In addition, 67% of men and 81% of women reported discomfort during sexual activity, and 28% of men and 41% of women experienced a decrease in sexual satisfaction. Moin, Duvdevany, and Mazor (2009) found that in spite of reporting the same level of sexual desire as women without disabilities, women with physical disabilities had lower sexual esteem, sexual satisfaction, and life satisfaction, particularly if they were younger and not in a committed relationship. Another disturbing trend that has been noted among women with physical disabilities is a greater risk to be a victim of all forms of domestic abuse, including unwanted sex (Arliksson-Schmidt, Armour, & Thibadeau, 2010; Smith, 2008).

These examples do not encompass all of the possible physiological impairments that could cause sexual dysfunction. Physical ailments such as diabetes, asthma, and heart disease put additional stress upon an individual's health, which can lead to sexual impairment. Chronic and terminal illnesses, such as cancer and HIV, can significantly impact one's sexual behaviors, although in varying degrees. Individuals battling physical ailments may experience grief at the loss of viewing themselves as fully functioning persons and sexual partners.

Psychosocial Stressors

The sexual behaviors and sexual values of others have a tremendous impact on an individual's mental and emotional well-being. Much like entering counseling for sexual consequences related to physiological issues, many clients seek support in coping with stressors related to the conflict between their sexual behaviors or sexual values and their environment. Some examples of such value conflicts include the experiences of sexual minority status and infidelity.

Although sexual orientation has not been considered a mental illness for decades, sexual minorities continue to struggle with specific stressors regarding the perception of others about their sexuality. In spite of the stigma associated with sexual orientation, sexual minorities are more likely to seek out counseling services than heterosexuals, particularly as they come to terms with their sexual orientation. Additional issues with which sexual minorities struggle are: worries about HIV, rejection, discrimination, increased risk of hate crime victimization, spiritual reconciliation, and internalized homophobia (Herek & Garnets, 2007).

While sexual orientation training has received a significant amount of attention in counselor education programs, there remains a considerable amount of tension about providing treatment to sexual minorities. When a counselor's religious beliefs are in conflict with the American Counseling Association's position to not discriminate on the basis of sexual orientation, there begins a debate about how to respect the rights of sexuality minorities to have access to treatment for their mental health issues and the right of mental health professionals to maintain both their professional licenses and their personal religious beliefs (Hermann & Herlihy, 2006; Johnson, 2010). Publicized cases could impact the motivation of sexual minorities to seek counseling services for fear of experiencing rejection, as well as discourage sexual minorities from entering the profession themselves.

There are times when a person may enter into counseling as a result of the betrayal of their partner rather than society. Couples counselors indicate that cases involving infidelity—to include Internet contact and pornography—are among the most challenging due to intense feelings of hurt, anger, jealousy, and disgust experienced by the betrayed partner (Becker, Sagarin, Guadagno, Millevoi, & Nicastle, 2004; Henline, Lamke, & Howard, 2007; Zitzman & Butler, 2009). In these situations, counselors may find themselves addressing values, behaviors, and transitional issues related to the clients' sexual behaviors.

Divorced persons may experience difficulty with their sexual functioning, especially if their marriage lasted for many years or if they have children. Conflict between a person's religious beliefs and their lived experiences may lead to inhibitions. Loss of a loved one, such as spouse, parent, or child, can have an impact on a person's sexual functioning as well. Grief and loss issues may lead to depression, which often impacts sexual desire. Virtually any life transition or stressor can have an impact on a person's sexual functioning.

Healthy Sexuality

Although there is certainly a need for counselors to have an understanding of sexual difficulties, dysfunctions, and disorders, it is impossible to isolate one's

comprehension of sexuality to only “problems” for the purpose of education, advocacy, and assessment of clients. Even among counselors, there are myths regarding human sexuality that are perpetuated and communicated to clients, either through verbal or non-verbal means. It is generally accepted that sexuality is an aspect of one’s self over the course of his or her life span. It is important, therefore, that counselors are adept in healthy sexual development to prevent potential harm through mis-information (Kontula & Haavio-Mannila, 2009; Thanasiu, 2004). Such information includes being knowledgeable about various theories regarding sexual identity development and how these theories may be applied to work with various populations. Knowledge of healthy sexuality will include training and knowledge regarding the expression and interaction of biological sex, gender identity, and sexual identity (Bilodeau & Renn, 2005).

Current Sexuality Training Practices

Although numerous articles on sexuality education within the mental health field are available from decades ago (Pollis, 1985; Scales, 1983; Valentich & Gripton, 1975; Vasquez, 1988), more recent sexuality training research appears to be concentrated into specialized areas. In a content analysis of articles published by the *Journal of Counseling and Development* between 1991 and 2000 conducted by Nilsson, Love, Taylor, and Slusher (2007), results indicate a surprising lack of focus on sexuality, with a slight increase in the past 10 years in particular aspects of sexuality, including sexual orientation, sexual boundary violations between counselors and their clients, and sexual abuse.

In accordance with the ethical standards established by the American Counseling Association, the Council for Accreditation of Counseling and Related Educational Programs (CACREP) established standards of training for counselors in 1981. Although CACREP standards highlight eight different areas of focused training, these standards do not specifically identify the incorporation of sexuality training into programs (Liles & Wagner, 2010). Ethics courses typically discuss boundaries regarding sexual involvement with clients, and sexual minority issues are addressed in diversity-focused courses. Sexual disorders are discussed in assessment courses, but human sexuality as a focus of training is relatively absent in counseling programs. Evidence of such deficiency is found in the ACA-ACES Syllabus Clearinghouse, available on the American Counseling Association website, a resource to assist counselor educators in developing courses who are also members of the ACA. The percentage of sexuality courses compared to other counseling courses provides insight into the emphasis placed on sexuality training. A review of the syllabi provided in the database shows that 57 out of 395 syllabi, or 9.4%, included the word “sex” in their content, but only four courses—about 1%—focused specifically on sexuality. Three of the courses focused on human sexuality and one concentrated on counseling sexual minorities (ACA-ACES Syllabus Clearinghouse, 2012).

The deficit in comprehensive training in sexuality places counselors at a disadvantage when providing services to clients of all ages. Even with the extensive attention paid to sexual abuse in research, sexual abuse training is not adequately addressed, with only 9% of programs in one study requiring a specific course on sexual abuse and 69% of programs offering no training whatsoever (Kitzrow, 2002). Counselor

education has focused on training in two specific areas—sexual orientation and sexual ethics.

Sexual Orientation

Within the mental health profession, there appears to be a consensus that incorporating training about sexual minorities is important (Carroll & Gilroy, 2001); however, there continues to be a debate about how to incorporate this topic into training programs. Fifteen years ago, Whitman (1995) recommended a curriculum to be incorporated into multicultural courses that includes teaching emerging professionals about sexual identity development, myths and stereotypes, and counseling issues specific to sexual minorities. Later, Carroll, and Gilroy (2001) advocated incorporating queer theory as a medium for sexual orientation training and re-affirmed Whitman's suggestion to use narrative texts and films to help train counseling students.

Pearson (2003) echoed both the use of these techniques in the classroom and educating about sexual identity development. In addition, Pearson (2005) believes counselor educators need to recognize that often the distress experienced by sexual minority clients is the result of the environmental response to their sexual orientation rather than the sexual orientation itself. Long and Serovich (2003) mirrored these findings in marriage and family therapy (MFT) programs, highlighting unique challenges faced by MFT programs with a religious affiliation, cautioning against making the assumption of "same-ness" regarding sexual minorities' life experiences and suggesting self-assessment in MFT programs to eliminate "heterosexist bias."

Sexual Ethics

In ethics training, counselors-in-training are educated about the detriment of becoming sexually involved with their clients. Heiden (1993) emphasized increasing counselors' awareness as a prevention technique for crossing sexual boundaries, including being mindful of the extent to which the counselor's personal needs are met by clients and maintaining appropriate boundaries. To prepare counselors for how to respond in sexually charged situations without violating ethics and laws, videos and role play scenarios can be used (Heiden, 1993). Each state has individual legislation regarding sexual relationships with clients, which do not necessarily correspond with the ACA code of ethics. In one study, Avery and Gressard (2000) found that 86% of the states who responded had specific laws against sexual conduct with a client; 62% had laws against sexual contact with former clients; and 42% had laws against sexual contact with supervisees.

Human Sexuality Training

Although dated, research exploring recommendations for educating counselors about human sexuality is available (Baber & Murray, 2001; Carroll & Gilroy, 2001; Heiden, 1993; Kitzrow, 2002; Long & Serovich, 2003; Pearson, 2003; Whitman, 1995). Over two decades ago, there was significant attention placed on human sexuality education, most of which focused on education for children and adolescents. Sexuality education was viewed as being a vehicle of social change through increasing awareness of sexual health, issues, values, and behaviors. Techniques involved using role plays and group discussions to explore these concepts through relationship skill-building. Concerns

were raised about potential gender bias against males in the approaches used in sexuality education (Scales, 1983). Pollis (1985) emphasized the importance of enhancing critical thinking skills in sexuality education rather than imposing the instructor's own sexual values and attitudes. Both of these authors emphasized examining sexuality within historical, political, and religious context.

Valentich and Gripton (1975) explored the process of introducing a human sexuality course into a social work program after noting "that our students were ill-equipped even to discuss sexual matters with clients, let alone help them with sexual problems" (p. 273). Topics covered in this seminar included: sexual vocabulary, sexual response cycle, sexual myths, sexual trends in society, sexual history, homosexuality, and interventions. More recent research in the area of sexuality training was found in psychology and psychiatry. Miller and Byers (2009) addressed deficits in graduate level sexuality training for psychologists, such as focusing more on sexual disorders than learning about healthy sexuality. These authors noted a tendency for psychologists to not ask about their clients' sexual functioning and to refer them to a sex therapist if sexual issues become apparent, disrupting the therapeutic process. Of the participants in their study, 70% requested additional training in sexuality. Sansone and Weideman (2000) examined sexuality training for psychiatrists and found that between 14 and 20% of graduate training programs did not offer sexuality training in any capacity.

Recognizing the Need for Sexuality Training

In examining the prevalence of issues related to sexuality in the mental health field, it is important to examine the impact of the current perspectives regarding sexuality and sexuality training. Three key points are beneficial to explore: the prevalence of sexual issues in mental health; assessment and treatment for sexual concerns; and the universality of sexuality.

The relevance of sexual behaviors and functioning cannot be overlooked as an indicator of overall health and well-being. It is important for all counselors to be knowledgeable about the social constructs regarding healthy and dysfunctional sexual behaviors to assess the comprehensive impact of each client's presenting issues. Counselors-in-training should have an opportunity in their programs to explore their own personal assumptions, biases, and values regarding sexuality and to examine the perspectives of others in a safe environment while in training. Increasing counselors' knowledge and encouraging self-reflection will also increase confidence and skills, perhaps leading to a decrease in the number of referrals to "specialists." Equipping counselors to address sexual issues will normalize the role of sexuality in overall mental health and set a precedent to address sexual difficulties within the context of presenting issues, therefore increasing the possibility that clients will address these issues.

It is important to understand how to assess sexual functioning in a manner that does not imply sexual dysfunction in clients, impose the counselor's values upon the client, or disrespect professional boundaries. Assessment is particularly difficult with children and adolescents. Counselors working with minors must respect the parents' role in educating their children about sexuality, in spite of potential dissonance between the sexual values of the counselor and the parent. When a child or adolescent presents with sexual issues, what label is most appropriate to use? Terms that have been used are

“sexually reactive,” “sexually aggressive,” “sexual behavior problems,” “sexually acting out,” “promiscuous,” “sexually abusive,” “sexual play,” and “juvenile sex offender.” How does a counselor determine which term is most appropriate? What symptoms constitute abnormality? Deciding on a term to use and what behaviors qualify as symptoms of abnormality is particularly difficult given that the *DSM-IV-TR* (2000) does not identify diagnoses specific to children and adolescents who present with sexual behaviors. Not having a specific diagnosis makes communicating with clients and their families about their symptoms subjective and places the counselor at a high risk of ethical violations. Additionally, the *DSM* varies with regards to its view of disordered sexuality with each edition published.

Embracing sexuality as a universal experience provides a basis for presenting discussions about sexuality from a wellness perspective rather than focusing on sexual dysfunction and disorder. Sexuality is not a “special topic”; it is the common experience among all persons with variation in sexual expression that ranges from healthy to unhealthy and from aversion to compulsion. Channeling sexuality training into special topics is intrinsically invalidating to the sexual experiences of all persons because it highlights sexual dysfunction rather than sexual health. Focusing on sexual dysfunction could serve to deter clients from being willing to talk about their sexual experiences for fear of being labeled as “one of those people.” Indeed, isolating sexual minorities through sexual orientation training inherently places them apart from their heterosexual peers and discriminates against heterosexual clients by not putting emphasis on training about heterosexual sexual identity development.

Neglecting sexuality training in counselor education programs leaves counselors incompetent to address sexual issues in their clients. Referring clients to a sex therapist has the potential to harm through the termination of a therapeutic relationship that may have been otherwise beneficial and the imposition of the stigma associated with seeing a sex therapist. Referring clients to a specialist—if one can be identified locally—can also stigmatize the counseling field as a whole as unable to treat sexual issues. Additionally, some clients may choose to not see a psychiatrist for sexual issues due to an opposition to psychotropic interventions. With the lack of emphasis on sexuality training in counseling programs, *are* counselors qualified to treat clients with sexual issues? How does a counselor interested in specializing in treating sexual issues gain the training and experience to work with this population?

Constructivism in Sexuality Training

Although a variety of instructional approaches are implemented in counselor education programs, constructivist strategies seem to provide additional benefit in addressing sensitive topics in training. Constructivism is one way to facilitate the professional development of counselors-in-training in the area of sexuality counseling while simultaneously respecting the diversity of values and perspectives.

Constructivism in Counselor Education

The constructivist perspective in education rejects the traditional passive approaches to teaching students and specifies a distinction between “knowledge” and “information” Prawat & Floden (1994). Information is readily available in books, articles,

television, and the internet, while knowledge involves how the student organizes new information with existing knowledge to create a new understanding of a concept (Halpern, 1994). An educator's responsibility, then, is not to transmit information but to facilitate the construction of knowledge in students. Additionally, the constructivist perspective emphasizes flexibility and respect for each individual's perspective and the learning process itself. Respecting each student's unique style of learning and worldview, the constructivist counselor educator uses a variety of techniques to facilitate the learning process in students (McAuliffe & Eriksen, 2002). This approach is particularly beneficial to counseling courses because the educator models skills essential to the counselor role, regardless of the particular counseling theory or population each student will gravitate toward as professionals. The educator demonstrates mindfulness throughout the learning process to assess the needs of each student and the success of techniques utilized. The educator guides each student through the expected dissonance of making sense out of the course material rather than imposing his/her own interpretations of the material. Such flexibility naturally respects diversity and accommodates a variety of learning styles.

Constructivist Strategies in Sexuality Training

Implementing a constructivist approach to sexuality training allows counselors-in-training a supportive environment in which to explore and challenge their personal biases, values, and perspectives regarding sexuality as they are exposed to a variety of social, cultural, and historical constructs of human sexuality. Using a variety of techniques, the instructor then facilitates the incorporation of new information into existing knowledge about sexuality. Baber and Murray (2001) advocated using this approach within a postmodern feminist pedagogical teaching philosophy in teaching human sexuality as diversity in sexual experiences is acknowledged and respected in this approach. According to these authors, perceiving sexuality as linear—heterosexual, bisexual, or homosexual—fails to assist students to acknowledge variations in sexual behavior based on geographical location, ethnicity, gender, etc.

The techniques utilized in the human sexuality syllabi shared on the ACA-ACES Syllabus Clearinghouse emphasize the inclusion of a variety of instructional and assessment techniques that parallel with the constructivist approach. In the three sexuality counseling courses, active learning was incorporated into the course, with group discussion based on required readings and an individual activity/project designed by each student. Other requirements in the courses that did not overlap included conducting a sexual history interview with a classmate, role-play, viewing media on class topics, and student presentations. Both courses utilized class participation and written papers as modes of assessment. One course used tests on assigned readings, while the other required a written assessment based upon the sexual history interview (ACA-ACES Syllabus Clearinghouse, 2010; Bachner, 2010; "Counseling & Human Sexuality," n.d.).

Consistent with the constructivist approach, the techniques included in these courses reflect significant opportunity for experiential learning. Specifically, viewing media can include observing depictions of sexual issues that may present themselves in the counseling sessions, persons expressing their personal views and biases about sexuality, and conflicts regarding sexuality. Conducting a sexual history interview will provide an opportunity for students to experience being the interviewer and the interviewee; practice mindfulness of their own biases, judgments, and assumptions

through the process; and note how their own sexual scripts impact conducting and participating in the interview process. Group discussion provides an opportunity for students to explain their learning experience with each other to receive both support and challenge from their classmates. Individual activities/projects accommodate students' unique learning styles and respect their boundaries and values regarding the manner and extent to which they wish to challenge their existing constructs. Having the freedom to choose supports the development of each student's morality rather than pressuring him/her to blindly accept the educator's "truth."

The constructivist approach can provide a means to reconcile conflicts between adhering to the ACA code of ethics and negotiating dissonance between a counselor's sexual values and a particular sexual behavior. Because constructivism postulates that truth is relative and developed within historical, social, political, geographical, and religious context, it validates the existence of all sexual scripts without adhering to any one particular set of sexual values (Halpern, 1994). The constructivist approach can help both educators and students be open to understanding other perspectives about sexuality without the pressure for any participant in the course to change. As the students explore their sexual knowledge, beliefs, and values with each other and are exposed to additional information through readings, media, guest lecturers, or some other mode of exposure, every student is expected to confront differences and move through the discomfort of dissonance to be effective counselors. Experiencing learning about sexuality in this way will equip counselors to address ethical dilemmas in their practice in a way that demonstrates adherence to the ethical guidelines. A constructivist approach could aid in the prevention of involvement in litigious situations for counselor educators and counselors as well through the emphasis on students' active involvement in the learning process; non-judgmental stance regarding the existing constructs of students regarding the material; and the parallel with the value of diversity in the counseling field.

Conclusion

In examining sexuality training in counselor education, more attention to sexuality is warranted given the lack of research and training, in spite of the prevalence of sexual issues. Given the relationship between sexuality and mental health, sexuality is a core issue for clients throughout their life span. A constructivist approach to sexuality training could be a viable method of enhancing sexuality training in a way that prepares counselors for the professional obligations of counseling and addresses conflicts within and between mental health disciplines.

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