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CNS 767 Human Sexuality

Assignment 3.2: Chapter 4 Takeaway Paper

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Takeaway #1: Sex Education

Although the data doesn't support their effectiveness, the U.S. continues to focus most heavily on abstinence-only types of sexual-education programs for teens. Regardless of this, 75% of teens want to learn more about sex, sexuality, and safe practices (Murray, Pope, & Willis, 2017). Research indicates that comprehensive sex education programs are generally more successful in creating positive changes in adolescent sexual behavior including delayed initiation of sex and increased contraception and condom use compared to abstinence only programs, which fail to show efficacy in these same areas (Kirby, 2008). If teens aren't provided with information through sex education programs or parents, they will seek this information elsewhere on their own, however, the risk is that they will not be accessing accurate information.

Even though it can be difficult for parents to imagine their kids having sex, talking about sex intelligently and honestly is best for everyone. Although schools often adopt an abstinence only approach due to regulations regarding federal or state funding for such programs, many also cite a fear of backlash from a vocal minority of parents, but research demonstrates that many parents are quite supportive of comprehensive sexual education for their teens (Peter, Tasker, & Horn, 2015). It's important to work with teens and families regarding comprehensive sex education that is multidimensional for adolescents to be able to make educated decisions about sex and their personal sexuality.

Takeaway #2: Physical Sexual Health

Even though one-half of all Americans will contract an STI in their lifetime, there is still a huge stigma about it and a lack in education (Murray et al., 2017). Doctors don't typically screen for STI's unless asked to do so, so clients need to be direct in asking for this service (Murray et al., 2017). The cost of many of these tests can be quite high, and many health

insurance policies do not cover them, presenting yet another barrier to access (Murray et al., 2017). In addition, several common STIs are becoming resistant to the common medications used to treat them (Murray et al, 2017) and stigma can lead to delays in seeking treatment, disclosure to partners, and in prevention of further infection (Wong, Chan, Boi-Doju, & McWatt, 2012).

Educating clients regarding low-cost services available locally such as those provided by Planned Parenthood or the local health department is another way to support the client's sexual health (Murray et al., 2017). The taboo surrounding discussions about sexuality represents a barrier to positive sexual health practices for individuals and it is important as counselors that we help our clients become more comfortable discussing sexual matters in general so they can feel comfortable talking to their other healthcare providers and seeking the screening and treatments they may need.

Takeaway #3: HIV

HIV and mental health issues co-occur quite frequently (Murray et al., 2017). There continues to be a stigma surrounding those with HIV, which may lead to or compound mental health issues for clients. Misinformation abounds regarding who is at risk (ethnic minorities, MSM youths, women) and this lack of awareness places these populations at continued greater risk. Substance abuse is a concern as well as it can lead to risky behaviors which can increase the chance of contracting HIV. A diagnosis of HIV can lead to changes in mental health status and behaviors not only due to the implications of their diagnosis, but due the stereotyping and discrimination received from society and media (Murray et al., 2017).

Takeaway #4: Disability & Chronic Illness

Many people make assumptions about people with disabilities and chronic illnesses and their sexuality. Those with physical or developmental disabilities are often treated like perpetual children, or it is assumed they do not want or cannot handle a sexual relationship (Murray et al., 2017). Between doctor appointments, surgeries (if necessary), and providing care, time for discussing sexuality with kids is not always set aside, especially if the disability is particularly time-consuming or burdensome to manage. This can be exasperated by a fear of abuse and a desire to be protective, leading to some parents to avoid the topic altogether (Richards, Miodrag, & Watson, 2006). Those with disabilities are 150% more likely to be abused (Sobsey, 1994; as cited by Richards et al., 2006). This same overprotectiveness can lead some parents to inadvertently isolate their disabled teens in an effort to protect them, which can impact the youth's developing self-concept (Richards et al., 2006).

Between 36% and 52% of adolescents with disabilities have engaged in sexual intercourse, however this is occurring during a time when most sex education is not designed to address the specific needs of those with disabilities nor the cognitive abilities of those with developmental disabilities (Richards et al, 206). Typical media images of beauty and sexuality are rarely inclusive of those with disabilities, potentially leading to the development of self-esteem issues. For those dependent on others for care, privacy is a major consideration, as well as access to suitable partners. As counselors, working with the individual and the family or caregiver to open a dialog about sexuality is a great first step towards positive sexuality for all parties.

Takeaway #5:

Half of all pregnancies in the U.S. are unintended (Finer & Zolna, 2014) and of those, 40% end in abortion, and that around 30% of women will have at least one abortion by age 45 (Jones & Kavanaugh, 2011; as cited by Steinberg & Rubin, 2014). Many factors contribute to

the risk of unintended pregnancy including mental health disorders that lead to risky behaviors or drug use, which itself leads to risk taking behaviors (Steinberg & Rubin, 2014).

Having an abortion does not lead to any greater risk for mental health problems, however there is still a stigma associated with abortions and that stigma may lead to lasting mental health effects. Stigmatized beliefs may also create difficulty in making the decision whether to abort, leading to delays in obtaining an abortion, potentially creating additional barriers to access (Gelman, Rosenfield, Nikolajski, Freedman, & Steinberg, 2016). This stigma persists, even among communities with higher rates of abortion such as lower income (Gelman et al., 2016). Many stigmas are due to a lack of education regarding the safety, the prevalence, or the lasting effects of the procedure.

In the United States, 35 states require counseling prior to have an abortion, and many dictate the content of those counseling sessions (Murray et al., 2017). As counselors, it is important to keep personal values and beliefs aside and allow the client to fully explore their own thoughts and feelings on the topic. It is not for a counselor to encourage a client to decide or feel one way versus another but to help them to discover their true feelings. This topic is one that is probably the most controversial for counselors to work with and clients will have many values and beliefs to work through if faced with this situation.

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