Developmental Disability, Sexuality, and Counseling: A Call for Action and Ecological Implications

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Despite significant efforts in changing the particular views that society holds about people with developmental disabilities, there had been only a few research attempts to understand the counselors' views and willingness to discuss and address sexuality issues in the work with these clients (Stinson, 2004). This article used Bronfenbrenner's ecological model (1979) to explore the intersection between sexuality and disability, and proposed action steps for advocacy and social change recommendations for counselors and counselor educators.

Keywords: Sexuality, developmental disability, ecological model, counselor education

Sexuality in people with developmental disabilities is a topic infrequently discussed in American culture or in the mental health field. The traditional societal views of sexuality involve youth and attractiveness, which tend to be inconsistent with the reality or stereotypes associated with people with developmental disabilities (Arokiasamy, Rubin, & Roessler, 2008). Constrained social perceptions of sexuality in developmental disabilities are manifested when affection, care, and love are rarely mentioned, being replaced by the emphasis given to capacity, techniques, risk, and dysfunction (Brodwin & Frederick, 2010). For example, psychological research focused on Lesbian, Gay, Bisexual and Transsexual (LGBT) individuals with disabilities tends to also be negative focused, concentrated in risky sexual behaviors and sexually transmitted diseases (Fraley, Mona, & Theodore, 2007). This manuscript presents an alternative ecological view of the counseling work with these persons.

Efforts from parents, care providers, advocates, and agencies have attempted to raise awareness of the importance of addressing issues of sexuality in the developmental disabilities field from a more humane and social justice perspective (Brodwin & Frederick, 2010). However, sexual education efforts and training for teachers and support staff have fallen short of emphasizing knowledge, access, and choice as critical components in developing, maintaining, and supporting sexually related experiences in these individuals (Bernert, 2011; Stinson, 2004). Authors have emphasized the importance of individuals with developmental disabilities being afforded the opportunities for the development of sexual identity and its free expression. For instance, Bernert (2011) found that women with intellectual disabilities experienced institutional oppression that impacted their sexual identity development and sexual expression, creating feelings of inadequacy and fear around sexuality. Moreover, when persons with disabilities identify with non-heteronormative gender identities, they are the subject of double environmental barriers and even more negative societal views that impact the open expression of their sexuality (Ballan, Romanelli, & Harper, 2011; Fraley et al., 2007).

Educative efforts have at the same time lacked effectiveness in raising awareness and instilling knowledge and sensitivity about the intersection of these topics in residential staff and mental health practitioners, as these professionals are usually reluctant to have these conversations for a variety of personal and cultural reasons (Juergens, Miller, & Berven, 2009; Kazukauskas & Lam, 2010; Meaney-

Tavares & Gavidia-Payne, 2012; Stinson, 2004). This has not only hindered the effectiveness and sensitivity of counselors' interventions, but has also further perpetuated oppressive views in the field. Therefore, the importance of developing a multidimensional view of sexuality in developmental disabilities and stressing the responsibility of mental health professionals for advocacy make necessary the elucidation of a valid set of practical implications for counselors and counselor educators. These implications are presented below.

Developmental Disabilities

The word *disability* directly makes reference to the lack of capability (Garland-Thomson, 2012) that is evidenced as a result of a critical incident (e.g., illness, accident) or by normative descriptions of time (Kafer, 2013). Moreover, the term *disability* is an umbrella term that culturally implies the person's lack of the ability to care for themselves (Bernert, 2011) or to participate in typical activities due to a physical or mental dysfunction in the body (Ballan et al., 2011). Despite the vast multiplicity and complexity of the disabilities field, this article aims to contribute to the evident dearth of counseling literature in the specific realm of developmental disabilities by examining the intersection of disability and sexuality and offering implications for the Counselor Education field.

In the counseling field, the definitions of developmental disabilities have been historically attached to the medical model and have rooted their emphases on pathology, deficit, and disadvantage in individuals with disabling conditions (Pledger, 2003; Stinson, 2004). These definitions have stressed the need for the medical field to address the abnormality in these atypical bodies (Kafer, 2013). This pathologizing and normative view of disability reduces the human experience to a dichotomous reality where the person is able or not (Linton, 1998). Contemporary models conceptualize disability as a social, cultural, and political phenomenon, and place more emphasis on the environmental variables surrounding the individual and the person's fit to the environment's demands (Pledger, 2003).

In these latter models, the emphasis is placed in the complex interactions between the individual and the larger social and political world instead of being considered an inherent condition of the person. Specifically, the Minority Group Model of Disability recognizes these individuals as part of a marginalized group, vulnerable to the same bias and discrimination as any other group based on race, ethnicity, sexual orientation, or religion/spirituality (O'Brien, 2011).

Moreover, more contemporary paradigms of disability do not seek to fix the individual but to address the larger social and political context by re-constructing the view of disability in our society through interaction and discourse (Ashby, 2012). Taken further, this view of disability and its relation to sexuality also emerges and is reinforced in the interactions between individuals and mental health providers, placing the responsibility on counselors for awareness and advocacy, and highlighting the importance for counselors to understand and be competent in this regard.

Societal Views and Myths of Sexuality

Because people with developmental disabilities often present cognitive and/or physical impairment, oppressive and stereotyped views of sexuality in this group have been prevalent from early civilizations to modern day (Arokiasamy et al., 2008). As a result of these negative views, myths surrounding sexuality and developmental disabilities have emerged and been maintained in the collective thinking, perpetuating inequalities and disenfranchisement in this minority group. Research shows that these myths affect not only the sexuality of people with developmental disabilities but also impact their self-esteem, the perception of their own bodies, and their motivation for independent living (Bernert, 2011; Brodwin & Frederick, 2010; Fraley et al., 2007).

The presence of cognitive impairment in adolescents and adults might perpetually foster child-like views of these individuals (Wolfe & Blanchett, 2000) who are, therefore, considered asexual (Brodwin & Frederick, 2010; Rivera, 2008). This misconception is reified through evaluations and support services decisions made according to the functional age of the individual. This practice seems to be institutionalized since psychological evaluations are based on measures such as the Vineland Adaptive Scale, which determines intellectual disability according to age-equivalent scores (Stinson, 2004) and potentially perpetuates beliefs that people with disabilities are not sexual beings or should not experience sexual desires.

Moreover, people with developmental disabilities might be considered over-sexed and as having uncontrollable urges (Stinson, 2004). Stinson (2004) describes society's mistaken expectation for individuals with developmental disabilities to know what is socially adequate, even when no formal or consistent sexual training is provided to these groups. The lack of an established and consistent concept of how to address sexuality issues might contribute to mental health and support systems (i.e., educational and residential settings) acting in consequence to sexual behaviors that

become problematic, instead of taking preventative steps to avoid potential issues and foster healthy sexuality (Stinson, Christian, & Dotson, 2002). For example, a myth about providing sexual information to these individuals suggests this information may act as a trigger to problematic sexual behaviors and sexual abuse. However, research has been conducted to understand the impact of providing sexual information to people with developmental disabilities, and findings indicate that sex education fosters positive changes such as increased appropriateness of sexual expression and more adequate social skills (Lumley & Scotti, 2001).

Along with the mistaken view that persons with developmental disabilities are paradoxically over-sexualized and infantilized at the same time, it is often assumed that they lack the necessary social skills and judgment to effectively navigate their sexuality (Brodwin & Frederick, 2010). This is also understood as a lack of skills for adequate sexual expression, to engage in meaningful relationships, and to effectively parent. These views impact the way persons with developmental disabilities internalize social rules of sexual engagement, resulting in distorted notions of sexual expression.

Bernert and Ogletree (2013) conducted an ethnographic study with forty-eight women with intellectual disabilities and found that even though these women displayed some sense of self-determinism in their sexual behavior, they also held negative perceptions of sex resulting in self-imposed abstinence predicated by fear of intercourse, intimacy, or their outcomes. The authors concluded that these women experienced: fear, erratic behaviors, increased risks for abuse and sexually transmitted diseases, involuntary abstinence, marginalization, embarrassment, and hopelessness. The authors also found significant amounts of emotional pain resulting from these women's internalization of socially transmitted views of them as unable to experience intimacy, sexual pleasure, parenthood, and freely embrace diverse sexual orientations (Bernert & Ogletree, 2013). This study stressed the impactful nature of these women's experiences and reasserted the importance of the sensitive incorporation of these topics into counseling work and research as a way to foster development and wellness.

People who provide mental health services are not necessarily free from the subtle impact of these views and stereotypes, which will influence how support is provided to these individuals (Bernert, 2011). The stance adopted by mental health providers, and the extent to which these perceptions are maintained and reinforced, often depend on individual values regarding sexual expression and disability (Stinson et al., 2002). Topics such as positive sexual identity formation,

sexual pleasure, positive sexual self-identification, LGBT identification, and successful sexual relationships of individuals with disabilities have been largely overlooked within the discipline of psychology (Fraley et al., 2007; Schulz, 2009). Furthermore, despite the impact that these negative views have in counseling persons with disabilities, Counselor Education programs, with the exception of Rehabilitation Counseling programs, might not emphasize a focus in disability issues (Smart & Smart, 2006). In the past, this was explained by the low likelihood of encountering these individuals in helping settings. However, this reality has changed because of sociopolitical factors (i.e., the Americans With Disabilities Act, of 1990) and counselors are frequently faced with individuals with different kinds of disabilities or their families in a variety of settings. For instance, people with disabilities in higher education and employment settings might access counseling services to address the impact of natural stressors of these environments in their mental health such as anxiety, depression, and relationship issues (Smith, Foley, & Chaney, 2008). Thus, because of changing sociopolitical factors, counselors and training programs need to be competent in working with clients with disabilities.

Difficult Conversations

In working with these individuals, counselors are required to evaluate their own biases and build awareness of their internalized stereotypical views to be able to understand the reality of sexual experiences in this group and its influence in their families (Ballan, 2012). For example, counselors need to be prepared to provide sensitive and unbiased help to individuals and their families concerned with sexuality, or individuals with disabilities transitioning though their coming out process (Ballan, 2012; Fraley et al., 2007; Ballan et al., 2011).

Furthermore, for counselors to be able to do this it is necessary that graduate programs focus on addressing the reactions of counselor trainees to having difficult conversations about ableism and other views that perpetuate oppression. In a study developed by Schulz (2009), findings suggest that psychology programs have focused on the impact that the disability has on the person's sexuality, and have emphasized theories about disability and sexual identity development. According to Schulz (2009), psychology programs have not focused on the helpers' reactions to these topics and their critical self-exploration, or on their ability to engage in these difficult conversations. Similarly, in the field of Counselor Education, including Rehabilitation Counseling, the need for efforts to study counselors' reactions and for the development of awareness and

sensitivity in this regard are also evident. Furthermore, the institutions that train these professionals might still maintain practices that reflect socially-embedded negative attitudes or beliefs about this marginalized group by not emphasizing such important aspects of the human experience, such as healthy sexuality (Stinson, 2004).

Watt et al. (2009) performed a study in a Counselor Education program accredited by the Council for Accreditation of Counseling and Related Educational Programs (CACREP) at a large U.S. midwestern university. In this study, students submitted journals and reaction papers that reflected socially-embedded attitudes regarding those who are perceived as being different in terms of race, sexuality, ability, and so forth. The most relevant reactions to the topic presented in this article were benevolence and false envy, that is, understanding people with disabilities as brave, and even wishing to have a disability as an indicator of personal strength.

Furthermore, in the field of Rehabilitation Counseling, studies have explored the willingness of counselors to discuss sexuality with their clients (Juergens et al., 2009), and their comfort level in doing so (Kazukauskas & Lam, 2010). Juergens et al. (2009) found that the willingness of these counselors to have conversations related to sexuality with individuals with disabilities was directly impacted by the counselor's knowledge of sexuality and their own comfort level with the sexual aspects of the counselor's life. The authors suggest that counseling programs should include sexuality education in their curriculum as well as instructional and experiential activities that increase the comfort level in students, which will enhance their willingness to discuss sexuality with their clients in the future.

Counselors' comfort levels in discussing sexuality were specifically studied by Kazukauskas and Lam (2010). Results indicated that knowledge and attitudes towards people with disabilities directly contributed to their comfort levels in addressing sexuality with their clients. Along with Juergens et al. (2009), the implications from this study emphasize the need for increased sexuality and disability education and training in counseling programs.

If Counselor Education programs are to generate opportunities for training and sensitization in this topic, they will likely encounter students' reactions to difficult dialogues as those described by Watt et al. (2009). Therefore, programs need to prepare students to review potential unidentified paternalistic and ableist reactions in working with individuals with disabilities, to unpack the multilayered privilege in their different cultural identities, to create critical consciousness, and ultimately to understand social justice issues related to their dominant cultural identities. The awareness resulting from engaging in difficult dialogues may foster counselors to move beyond ethnocentrism and able-centrism to a more honest, sensitive, and respectful interchange with others (Ballan et al., 2011; Watt et al., 2009).

Advocacy and Social Change

Advocacy and social change have been considered growing forces in the counseling profession (Chang, Crethar, & Ratts, 2010) and a central competence identified by the American Counseling Association's (ACA) *Code of Ethics* (ACA, 2014). These actions have augmented the awareness of counseling students, who increasingly receive more training in advocacy skills throughout their programs of study. Moreover, the concept of social advocacy has been introduced in the literature to pinpoint counselors' responsibilities for working on behalf of clients to minimize oppression and discrimination (Chang et al., 2010; Glosoff & Durham, 2010) with the goal of obtaining fair, just, and equitable treatment or access to services (Chang, Hays, & Milliken, 2009). In preparing counselors for social justice in this regard, counselors-in-training need to acknowledge issues of privilege, power, intentional and unintentional oppressive views, and their intersectionality with other dimensions of the human experience.

Counseling programs and clinical supervisors have the responsibility to raise issues of diversity, power, and privilege with their supervisees (Hays & Chang, 2003), even though some of them may be reluctant to engage in these difficult dialogues. This reluctance reveals the need for instructional and experiential activities that help students think sensitively about the clients they serve, embrace diversity, and understand the multilayered nature of the counseling work (Bartoli, Morrow, Dozier, Mamolou & Gillem, 2014). Stinson (2004) used Bronfenbrenner's (1979) model to present and explain the interplay of systemic factors between social systems and the individual. This model's interplay is depicted in four different layers (see Figure 1) that use the analogy of nesting dolls with various levels of systems nested within each other. Bronfenbrenner's (1979) model is used and expanded in this article by incorporating advocacy and social change implications for counselors in all systemic levels.

Ecological Review and Advocacy Recommendations

The individual is usually situated in a multisystemic reality described by Bronfenbrenner

(1979) where the person can be blamed for the surrounding social injustices (Stinson, 2004). People with developmental disabilities may exhibit frustration and anger through problematic behaviors or may engage in inappropriate sexual behaviors if they are not afforded knowledge and opportunities for healthier sexual options (Robinson, Conahan, & Brady, 1992). Consequently, these behaviors may reinforce negative beliefs and attitudes from the environment (Strickler, 2001), specifically with those closer to the individual, such as support staff, mental health providers and family. In return, individuals internalize those negative social messages and conform to oppressive social expectations by integrating values and assumptions that devalue their personhood based on their sexual identity (Ballan et al., 2011)

Counselors working with these individuals might need to address the individual's concerns by understanding the impact of social systems on their presenting problems. For this to happen, it is necessary that counseling programs prepare students to gain awareness about the various guidelines laid out by professional organizations (Fraley et al., 2007), and to expand their understanding and views of people with disabilities through training and awareness building of their own negative views. The goal of these training programs is for counselors to be able to recognize the individual's presenting problems as indicators that respond to systemic or internalized oppression, to identify strengths and resources of the clients, and to advocate for their clients by empowering them. This empowerment may assist clients in identifying internalized barriers and gain access to the resources needed.

Bronfenbrenner (1979) defined the Microsystem level as the institutions and groups most intimately related to the individual. These interactions include peers, family members, friends, romantic partners, counselors, doctors, and support staff. For people with disabilities, family and support staff are likely to represent a highly-significant microsystem and main source of support (Goble, 1999). However, negative societal views of sexuality and disabilities have a multilevel impact, which can be perpetuated by staff, family, and mental health professionals as well, impacting the opportunities for knowledge, access, and choice for these individuals regarding their sexual experiences. Also, people with developmental disabilities might be in disempowered positions in their relationships, having to unquestionably follow directions from health providers, or having minimal power to enforce their preferences, opinions, and choices. This power differential confirms counselors' responsibility to gain awareness about power factors (i.e., knowledge, gender, race, class, etc.) as they advocate for clients.

Counselors working with these individuals need to involve different subsystems that are cultivating and maintaining oppressive views in individuals with disabilities' lives. It is important that counselors engage these persons and their families to understand the social dynamics and to strive for minimizing the effect of intentional and unintentional family messages on the sexuality of these individuals (Stinson et al., 2002). Counselors have the responsibility to advocate for the change of these views not only at the individual level but also at the micro level with their families, support staff, and other people involved in treatment and rehabilitation.

For example, counseling programs could intervene by strengthening the training in systems approaches to help the counselor articulate sessions involving the identified client, and also significant others that surround the individual. Moreover, according to Lewis, Arnold, House and Toporek (2003), counseling programs need to raise awareness about the importance of the development of students' advocacy competencies and other skills needed to identify barriers, develop alliances with subsystems, and negotiate relevant services and education systems on behalf of their clients. A potential example of this might be the active and intentional incorporation of advocacy competencies to be demonstrated in case presentations to foster systemic change at the micro level.

The Mesosystem level consists of the interactions between microsystems (Bronfenbrenner, 1979) and reflects how intentional or unintentional negative views are transmitted, maintained, and expanded. This level includes the interactions between the individual and family, day programs, direct support staff, mental health providers, service coordinators, doctors, et cetera. Research suggests that sexuality issues should be addressed not in isolation but through interdisciplinary team work (Lumley & Scotti, 2001). However, counselors working with other providers and family members might encounter difficulties in advocating for healthy sexuality decisions as counselors might still be opposed to attending sexual issues or changing their views regarding this topic.

Counselors need to be mindful of the interplay of different microsystems and its impact on the sexual experiences of people with disabilities, their transformative power in serving as a bridge between these subsystems, and their misconceptions about sexuality in these individuals. Consequently, counselors need to interrupt the perpetuation of negative views and include sexuality related issues into the planning of interventions in clinical treatment. Counseling programs can prepare students to identify this multisystem reality and its impact on the individual, to develop skills for creating alliances between microsystems, to instill empowerment for assuming a

collaborative role in their work with people with disabilities, as well as obtain the tools to deal with resistance and negative responses to social change (Lewis et al., 2003). One example would include encouraging counseling students to actively identify stereotypes that are perpetuated in the collaborative work with other mental health professionals and which result in barriers for people with disabilities to experience a healthier sexuality. Counselor educators might also foster discussions of these identified stereotypes to spark meaningful dialogues and critical thinking in students.

The Exosystem level consists on the interplay between social settings where the individual might not have direct influence or might not be a direct participant (Bronfenbrenner, 1979). This system level includes mass media, support systems, social security system, religious organizations, the law enforcement system, and sexual policies in the individuals' environment (i.e. day program). Even though individuals with disabilities, their families, or mental health providers might not typically participate in state divisions such as the state offices for people with developmental disabilities or national initiatives as the Americans with Disabilities Act (1990), their lives are influenced by the decisions made in these domains in terms of making resources available. Decisions about how resources are allocated for residential, vocational, educational and recreational services will impact the possibilities of mental health providers, and specifically, counselors. According to the National Association of Developmental Disabilities Councils, many of these efforts have strived for increasing self-determination, independence, inclusion and productivity in these individuals ("About Councils on Developmental Disability," n.d.). However, work still needs to be done as negative views socially held about other minorities with disabilities (LGBT) still reinforce institutional barriers that impact their possibilities for healthy sexuality at the knowledge, access and choice levels (Fraley et al., 2007).

Specifically in graduate counseling programs, concepts such as the intersection of disability and sexuality have been segregated. This has created limited training or few exposure opportunities to experiential activities aimed at raising awareness and stronger multisystemic understanding. Despite efforts to include disability aspects into counseling curricula, the number of required courses on disability issues at accredited graduate institutions is still not enough. Moreover, similar to psychology programs, "the absence of disability issues in textbooks, curricula, and in the discourse among peers and professors communicates a powerful message about marginalization of people with disabilities and trains students not to notice their absence from the field" (Olkin & Pledger, 2003, p. 57).

This might contribute to professionals graduating with deficiencies in competence and sensitivity to intervene effectively, and counselors unintentionally perpetuating marginalizing conditions for people with developmental disabilities in their access to a healthy sexuality.

The role of counseling programs includes facilitating students' identification of the impact of systems' policies in the individual's mental health and development. According to Lewis et al. (2003), counselors also need to be able to build alliances and disseminate information to debunk stereotypes regarding sexuality in people with disabilities. Counseling programs have the responsibility to equip students with the necessary tools to overcome internal barriers to truthfully look at these issues, and to encourage students to advocate for these clients in different domains (i.e., health system, agencies, graduate programs, etc.). Counselors could advocate at the agency level to foster positive and realistic views of these individuals, to make resources available for clients with disabilities, and also advocate for training opportunities in this area. Brodwin and Frederick (2010) affirm that these training suggestions are also opportunities for professionals to examine their attitudes, values, and beliefs related to these issues. Another way to intervene in the exosystem could be by encouraging faculty and supervisors to engage students in research and scholarly opportunities to foster research on sexuality issues in people with developmental disabilities (Fraley et al., 2007).

The Macrosystem level consists of the culture surrounding the individual (Bronfenbrenner, 1979) and includes societal values, belief systems, and attitudes towards sexuality and disability, gender and sexual orientation as well as the interplay with other cultural identities (race, ethnicity, age, etc.). Due to emergent views of disability that detach from the medical model, there is a growing intention to conceptualize disability as a socially constructed construct instead of an individual's pathologizing condition. However, much work is needed to bring society to a uniform view of disability as an experience instead of an excluding criteria. Moreover, the sexuality topic is greatly influenced by other cultural (e.g., spiritual and religious) views that undeniably impact counseling students and professionals at different levels.

Myths and stereotypes influence people's view of courtship, sexual relations, intimacy, and parenthood in people with developmental disabilities. For instance, reproduction and parenthood in people with disabilities have historically been defined by negative views and degrading actions as compulsory sterilization, denial of parenting opportunities, beliefs of genetic transmission of disability to offspring, prenatal testing and selective abortion, et cetera. These macrosystemic beliefs emerge in these individuals' interactions with the environment

and might reinforce oppressive cycles. The discussion of these stereotypes and oppressive cycles may create interference with other cultural values (i.e., niceness, altruism, etc.) and discomfort-laden experiences in members of mainstream culture. This might generate resistance and unwillingness to address these issues and ultimately, further marginalization for people with developmental disabilities (Stinson, 2004).

Counselors have a critical responsibility to overcome the ambivalence that generates unwillingness to address these issues and continued marginalization for people with disabilities. According to Lewis et al. (2003), counselors need to recognize the impact of oppression and also identify environmental factors that contribute to it in their clients. Counseling programs have the ethical responsibility to prepare students to become advocates in the public arena to inform, educate, and transform the oppressive policies that affect people with developmental disabilities. Furthermore, counseling programs and supervisors need to train counseling students for making alliances, influencing legislators, organizing efforts, and maintaining open dialogues with communities and clients. A potential way to do this is by encouraging critical, and often difficult, dialogues in counseling students about able-body privilege and macrosystemic negative views that perpetuate marginalization and oppression in people with disabilities.

Conclusion

The field of developmental disabilities has been historically influenced by misconceptions, societal negative perceptions, and dehumanizing practices. These negative societal views and historical antecedents not only inform the way people perceive individuals with disabilities, but also how these individuals perceive themselves (Brodwin & Frederick, 2010; Stinson et al., 2002). This situation becomes more complex when disability identity intersects with other oppressed identities. For example, in the case of women or LGBTQ individuals, the stereotypes people hold might place them in a situation where they might be devalued because of their disability and also because they are associated with other historically oppressed groups (Fraley et al., 2007). However, for individuals with developmental disabilities in general, these societal views and stereotypes may impact almost every aspect of life such as relationships, achievements, happiness, creativity, and intimacy (Brodwin & Frederick, 2010). Thus, the disability field poses an imperative call for mental health professionals to overcome their personal barriers in talking about sexuality in developmental disabilities, understand the multisystemic reality of oppression, and respond to

client needs by advocating and fostering social change. Counseling programs need to empower students to understand and take on their revolutionary role in the professional field as well as embrace their advocacy power.

In her study, Gougeon (2010) affirms the difficulty to translate knowledge into practice when addressing sexual knowledge in individuals with developmental disabilities. Stinson (2004) asserts the same difficulty in the mental health field as social change takes time and united efforts. She suggests that professionals work under the model of small wins where success is not measured by the solution of all the issues described in this article, but by small victories in every ecological level, each day. Counseling programs could benefit from using this approach when integrating advocacy skills into curricula and when prompting students to engage in difficult dialogues. Thus the transformational power is processed in a less overwhelming manner and becomes more manageable for counseling students and supervisors. As counselor educators, it is our ethical responsibility to make this happen and instill in our students that "there is no single reason why people with developmental disabilities continue to be at a disadvantage when it comes to sexual development and expression" (Stinson, 2004, p. 142).

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