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Sex Topics in Therapy: A Literature Review and Proposal for Continuing Education

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Abstract

Sex topics should be welcome in the therapy room. Sexual identity, practices, concerns and questions should not be considered a "taboo" subject in the therapy room, yet clients remain reluctant to bring up such topics with their therapists. In order to ensure that clients feel free to bring into the room such themes that are a large part of their life, clinicians need to be trained and competent in sex topics. The following literature review examines the history of femininity and masculinity and what "facts" have continued to permeate into our profession, the history of sex expectations, language about sex topics, and the difference between men and women and the sexual double standard for the purpose of highlighting the many nuances involved in sex topics. Following is a recommended brief curriculum for a continuing education course for psychologists around sex topics in the therapy room. Recommendations for requirements in the state of Colorado for psychologist supervisors are also provided.

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SEX TOPICS IN THERAPY: A LITERATURE REVIEW AND PROPOSAL FOR CONTINUING EDUCATION

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SEX TOPICS IN THERAPY

Introduction

Sex topics should be welcome in the therapy room. Sexual identity, practices, concerns and questions should not be considered a "taboo" subject in the therapy room, yet clients remain reluctant to bring up such topics with their therapists. In order to ensure that clients feel free to bring into the room such themes that are a large part of their life, clinicians need to be trained and competent in sex topics. Over the course of my clinical training, I questioned one supervisor's comfort with and ability to address sex topics in a non-judgmental and professional manner, particularly in regard to the sexual double standard. The following literature review examines the history of femininity and masculinity and what "facts" have continued to permeate into our profession, the history of sex expectations, language about sex topics, and the difference between men and women and the sexual double standard for the purpose of highlighting the many nuances involved in sex topics. Following, I will provide a recommended brief curriculum for a continuing education course for psychologists, of whom many are supervisors, around sex topics in the therapy room through the format of a 4-credit continuing education course. The purpose of the course will be to provide education around gender and sex issues and help psychologists examine their own biases so they can interact appropriately with their clients, and when applicable, their supervisees. I will also provide recommendations for requirements in the state of Colorado for psychologist supervisors, as there are currently no requirements to provide supervision in Colorado other than being a licensed psychologist.

Gender

While gender identity, fluidity, and transgender issues are more frequently presenting themselves in the therapy room, they remain complex and nuanced to the point that even those

within the same self-identified community disagree and express frustration with certain terms and identities. The world as a whole and psychology as a field appear to be moving toward understanding and acceptance; however, debates and discussions around what makes someone male vs. female or masculine vs. feminine and challenges to the gender binary and how individuals present themselves "correctly" are ever present.

Martin and Finn (2010) examined masculinity and femininity and how those terms have been measured over time. They described that "Masculine and feminine are words that most of us use confidently in everyday conversation, and we generally feel comfortable that our message has been conveyed when we describe someone or something as masculine or feminine" (p. 1). Authors added that "masculinity and femininity seem to be integral to the way people make sense of their world" but also posited the importance of keeping in mind "the dangers and necessary safeguards when applying nomothetic methods to individuals" (p.6).

One argument for the strict masculine vs. feminine dichotomy comes from evolutionary psychology. Buss and Schmitt (1993) argued that men and women have historically confronted different adaptive problems in different mating contexts (i.e., short-term vs. long-term). Historically speaking, "Humans are like most mammals in that women tend to be the more heavily investing sex. This occurs in part because fertilization, gestation, and placentation are internal within women" (p. 206). Buss and Schmitt pointed out that women, when reproduction is the goal, invest more, leading to their historical tendency to be "pickier" as they needed partners who could protect and provide. Men, on the other hand, have a goal to "spread their seed", with less consequences. Buss and Schmitt discussed Trivers's 1972 theory that women "should be the more selective or discriminating sex…whereas men should be less discriminating and be more vigorous in intrasexual competition for mates" (p. 207).

Trivers (1972) also noted that sex-typed features of human behavior evolved through male competition and female choice of mates, and because females devoted greater effort and parental investment, they were a limited resource for men. Men were the less investing sex and did not have time restrictions that women have and therefore competed for access to women. Eagly and Wood (1999) summarized and added that "As the more investing sex, women were selected for their wisdom in choosing mates who could provide resources to support their parenting efforts" which thus put pressure on men to satisfy that criteria (p.410).

Eagly and Wood (1999) added that evolutionary psychology posits that "women and men possess sex-specific evolved mechanisms" and that, because of this, they "differ psychologically and tend to occupy different social roles" (p.408). Evolutionary psychologists believe that men and women have historically faced different pressures in different environments and that, historically, the reproductive status of men and women were a key feature of their lives and it shaped different problems that each sex encountered. The sex of individuals not only influenced the problems people faced but also influenced the way in which individuals solved problems, creating "sex-specific evolved mechanisms that humans carry with them" (p. 408). Evolutionary psychology views sex-specific evolved traits and tendencies as built through genetically mediated adaptation to the environment over time and that current environmental factors interact with those adaptations and yield contemporary sex-typed responses.

Evolutionary psychologists argue that human sex differences reflect adaptations to environmental pressures, both physical and social, that males and females experienced during primeval times (Tooby & Cosmides, 1992). As males and females faced different adaptive problems as they evolved, they developed varying strategies to ensure survival and to maximize their reproductive success. Since culture influences developmental experiences, culture is

important to the expression of adaptive mechanisms (Tooby & Cosmides, 1992). According to Buss and Kenrick (1998), sex differences arose from differing fitness-related goals that followed from their different sexual strategies. Specifically, because men competed with other men for reproductive access to women, they evolved traits that favor competition, violence, and risk taking while women developed a preference for long-term partners who could support their family. Because of this, men worked to acquire more resources than other men in order to appeal to women, and women developed a preference for ambitions, hard-working, successful men who could provide resources.

Eagly and Wood (1999) also added that "evolutionary psychologists readily acknowledge the abstract principle that environmental conditions can influence the development and expression of evolved dispositions" but that they give "limited attention to variation of sex differences in response to individual, situational, and cultural conditions" (p. 408). Buss and Schmitt (1993) also noted that "lifelong mating with a single person does not appear to be the norm for humans", due to divorce rates and the prevalence of polygamous type societies (p. 204). They also note that "men and women have faced different mating problems over human evolutionary history…and therefore the principles that govern the mating of women and men are predicted to be different in these domains" (p. 205). This suggests that due to different circumstances and contexts, men and women have grown to behave in ways that are conducive to their lifestyle and circumstance. For example, birth control, abortion, and adoption are available as options that may make women feel safer to engage in shorter-term relationships as they are not at risk of getting pregnant or having to enter parenthood. Additionally, many women and men are choosing not to have children at all, yet they still engage in sex relationships for reasons other than reproductivity.

Linda Gannon (2002) provided an extensive critique of evolutionary psychology. Gannon noted that a "crucial assumption in evolutionary psychology is that all selection is sexual selection" and that the overriding motivation for all social behavior is reproduction (p. 177). To counter this argument and posit that the primary motivation for all men is not reproduction, Gannon stated that "the assumption that reproductive success is the prime motivation for human behavior is contradicted by the observation that men are not lined up for miles to donate to sperm banks (p. 184). Additionally, Gannon discussed how evolutionary psychologists often counter other theories by saying they are motivated by political or social issues (e.g., feminism); however, Gannon noted that evolutionary psychologists may be guilty of the same thing. For example, rather than comparing human behavior to Bonobos, evolutionary psychologists often site the behavior of flies, claiming they are close enough to humans to be a valid comparison. "Bonobos…whose culture is characterized by female centeredness, non-reproductive sex, unknown paternity, cooperation, homosexuality, rare physical violence, the capacity for empathy and care, and flexible status…are not cited as a 'relevant' species" despite the fact that they are as genetically similar to humans as chimpanzees" (Gannon, 2002, p. 199).

Feminism and Evolutionary Psychology have long been at odds (Eagly & Wood, 2011). Authors noted that the ongoing debate between evolutionary psychology and feminism "is framed by the disagreement about the potential for change in female and male behavior patterns" (p. 759). Evolutionary psychologists view male-female inequality as "inevitable consequences of evolutionary adaptations" and "largely unresponsive to socioeconomic and political changes in society" (p. 759). Feminism, on the other hand, believes in the malleability of male and female behavior over time. Some feminists have argued that differences between men and women exist or change due to the social context in which they are in and social identities other than gender.

Eagly and Wood (2011) added that "comparing the sexes without taking into account other identities produces overly broad generalizations that can be quite inaccurate for some subgroups of women and men" (p. 761).

The Sexual Double Standard

Buss and Schmitt (1993) stated that "The costs incurred by women are likely to be more severe than those incurred by men when pursuing a short-term sexual strategy…they risk impairing their long-term mate value by acquiring a social reputation as promiscuous…[and] it is to be more severe for women than for men" (p. 218). The risk of a poor reputation and the tendency for women to be viewed more negatively for the exact same behavior as men is ever present in society today. Authors also posited that, according to evolutionary psychology, "women of high mate value are generally more discriminating than women of low mate value…[so] sexual promiscuity may be interpreted as a sign that a woman cannot obtain a long-term mate of high quality who is willing to commit resources and parental investment" (p. 219). Therefore, women are less desired when they have multiple partners whereas it does not impact men the same way.

Because of this double standard, female clients, in particular, may feel uncomfortable talking about their sex lives in therapy. Tolman, Anderson and Belmonte (2015) posited that girls and young women's sexuality is complex. They added that the one-dimensional slut/virgin divide is insufficient. There are a variety of alterations in gender norms, moral codes, and language used to describe young girls' sexual behavior (Tolman, Anderson & Belmonte, 2015). From prude and virgin to slut and promiscuous, women are constantly waging a battle against labels. Authors added that even women who expect sexual experiences to be pleasurable and feel powerful understand the risk that they will be labeled a slut. Women may be labeled for being "too young" for a behavior or sex activity, for engaging in sexual expression, for having "too many" partners,

and engaging in sexual behavior outside of "condoned conditions," like long-term, monogamous relationships (Tolman, Anderson & Belmonte, 2015, p. 302). Not only can white women be labeled as a "slut," Tanenbaum (2015) also found that there are also "good" and "bad" sluts, often related to other aspects of their identity (Tanenbaum, 2015). Tanenbaum (2015) added that those who identify as Black, Latina, queer, disabled, poor, or religious often do not have access to the "good" slut label and are "bad" sluts.

Attwood (2007) discussed the history of the word, "slut." The term "sluttish" was used in the fourteenth century to mean "dirty and untidy," and it took on the meaning of "kitchen girl" in the fifteenth century, and soon came to mean "bold," "saucy," or "brazen" girl (Attwood, 2007, p. 233). It then became associated exclusively with women and acquired the negative, "promiscuous" meaning (p. 233). In the twentieth century it became a derogatory term used for women who did not accept the "double standards of society" (p. 233). Not only did men call women sluts and other derogatory terms, but women also used the terms to describe one another. Over time, Attwood indicated, "slut" has broadened in its application to include gay men, bisexual men and women, and teenagers. The word, he added, works to make women feel they are gross, desperate, wrong, "miserable and empty inside," used, dirty, and undignified (p. 238).

Farvid, Braun and Rowney (2016) shared dictionary.com's definition of a "slut" as an immoral or dissolute woman, a prostitute, a slovenly woman, or a woman of loose morals. Authors also noted that there are no equivalent terms available in the English language to describe men who behave the same. Authors examined young, heterosexual women's experience of casual sex in relation to this sexual double standard and found that although there have been some recent positive shifts in women's articulation of their desire for casual sex, the sexual double standard is implicated in (and shapes) women's experience and accounts of casual sex. Women are engaging

in a constant battle as the double standard threatens to label them as a "slut" while they are pressured to be "sexy," sexually knowledgeable, and sexually experienced at the same time (Farvid, Braun & Rowney, 2016). While the popularity of girls decreases with an increase in number of sexual partners, according to the authors, popularity of boys increases with the more sexual partners they have. Authors also noted that even if men are negatively labeled (i.e., man-whore), the connotations of such labels do not carry the same "cultural sting" (Farvid, Braun & Rowney, 2016). As Jackson and Cram (2003) also noted, desiring sexuality is positively regarded in men, but regulated by negative labels in women.

Furthermore, Jonason and Fisher (2009) examined how the sexual double standard effects the way women and men report their own sexual behavior. Authors pointed out that men, on average, *report* having significantly more lifetime sexual partners than women do; however, the actual difference in number may not be very different. Men reported higher numbers and women reported lower numbers, regardless of their actual number, due to a variety of factors. First, "Young men who were higher in hypermasculinity tended to exaggerate their number of sexual partners when they were (falsely) informed that women now have more sexual experience and more permissive attitudes than do men" (p. 152), which suggests that men perceive higher status in having more sexual partners than women. Authors also pointed out another argument: "men's striving for dominance may be a motive that leads to over-reporting number of lifetime sexual partners" (p. 152). While Jonason and Fisher (2009) discussed that women are less concerned with the "prestige" that comes for men who report higher numbers, they do not fully examine the impact this has on women and their report of sexual partners. It is this author's perspective that women, over time, have learned several lessons. One, is that women must protect the man's ego and report fewer partners so that our male partners feel better, and two, that we may be labeled a slut or

promiscuous if we report a certain number of partners. These issues impact the way women discuss their sexual relationships with each other, with their partners, and with their therapists. "Evidence clearly points to the fact that the gender difference in reported sex partners between men and women is an illusory difference created by attitudes related to sexual success as prestigious which in turn impact self-reports" (Jonason and Fisher, 2009, p. 158).

Heteronormativity

Farvid, Braun and Rowney (2016) stated that the gendered heterosexuality is also tightly tied to notions of heteronormativity, where there is a general and dated assumption that there are only two genders and that only sexual attraction among these two genders are natural and acceptable. Authors added that monogamy is idealized as the "best" way to have a relationship and life-long love relationships are more acceptable and preferred than friendships or casual sex. "Casual sex" can take on many meanings but usually refers to brief or one-time sexual encounters as well as ongoing sexual arrangements among individuals who are not in a committed relationship (Farvid, Braun & Rowney, 2016, p. 547). Farvid, Braun, and Rowney stated that there are three discourses that view casual sex differently. A "permissive discourse" maintains that men and women both have a desire for and a right to engage in casual sex; a "neoliberal discourse" maintains that individuals who engage in casual sex are rational beings who choose to do so and they are not constrained by social conventions; a "moralistic discourse" maintains that casual sex is aligned with promiscuity, risky sex, and disease (Farvid, Braun & Rowney, 2016, p. 547). Because of the enduring sexual double standard, authors suggested that women may only talk about casual sex in a context where they will not be negatively labeled as a result of such disclosures, thus the importance of safe therapeutic space.

Men and women often attend therapy to further develop their sense of self, increase their self-esteem, manage relationships and set personal goals. If they do not feel they can talk about sex topics with their therapist due to fearing judgment, a large part of their life is left out of therapy. It is so valuable that psychologists receive training in discussing sex topics professionally and engage in self-reflection around their own biases regarding sex. This training often happens in supervision, so we must be able to rely on supervisors to be willing and able to discuss sex topics in thorough and thoughtful ways.

Sex Topics in Therapy and Gender Differences in Diagnosis

Clinician comfort with discussing sex topics and their ability to be nonjudgmental and professional is important not only for the therapeutic relationship but also for diagnosis and treatment. Swartz (2013) noted that feminism has had a lasting influence on the way psychiatry describes and treats women's sexuality. Feminists have challenged Freudian psychoanalytic diagnoses and have allowed new definitions of female identity formation; however, the psychiatry industry is extremely powerful, and misdiagnosis can have lasting negative consequences for women (Swartz, 2013). Swartz noted that the stigmatizing and disempowering effects of diagnoses that are used too freely or too loosely (i.e., Borderline Personality Disorder, BPD) does occur. The psychiatry industry, Swartz added, is an accepted instrument where human behavior and experience is categorized as either "normal" or "abnormal," and impacts drug companies, researchers, and medical insurance companies across the world. The tendency to ignore the impact of trauma, for example, before providing diagnoses of BPD is real. There is a gender imbalance in BPD and mood disorder diagnoses such that volatile, angry, demanding, and sexually expressive women may be diagnosed with BPD, prescribed a range of medications and described as suffering from "internal instability," whereas men do not receive such labels (Swartz, 2013, p. 46). While

diagnoses can be invaluable for treatment planning and medication management, clinicians must be thoughtful as to not misdiagnose based on their own biased opinion of what is "normal" female behavior.

Gannon (2002) noted that evolutionary psychologists often posit that depression "is common in people pursuing unreachable goals" and that they argue that depression "should be common in people who are unable to disengage from unreachable goals" (p. 201). This theory of depression is often termed "learned helplessness." It is possible that, due to societal double standards that posit that it is harder for women to do certain jobs than men, that this is a piece of the puzzle when it comes to our tendency to diagnose more women with depression. Gannon introduced the Simpson's 1995 article where the author asked, "why do some men display a restricted sociosexual orientation…and why do some women evince an unrestricted sociosexual orientation" (p. 73). Gannon pointed out that Simpson "reveals ideological influence by implying that men who have few sexual partners and women who have many require an explanation" (p. 206). One way we "explain" the behavior of women is by providing certain diagnoses.

Teri (1982) warned that psychotherapy has perpetuated negative sex-role stereotypes and devalued women for years. Teri asked clinicians to rate vignette descriptions on the criteria of adjustment, prognosis, maturity, and preferred treatment approaches and investigated client and therapist sex differences, client and therapist sex-role styles, and their effect on clinician judgment. Teri found that "clients" exhibiting more stereotypically feminine behavior were rated more maladjusted and less adequately functioning than clients whom exhibited more stereotypically masculine behavior. Additionally, female clients were rated more adequately functioning than identically described male clients, suggesting that behavior was more acceptable and viewed less negative if it was a female, which may suggest that therapists had lower expectations of female

clients. Teri argued that therapists may devalue stereotypically female behaviors, regardless of therapist sex. Jackson and Cram (2003) stated that voices of resistance to this double standard can be recognized and supported by those working with women. When women do not have a safe space to express desires, and talk about sex and their sexual needs, Jackson and Cram warned that talk of desire will always remain related to male needs, male bodies, and male desires.

Thus, male and female clinicians need training and introspection to ensure a nonjudgmental and professional therapeutic space for sex topics. While women often scoff at the notion of slut-shaming and judging one another for their sexual behaviors, women are guilty as well of labeling and judgment.

When it comes to diagnosing clients, psychologists do their best to be accurate and thoughtful. While many DSM-5 diagnoses, such as anxiety, carry little stigma as mental health has become a more accepted field, there are diagnoses that carry a lot of weight and can negatively impact the future of our clients and the way they view themselves. Clinicians need to be cognizant of the impact diagnoses have on men versus women and must continue to be thoughtful about how certain symptoms are perceived when experienced by men versus when they are experienced by women and consider whether that difference impacts the diagnoses we give our clients.

The American Psychological Association's Diagnostic and Statistical Manual of Mental Health Disorders (DSM) has been continuously edited and updated since 1980 to reflect current times, social and medical developments, and to adjust language. Diagnoses that have generated the most controversy were so because of their questionable application to one sex over the other. Hartung and Widiger (1998) examined the evidence behind criteria of DSM disorders through the DSM-IV and discuss the ever-present sex bias, both in sampling groups and in the language of diagnostic criteria.

Authors defined "a sex bias" as "a systematic deviation from an expected value that is associated with the sex of the individual" but also noted that these deviations are not necessarily due to poor intentions (Hartung & Widiger, 1998, p. 261). Some sex differences do exist, and it is unlikely that the prevalence rate for any mental disorder will be identical; however, just because a disorder may be more common in women or in men, does not mean that a particular person has that disorder because they meet certain sex-based criteria. Hartung and Widiger (1998) discussed bias in sampling and biases within diagnostic criteria. Authors posited that an important part of sampling bias comes from sex-related differences in one's willingness to seek treatment and one's ability to acknowledge the presence of a problem. It is possible that women are more likely to acknowledge the need for and seek help, which is why they often are the compared sample for certain diagnoses. Hartung and Widiger (1998) continued to make the interesting point that "the adult sections of the DSM-IV may be relatively more sensitive to disorders that are troubling to the identified patient, whereas the childhood sections may be relatively more sensitive to disorders that are troubling to others" (p. 264). They added that the most common childhood mental diagnoses concern behavior disorders (male children are more frequently diagnosed with mental health concerns than female children) for which there are no comparable disorders or sections for this domain of psychopathology within adults. This may explain the lack of men receiving mental health supports or being part of a study sample.

Biases within diagnostic criteria can impact the way clinicians view and diagnose their clients. Many criteria sets have disproportionately favored the manner in which disorders appear in one gender relative to the other, and gender neutrality is very difficult to achieve. Many disorders are expressed differently in males and females and involve maladaptive variants of gender related

behaviors (Hartung & Widiger, 1998); therefore, clinicians need to be aware of these nuances and consider them when diagnosing their clients.

First, Hartung and Widiger (1998) considered orgasmic and sexual desire disorders. The higher rate for women experiencing orgasmic disorders was reported to be due, in part, to the masculine-biased assumptions about what behaviors are healthy or what behaviors are "crazy". "For a diagnosis in women, the clinician must consider whether their orgasmic capacity is less than would be reasonable for their sexual experience, and it is noted that women 'exhibit wide variability in the type or intensity of stimulation that triggers orgasm' … [and there are] no such qualifications…made for the diagnosis in men" (p. 267).

Next, Hartung and Widiger (1998) considered Histrionic Personality Disorder. "The diagnostic criteria for histrionic personality disorder include features that are related to stereotypically feminine behavior (e.g., emotional lability, concern with physical attractiveness, and sexual seductiveness)" (p. 268). Given this, males are less likely to meet the threshold for diagnosis. Authors added that "any disorder that involves gender-related behaviors will be susceptible to sex biases within its diagnostic criteria" (p. 268). The language used to describe the criteria also may elicit clinician bias. For example, the criteria of "consistently using one's appearance to draw attention to oneself" is not inherently or necessarily maladaptive, and the negative connotation may be put upon the client by the clinician who makes a judgement of their own that the client's relationship with their own appearance is maladaptive.

Benson, Donnellan and Morey (2017) examined the gender-related diagnostic criteria for Borderline Personality Disorder (BPD). Authors noted that there is a long-standing controversy surrounding BPD and that case-vignette approaches of study have identified the misdiagnosis of BPD involving stereotypical female-centric behaviors. Oltmanns and Powers (2012) found that

there is a tendency to apply the BPD diagnosis to women but a separate diagnosis to men when the case conceptualization differed only in the gender of the client.

Women receive more diagnoses than men and are the target of specific diagnoses with no male counterpart such as premenstrual dysphoric disorder in the DSM-IV. Some research has identified much bias in the application of diagnostic criteria to men and women (Becker & Lamb, 1994; Crosby & Sprock, 2004). However, it is also argued that men are more likely to exhibit the most stigmatized disorders (American Psychiatric Association, 2013; Boysen, Ebersole, Casner, & Coston, 2014). People view certain disorders as being 'masculine' or 'feminine', and disorders perceived as masculine are seen as more stigmatized (Boysen, Ebersole, Casner, & Coston, 2014, p. 546). Authors stated that women are stereotypically considered to be "caring and emotional" and men are considered "active and strong", and that these stereotypes intersect with mental health (Boysen, Ebersole, Casner, & Coston, 2014, p. 547). Women are more likely to have anxiety disorders, mood disorders, eating disorders, and sexual dysfunctions where men are more likely to have substance use disorders, impulse control disorders, and paraphilias. Women are more likely to have avoidant, dependent, paranoid, borderline, and histrionic personality disorders while men are more likely to have antisocial, schizoid, and obsessive-compulsive personality disorders. Authors stated that gender differences in mental disorders are often explained as a result of men's and women's general tendency to exhibit externalizing and internalizing symptoms (Boysen, Ebersole, Casner, & Coston, 2014, p. 548). "[Aggressive], tough, independent, unemotional, stable" men and men who are "unconcerned about their appearance" are perceived as "healthy", and "talkative, gentle, expressive, sensitive" women and women who are "concerned with their appearance" are perceived as "healthy" (p. 549).

While there may not be an easy or thorough fix to the nuances of diagnoses and language, it is clear the importance of being thoughtful when diagnosing clients. Clinicians should challenge themselves to think about the language of diagnoses and symptoms as well as any sex or gender related biases it may bring up for them.

Supervision Training

Ballantyne and Cummings (2014) found that less than 20% of clinical supervisors have received formal training in supervision in general and that only 34% of graduate training programs offer coursework or practicum in supervision. Authors stated that bad supervision was identified by the presence of "negative supervisory events," which included the supervisor being perceived as overly critical, judgmental, and disrespectful (2014, p. 231). Authors noted that bad supervision leads to limited training, limited learning, and even potential harm to trainees. This can lead to a vicious cycle of poor training, as most supervisors without supervision training base their own supervisory style and methods on their own experiences as a trainee. Ballantyne and Cummings noted that in one study, half of the student sample reported their supervisors lacked multicultural competence in general and that bad supervision may adhere to cultural stereotypes, using broad or over-inclusive categories to guide clinical practice and supervision. When supervisees perceive their supervisors as judgmental, they may not bring up certain topics in supervision. For example, if a client shares with their therapist that they are sexually active and have a number of sexual partners, supervisees may not choose to disclose this information with their supervisor. Supervisees may want to protect their client if they are fearful that the supervisor will respond in a judgmental and nonprofessional manner. Ballantyne and Cummings (2014) recommended that clinicians who take on a role as supervisor engage in formal training, develop a model of supervision they identify with, set goals and expectations, are willing to provide difficult feedback,

provide regular and ongoing feedback to supervisees, create a positive interpersonal environment, and importantly, are aware of potential influences of diversity issues.

Berger and Quiros (2016) examined the effects of a supervisor training program on supervisor, supervisee, and evaluator perceptions of supervisory competence. Authors observed significant improvements in competence from before and after the training, despite supervisors reporting no change. Overall, this study supported the effectiveness of supervisor training in general. Clough, O'Donovan and Petch (2017) argued that there is little evidenced-based literature to guide psychologists on training supervisors. Authors noted that most supervisor training research is not focused on psychologists but on training teachers, paraprofessionals, and human services staff.

Multicultural Competence in Supervision

Gloria, Hird and Tao (2008) examined self-reported supervision practices, experiences and multicultural competence of white supervisors of predoctoral interns at sites within the APPIC directory. Authors found that female supervisors reported higher multicultural supervision competence and spent more time processing cultural differences with their supervisees than their male counterparts. Additionally, training directors reported higher multicultural competence than staff psychologists, and the number of interns that supervisors previously trained significantly predicated multicultural supervision competence. Gloria, Hird and Tao discussed three broad competency areas: a) an understanding of one's cultural influences on attitudes, values, and beliefs, b) knowledge of the worldviews of culturally different clients, and c) use of culturally appropriate counseling skills and interventions (p. 129). Ensuring that these broad competency areas are addressed in training, and generalized as well to supervision experiences, is necessary.

Not only is multicultural competence fundamental for clinicians and supervisors on a skill level, but it is equally important to the working alliance between the supervisor and supervisee (Gloria, Hird and Tao, 2008). When supervisors are willing and able to engage in discussions around multicultural topics, both supervisor and supervisees report more favorable supervision outcomes. Multiculturalism, including sex and gender differences, should be a focus of supervision.

In "What Therapists Don't Talk About and Why" by Pope, Sonne, and Greene (2006), authors discussed many "taboo" topics in psychology. Authors discussed a variety of myths, including therapists being "ageless," that therapists always grasp logic, and that therapists always act ethically. An entire chapter, titled "Therapists' Sexual Arousals, Attractions, and Fantasies: An Example of a Topic That Isn't There," is devoted to the topic of sex. Authors reported that in surveys, many graduate training programs were found to have stopped short of addressing sex topics entirely or adequately and that 10% of participants in this research indicated that their program training provided no coverage at all about sex topics and how it can interfere in the therapy room.

Training in Sex Topics

Burnes, Singh, and Witherspoon (2017) explored the need for inclusion of sex-positivity training in psychology doctoral programs and concluded that, in their sample of programs, only 16% of programs (4 of 25) featured one or more course entirely devoted to human sexuality and that 32% had no courses dealing with human sexuality at all, with 52% offering one or more courses in which sexuality "comprised a component, usually a small one" (p. 512). Nogasaki (2015) found that many psychology programs provided training about sex that almost solely focused on disease and infection as opposed to other more sex positive approaches. Williams, Prior

and Wegner (2013) identified sex-positive approaches as supportive of sexual exploration and desire and added that sex is normative and creative. Focusing solely on sex from a biological lens is unhelpful for many of our clients.

Burnes, Singh and Witherspoon (2017) added that "sex-positivity advocates view sexual expression as one of many aspects of diversity and acknowledge the numerous sociopolitical and value-based factors that influence normative sex practices and beliefs" (p. 505). Authors also stated to believe that lack of sex-positive training can have negative implications for clients such as reluctance to broach sexual topics with clients, unintentionally impeding client disclosure of sexual issues, reduced counselor willingness to treat sexual concerns and avoidance of sexual problems. While referrals to a specialist are occasionally necessary, it can "interrupt a client's therapeutic progress by inappropriately isolating sexual issues from the client's larger personal growth and developmental goals" (p. 506-507).

Psychology programs provide education through required and elective coursework, supervision, practicum, workshops, and more. Some programs rely on supervisors to bring up sexual issues while others assume it will be covered through practicum experiences, so no courses are offered. Burns, Signh and Witherspoon (2017) noted that because sexuality represents a "crucial and cross-cutting competency" it is necessary to include multimodal sexuality training for clinicians utilizing all modes of training (p. 507). In addition to opportunities throughout graduate school, authors also found that one of the only programs that reported discussing sexuality in more than one lecture or course is in California, a state that requires some education in human sexuality in order to apply for licensure (p. 510).

If psychologists are not guaranteed training in graduate school, Colorado must require licensed psychologists in its state to pursue continued education in sex topics, particularly if they are to supervise students.

Continuing Education Course: Sex Positivity in the Therapy Room and its Implications for Diagnosis

Psychologists need to be adequately trained in order to ensure that they are engaging appropriately with their clients and supervisees around sex topics. Because of the difficulty fitting sexuality training into graduate school curriculums, and because Colorado may bring psychologists from a variety of training programs, we must ensure that licensed Colorado Psychologists are competent by providing continuing education (CE) in a variety of sexual topics. Following is one such proposed curriculum for a CE course directed toward therapists that will address sex biases, sex positivity, and diagnosing errors. The course emphasizes sex-positivity, exploration of awareness and assumptions about sex and sexuality, knowledge of sex-positive terms and frameworks, and skill development for working with diverse sex behaviors and practices.

In accordance with Standard C (Educational Planning and Instructional Method) of the APA Standards and Criteria for Approval of Sponsors of Continuing Education for Psychologists (August 2015), successful continuing education in psychology requires educational planning that results in a clear statement of educational objectives, the use of appropriate educational methods that are effective in achieving those objectives, a clear connection between program content and the application of this content within the learner's professional context and the selection of instructional personnel with demonstrated expertise in the program content (p. 7). Hiring and vetting professional educators is out of the scope of this current paper; therefore, it will be

important for sponsors of this continuing education program to ensure the inclusion of experts in sex positivity, sexuality, and LGBTQ+ topics. Similarly, the course is a recommendation, and will need to be refined by experts should this course be offered.

Per Standard F (Standards for Awarding Credit), sponsors must award 1 CE credit for 1 hour of instructional time (August 2015, p. 14). Thus, the following program will be 2 hours of face-to-face time and 2 hours of required reading; participants will earn 4-hours of CE time. It is recommended that psychologists participate in person due to the discussion and reflection nature of the courses; the course may be filmed and posted online for viewing, and psychologists who use that method will receive 3 CE credits due to not being able to participate in the educational discussions during the face-to-face course. A maximum of 30 participants per course offering is recommended in order to have meaningful large group discussion as well as a maximum of 5 persons per group for small group discussion.

Required Readings and Pre-Course Education (approx. 2 hours of reading)

1) Burnes, T., Singh, A., & Witherspoon, R. (2017). Graduate counseling psychology training in sex and sexuality: An exploratory analysis. *The Counseling Psychologist*, *45*(*4*), 504-527.

2) Burnes, T., Singh, A., & Witherspoon, R. (2017). Sex positivity and counseling psychology: An introduction to the major contribution. *The Counseling Psychologist*, *45*(*4*), 470-486.

3) Boysen, G. (2017). Explaining the relation between masculinity and stigma toward mental illness: The relative effects of sex, gender, and behavior. *Stigma and Health*, *2*(*1*), 66-79.

4) Boysen, G., Ebersole, A., Casner, R. & Coston, N. (2014). Gendered mental disorders: Masculine and feminine stereotypes about mental disorders and their relation to stigma. *The Journal of Social Psychology*, *154*(*6*), 546-565.

5) Swartz, S. (2013). Feminism and psychiatric diagnosis: Reflections of a feminist practitioner. *Feminism & Psychology*, *23*(1), 41-48.

6) Hartung, C., & Widiger, T. (1998). Gender differences in the diagnosis of mental disorders: Conclusions and controversies of the DSM-IV. *Psychological Bulletin,* 123(3), 260-278.

7) Explore ‘The Safe Zone Project’ at https://thesafezoneproject.com/ and check out available resources and the vocabulary section.

Sample Course Agenda

9:00am **Welcome and Introduction**

Why Is This Course Important? Instructor shares information and facts from Hartung & Widiger (1998) (read by class), The Safe Zone Project website (explored by class), and Pope, Sonne, & Greene (2006) (instructor will reference, ‘What therapists don’t talk about and why: Understanding taboos that hurt us and our clients.’ Didactic around sex topics in therapy and the duty of psychologists to be thoughtful and open.)

9:30am **Sex Positivity and Therapy**

Small Group Discussion re: Burnes, Singh, & Witherspoon’s 2017 article, ‘Sex positivity and counseling psychology: An introduction to the major contribution’ (15 minutes).

Large Group Discussion (5 Minutes).

Vignette (10 Minutes) with Discussion Questions in Small Group.

Brief vignette example: A supervisee brings concerns to you, as the supervisor, regarding their client who brings in topics of his/her own sexual behavior and interests to the therapist in session. The therapist/supervisee is uncomfortable with the topic and wants to tell the client those topics are ‘off limits’. How should the supervisor respond?

10:00am **Diagnosis and Gender**

Large group discussion of Boysen (2017) and Boysen, Ebersole, Casner, & Coston (2014) (15 minutes).

Instructor may pose questions. Samples:

Thoughts on gender and stigma among society? Among psychologists and mental health professionals?

Why might our clients disclose certain symptoms to us based on their own identified gender?

What are the dangers of misdiagnosis due to gender expression differences?

Small group discussion re: DSM-5 diagnoses and how they may present differently by gender (15 minutes).

Sample discussion points: Each group may get a different diagnosis and discuss how those individuals of different gender may 'present' differently and how the diagnosis may have symptoms that are largely 'feminine' or 'masculine' that may impact the frequency of diagnosis.

Large group sharing (5 minutes).

10:35am **Therapists' Own Biases**

Large group discussion around the importance of acknowledging our own biases around gender and sex (10 minutes).

Sample discussion questions:

In what other areas of diversity and multiculturalism is it important that we look at our own biases?

Are/why are gender and sex biases different?

How might gender and sex biases impact how we engage with our clients? Examples?

Individual activity: write down your own biases or values (5 minutes)

Small group activity: discuss how biases and values may influence your therapeutic work and how you can challenge that to ensure client care (18 minutes).

11:00am Closing and Recommendations for Continued Independent Learning

Suggested Requirements for Providing Supervision in Colorado

As the above sections emphasize, training clinicians adequately and thoroughly is incredibly important. All clinicians receive many hours of supervision during their training and many may site supervision as the most meaningful training experience. Thus, it is essential that supervisors receive adequate training to provide the best supervision possible. The only current requirement for providing supervision in Colorado a doctorate degree and licensure. The bare minimum standard for providing supervision to doctoral level psychology students should be based on those like the state of California. In the state of California, in addition to being licensed psychologists, supervisors must complete six hours of continuing education credits in supervision every two years (California Code of Regulations, 2019). The following are suggested additional recommended requirements for supervisors in Colorado.

1. Licensure in the state of Colorado.
2. 6 continuing education credits on supervision per two years

3. 6 continuing education credits on multiculturalism and/or diversity topics per two years (i.e., the course outlined above)
4. Engagement in a once monthly consultation/peer supervision of supervision for the first year of supervising

There are 141 offered continuing education courses through athealth.com ranging from 1 credit to 9 credits. There are four supervision focused courses: Strengths-Based Clinical Supervision (5 credits), Clinical Supervision-Principles and Practice (5 credits), Issues in Supervision (3 credits), and Psychotherapy Driven Supervision (1 credit). Psychologists also have the option to read articles or watch videos and interviews and take a CE Test for credit (psychotherapy.net/continuing_education). This resource offers several videos in consultation but few in supervision (2). CE4less.com, another APA approved site for continuing education courses, provides 6 courses in supervision (Supervision Essentials or the Practice of Competency-Based Supervision; Clinical Supervision, Legal, Ethical, and Risk Management Issues; Helping Others Help Children: Clinical Supervision of Child Psychotherapy; Supervision: A Guide for Mental Health Professionals – Revised; Clinical Supervision and Professional Development of the Substance Abuse Counselor; Clinical Supervision: A Competency Based Approach). With these options, and many more uncited, it should be manageable for Colorado psychologists to obtain 6 continuing credit courses in supervision over two years if they choose to provide supervision.

In terms of diversity and multiculturalism, there are also a variety of course options. Athealth.com provides six courses in "Cultural Competence" ranging from one credit to four credits, and four courses in "Sexuality" ranging from one credit to five credits. Psychotherapy.net provides at least two courses in "Multiculturalism" ranging from 1.5 credits to five credits. Psychotherapy.net also has 12 courses in "Sexuality" ranging from one credit to 5.5 credits. In

addition to videos and articles online, psychologists can attend trainings or workshops, as well as conferences that provide multicultural components.

The American Psychological Association website (https://www.apa.org/ed/ce/resources/video-recordings.aspx, n.d.) also provides a variety of continuing education courses. APA provides 1-2 hour presentation recordings and four and seven hour recordings of workshops and trainings from APA conventions as well as independent study programs including book-based exams, video on-demand recordings, and article based exams in order to obtain CE credits which can help psychologists meet the 6-credit requirements for multiculturalism and supervision topics.

Once monthly peer supervision or consultation experiences are also highly recommended. Supervising is a unique experience different from teaching, consulting, and mentoring. Providing supervision is often a fun and different part of being a psychologist that many are excited about and look forward to. However, as noted previously, supervision is an incredibly important aspect of training and needs to be taken very seriously. At a minimum, psychologists providing supervision for the first time should receive, ideally, supervision of supervision. Another option is peer supervision or consultation in their first year. This can help supervisors ensure they are acting appropriately, accurately processing concerns and conflicts that arise in supervisory relationships and can help hold supervisors accountable in their roles. This author suggests that consultation phone calls or meetings can be arranged via an online portal for Colorado supervisors that will need to be created.

Overall, psychologists can shift the way they use supervision. Supervision is an integral part of training future psychologists and ultimately determines the future of psychology. If psychologists do not use supervision in a forward-thinking manner that can help students be the

best and most ethical versions of themselves, clients and the field of psychology will suffer. New psychologists upon licensure may not take the most care, they may not analyze and consider their own biases, and they may, unknowingly or otherwise, negatively impact those with whom they work. Colorado psychologists can lead the way in providing thoughtful, ethical, and multicultural supervision and can set the standard for best practice. Colorado can be a leading force in ensuring our supervisors are trained well, passionate, and engaged in the process of supervision as a learning component for their supervisees.

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