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Sexuality as a Competency: Advancing Training to Serve the Public

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Abstract

Sexual health and sexual well-being are vital components of overall physical and mental well-being yet remain largely understudied, approached mainly from disease prevention and intervention perspectives, and generally excluded from most health service psychology training programs. People of color; women; lesbian, gay, and bisexual people; trans and gender diverse; disabled; and poor people are disproportionately adversely impacted by a lack of access to suitable sexual health services and reproductive healthcare. Sex education is inadequate in the United States across the lifespan, including in health service psychology training programs. Therapy clients often have sexual concerns they want to discuss, yet because sexuality is seldom covered adequately in training programs, psychologists are often ill prepared and uncomfortable addressing sex. Drawing from the Benchmarks Competencies (Fouad et al., 2009; Hatcher et al., 2013), we provide a rationale for and application of several key foundational and functional competencies to explicate a template for addressing sexuality in training psychologists and positioning sexuality as a competency that should be centralized in graduate psychology training. We offer both a roadmap for a graduate course in sexuality and several ideas for infusing sexuality across the curriculum for programs that may be unable to dedicate a course to the study of sexuality.

Public significance statement: Sexuality, related to relationship and life satisfaction, is not typically a required component of health service psychologists' training. We position sexuality as a proposed competency, providing justification and curricular guidance for doctoral training programs.

Keywords: human sexuality, sex education, competencies, health service psychology

Sexual health encompasses physical, psychological, and social well-being related to sexuality and consists of positive, pleasurable, and safe experiences, including access to reproductive healthcare (World Health Organization [WHO], 2017). Influenced by a person's sexual health, sexual well-being refers to individuals' cognitive appraisals of and affective responses to their sexual lives, including satisfaction with their sexuality, sexual relationships, and sexual functioning (Byers & Rehman, 2014). Despite the relationships between sexual well-being and life satisfaction, psychological well-being (Muise et al., 2016; Stephenson & Meston, 2015), and relationship satisfaction (Dew et al., 2020; Fallis et al., 2016; Impett et al., 2019), researchers have consistently found that few psychologists receive training related to human sexuality, study sexuality using a sex-positive framework emphasizing "diversity, empowerment, and choice" (Williams et al., 2015, p. 6), or report competence addressing sex and sexuality in their primary roles (Burnes et al., 2017; Hargons et al., 2017; Miller & Byers, 2010; Mollen, Burnes, et al., 2018; Wiederman & Sansone, 1999). Health service psychologists can serve the public by advancing sexual health and sexual well-being, helping to improve people's lives, and contribute meaningfully to the greater good. While we focus here primarily on doctoral-level education, trainers at each stage of psychologists' education (predoctoral internship and postdoctoral training programs) can juxtapose our discipline's values with the advancement of a scientifically accurate, sex-positive, intersectional approach in order to champion sexual health and sexual well-being via sex education. We offer a framework for preparing psychologists to achieve competence in human sexuality consistent with our discipline's expectations for psychologists' competence in other vital domains.

The Benchmark Competencies were developed to provide a practical, necessary guiding structure for training programs and licensing boards to assess trainee readiness for practicum, internship, and professional practice stages of their development; guide intervention with and support for trainees experiencing difficulty; and assist in development of training program curriculum (Fouad et al., 2009; Hatcher et al., 2013). The initial contribution (Fouad et al., 2009) delineated 15 foundational and functional competencies across three stages of professional development. Hatcher et al. (2013) streamlined the original competencies, resulting in three clusters each of foundational (Professionalism, Relationships, and Science) and functional competencies (Application, Education, and Systems), offering flexibility with regard to which competencies are adopted by training settings, how those competencies are demonstrated by trainees, and trainee evaluation (Hatcher et al., 2013). In the ensuing section, we outline the relationship of sexual health and well-being to several established domains for assessing trainee competence. We conclude by offering specific suggestions for the integration of human sexuality into curriculum.

Sex Education in the United States

Sexual health and sexual well-being begin with early, consistent sexual education that is medically accurate and developmentally informed. Formal school-based sex education in the US has steadily declined since 1995 with particularly low rates of education among female, rural, and poor students (Hall et al., 2016). Despite widespread support for comprehensive sex education, federal funding for abstinence-only until marriage (AOUM) sex education has increased (Society for Adolescent Health and Medicine [SAHM], 2017). AOUM programs are ineffective in delaying sexual intercourse, lowering the number of sexual partners, and reducing risky sexual behaviors (Santelli et al., 2018). Students with marginalized identities report harmful sexist, heterosexist, and racist messages through abstinence-only sex education (Hoefer & Hoefer, 2017). By contrast, LGBTQ youth whose schools offer inclusive sex education are less likely to be bullied and at less risk for adverse mental health concerns (Proulx et al., 2019), and college students who receive comprehensive sex education are at lower risk of experiencing later sexual assault (Santelli et al., 2018).

Given the lack of quality sex education in schools and in families (Flores & Barroso, 2017), US American adults' knowledge about sex is generally inadequate, with limited understanding about pregnancy risks and types and effectiveness of contraception (Cabral et al., 2018), trouble distinguishing between emergency contraception and medication abortion (Hickey, 2009), and underestimating the risks of giving birth while overestimating the risks of using contraception (Wiebe et al., 2015). These insufficient levels of sexual health knowledge extend to health care practitioners, including medical students (Warner et al., 2018) and psychologists and psychology graduate students (Mollen, Hargons, et al., 2018). The state of sex education in the US has an impact on the sexual knowledge of clients whom health service psychology trainees serve, and likewise influences trainees' sexual knowledge, especially those educated in the US. Sexuality education is necessary for psychologists to be adequately prepared to provide competent care to those with whom they will work.

Among their myriad roles, psychologists serve as educators; accordingly, trainees are expected to demonstrate readiness for entry into practice by applying teaching methods across settings (Functional Competency: Education, Domain: Teaching; Fouad et al., 2009). For example, they may be classroom instructors, clinical supervisors, consultants, and therapists providing psychoeducation. Health service psychologists are likely to encounter students with low levels of sexual knowledge, supervisees learning to work with clients' sexuality-related concerns, organizations in which sexual health inequities and reproductive injustice (e.g., difficulty accessing pregnancy care, sexually transmitted infection [STI] prevention and care, and abortion) are pertinent to their clients, and clients seeking more pleasurable sexual experiences. It is important trainees learn specifically how to disseminate sexuality-related knowledge with comfort and skill. Sexuality training positively influences psychologists' comfort with and competence in addressing sexuality with those they serve (Hanzlik & Gaubatz, 2012).

Human sexuality education aids in the promotion of sexual health, well-being, and enjoyment and reduces the possibility of sexual exploitation (Baber & Murray, 2001). Trainees should be prepared to provide accurate information, advance sex-positivity, educate

with a rights-based lens, and advance scientifically accurate sexual knowledge (World Association for Sexual Health [WAS], 2014). Rights-based and comprehensive forms of sexuality education result in more sexual knowledge, better communication about sex, and increased self-efficacy (Constantine et al., 2015), reduced rates of STIs and unintended pregnancies (Haberland & Rogow, 2015), and reduced likelihood of harm to sexual minorities through perpetuation of heteronormative sexual scripts (Hobaica & Kwon, 2017), compared to more common basic sex education curriculums. Educating health service psychology trainees regarding sex and sexuality, from a sexual rights perspective in particular, is therefore also consistent with our discipline's expectations that health service psychology trainees take action to promote change in their various service roles at the individual, institutional, community, and societal levels (Functional Competency: Systems, Domain: Advocacy; Fouad et al., 2009; Hatcher et al., 2013). Sexuality training prepares health service psychologists to help implement programs that promote and affect change regarding sexual rights with respect for the cultural values and needs of the people and communities they serve.

Sexual-Reproductive Health Inequities in the US

Sexual health outcomes among US Americans tend to be poor, with nearly half of all pregnancies unplanned (Guttmacher Institute Fact Sheet, 2019), the highest rate among developed nations. Concurrently, rates of STIs have increased dramatically, particularly for gonorrhea and syphilis (Feldstein Ewing & Bryan, 2020). Poor sexual health outcomes disproportionately affect individuals from marginalized groups and represent persistent health disparities across gender, racial-ethnic, regional, social class, and sexual orientation identities. For example, people with less education, who live in the South, and have greater poverty rates are more likely to experience unplanned pregnancies and STIs, including HIV (Centers for Disease Control and Prevention [CDC], 2018; Guttmacher Institute Fact Sheet, 2019; Jozkowski & Crawford, 2016; Su & Addo, 2018). People with disabilities, particularly disabled women, are often erroneously viewed as asexual, resulting in the neglect of their sexual and reproductive needs (Addlakha et al., 2017). Sexual minority adolescent women are more likely to experience teen pregnancy and receive an STI diagnosis, particularly those living in states with high levels of structural stigma (Charlton et al., 2019) compared to their heterosexual peers. While the incidence has decreased overall, rates of HIV increased 65 and 68%, respectively, among Black and Latino men from 2010 to 2016 (CDC, 2018). For marginalized groups including older adults, migrants and refugees, sexual minorities, and gender diverse people, sexual health inequalities persist, are inadequately addressed, and are detrimental for overall physical and mental health (Aboderin, 2014; Keuroghlian et al., 2017; Metusela et al., 2017).

Sexual-Reproductive Health (SRH) disparities for women of color are pronounced, with much higher rates of contraceptive failure (Sundaram et al., 2017) and resultant unplanned pregnancy (Guttmacher Institute Fact Sheet, 2019; Su & Addo, 2018) compared to White women. In 2018, maternal mortality among Black women was 2.5 times the rate among White women, due in part to structural policies and practices that negatively impact "the quality of their health care and standard of living" (Douthard et al., 2020, p. 6).

Additionally, anti-Black racism leads to controlling images of Black women in the US as hypersexualized and bad mothers and assumes Black male bodies as inherently sexually predatory, both of which have widespread consequences, including the criminalization of sexuality (Collins, 2004).

Students in health service psychology are trained to acquire and demonstrate knowledge and understanding of the self and others with regard to cultural diversity and context, and application of these understandings in all aspects of their professional work (Foundational Competency: Professionalism, Domain: Individual and Cultural Diversity; Fouad et al., 2009; Hatcher et al., 2013). The omission of education related to important aspects of SRH has adverse physical and mental health-related consequences, especially for those with fewer resources and marginalized social statuses. Although few are trained to do so in the context of SRH (Graham et al., 2012; Miller & Byers, 2010; Swislow, 2016), psychologists are uniquely suited to conceptualize, treat, and advocate using intersecting sociopolitical frameworks to guide their work (Rohleder & Flowers, 2018). Given the significant intersections of SRH with sociocultural locations, health service psychologists should be educated about and learn to address SRH issues in therapy (Grzanka & Frantell, 2017).

Sexual Well-Being in the US

Sexual well-being includes knowledge about and access to sexual pleasure. Although sexual satisfaction among healthy, educated, young, and middle-aged adults is generally high, adults with depressive and anxious symptoms or chronic health conditions report comparably lower sexual satisfaction and sexual health (Flynn et al., 2016; Higgins et al., 2011). Similarly, women with less education, women of color, and lesbians and bisexual women report significantly less sexual satisfaction than their higher social status counterparts (e.g., White, highly educated, heterosexual women; Fahs & Swank, 2011).

In the US, discourse related to sexual pleasure and desire, especially among women, has been historically silenced (Jolly, 2016). Trainers can prepare psychologists to help clients centralize the right to sexual satisfaction. In the context of other core competencies including Individual and Cultural Diversity and Education, health service psychologists are well suited to improve upon and adapt cross-culturally existing advocacy efforts regarding clients' sexual right to pleasure. For example, even healthy sexuality frameworks that position sex and sexual desire as normative are often based in Western psychology, emphasizing constructs like self-efficacy, and may be culturally encapsulated (Jolly, 2016).

Sexual pleasure can be impeded by the presence of sexual dysfunction. Sexual problems are often medicalized; however, they frequently have multiple causes, including sexual attitudes communicated by family of origin, the nature of the interpersonal relationship with one's sexual partner(s), organic disease or disability affecting sexuality, sociocultural factors that create unrealistic perceptions of sex and sexuality, and the quality of erotic encounters (Kleinplatz, 2016). Scientists studying sexuality often focus on sexual dysfunction that is markedly sex-negative (i.e., focusing on disease and negative consequences of sexuality; Arakawa et al., 2013) and relying nearly exclusively on White samples (Hargons et al., 2017).

Lehmiller (2017) maintained that despite the growth of sex research in recent decades, research findings that contrast popular beliefs are most often "ignored, misconstrued, or attacked . . . the researchers . . . sometimes smeared in the process," while the sex research that draws the most attention publicly tends to promote longstanding stereotypes (p. 1). Consistent with the Hatcher et al. (2013) emphasis on Science as a Foundational Competency, we maintain that trainers should integrate sexual knowledge as a component of programs that prepare psychologists to be consumers and producers of sexuality-related research, develop more accurate and comprehensive knowledge of sexual well-being, and apply findings from sexuality research in their work.

Although sexuality researchers have disproportionately examined sexual dysfunction, and sex-positive approaches to sexuality are needed, psychologists must be prepared to treat sexual disorders informed by scholarship. Almås (2016) and colleagues (Almås & Almås, 2016) posited that randomized control trials (RCTs) were not as applicable in psychological practice as in medicine, which may be especially relevant in the practice of sex therapy and addressing of sexual concerns that are often medicalized. The authors found an increasing trend in studying psychological interventions to address sexual concerns in therapy, with most offering advances in theory, clinical observations, and theoretical considerations rather than RCTs. Almås (2016) stressed the importance of adapting a biopsychosocial approach to treating clients with sexual concerns inclusive of a relational approach, cultural factors, and social changes, drawing from those forms of research design that may be ideally suited to inform and advance science-based practice for sexuality-related concerns and issues, including clinical observation, qualitative research, case studies, and guidelines for best practices.

Fouad et al. (2009) called on trainees and psychologists to employ scientific-mindedness, engaging in critical thinking, valuing scientific methods to inform practice, and applying scientific knowledge and skills (Foundational Competency, Science: Domains: Scientific Knowledge and Methods, Research/Evaluation). Though the domain of Evidence-based Practice was initially designated as part of the Scientific Foundation of Professional Practice (Fouad et al., 2009), it is currently categorized as a Functional Competency along with Assessment, Intervention, and Consultation (Hatcher et al., 2013). Sexuality training related to engaging in and consuming sex research and providing empirically supported psychotherapy related to sexual concerns and disorder is congruent with both aims.

Human Sexuality Training in Health Service Psychology

Among clinical and counseling psychology training programs in the US and Canada, human sexuality courses are rarely offered and when available, are typically electives (Asher, 2007; Wiederman & Sansone, 1999). Though graduate programs typically provide training related to LGBTQ identities and sexual abuse and trauma, very few attend to diverse sexual expression, reproduction, sexual ethics, and sexual health (Mollen, Hargons, et al., 2018). Relatedly, psychologist trainees report discomfort discussing sexuality (Hanzlik & Gaubatz, 2012). Therefore, although opportunities abound to advance the sexual health and rights of the public, consistent with our expectations for Health Service Psychology (HSP) competency, we do not currently adequately prepare psychologists to do so

individually or systemically. We offer a template for a graduate sexuality course as well as provide supplementary clinical and pedagogical techniques for infusing sexuality across the curriculum, which may be especially helpful for programs with insufficient room in existing curricula to add a course.

Developing a Human Sexuality Course for Health Service Psychology Training

We have developed a comprehensive, sex-positive elective graduate sexuality class that is scientifically grounded, centered on the needs and interests of diverse groups, experiential, and clinically focused to allow students to consider both the implications of the material on themselves as therapists and its practical application. The course emphasizes sexual health and wellness, covering a range of topics, including sexual anatomy and physiology, sex education, sexual pleasure, menstruation and puberty, pregnancy and birthing, contraception and abortion/pregnancy loss, sexuality across the lifespan, gender identity and sexual orientation, sex and relationship variations [i.e., polyamory, kink, consensual bondage, discipline, dominance and submission, and sadomasochism (BDSM)], and the clinical treatment of sexual disorders and dysfunctions. We include a wide array of pedagogical techniques such as using music, films, TED talks, guest speakers, idea generation, and group discussions. We regularly provide empirical and clinical practice readings with a significant focus in class on applying the material in therapy and multicultural considerations.

Cultivating a reflective approach to practice, including "considering [one's] own personal concerns and issues; articulating attitudes, values, and beliefs toward diverse others, [and] . . . reflectivity in context of professional practice" (Fouad et al., 2009, p. S10) is a foundational competency both of the original benchmarks and the updated design Hatcher et al. (2013) proposed. Consistent with the American Psychological Association (APA) Ethics Code (2017, Standard 7.04), we inform students in programmatic materials and course syllabi of the possibility of disclosure of personal information in all relevant courses, though we emphasize that self-disclosure is at the students' discretion and unrelated to evaluation. Rather, we infuse sexuality coursework with the opportunity to consider values, messages, and the relative adequacy of students' previous sexuality education in preparing them to work effectively with clients. We assert that such reflective assignments are imperative in developing competency in human sexuality. Examples of such assignments and activities, and the respective Competencies they address, are outlined in Table 1.

Table 1. Recommended Assignments and Activities

Assignment	Assignment description	Competencies addressed
Sexuality-related bias discussions	Using the reflective questions in Cruz et al. (2017) Appendix, "Psychologists' common biases on the intersections of diverse identities with sexuality," in small groups in class or online Discussion boards, have students discuss their reactions to prompts (e.g., Do I consider clients with physical disabilities sexual beings? Do I assume cisgender people have mostly satisfying sex?). Each week assign and explore a different diversity area (e.g., age, social class). Alternatively, students could individually journal their reactions to each week's area.	Professionalism • Reflective Practice • Individual and Cultural Diversity
Sexual autobiography	Instruct students to write a reflective paper, chronologically exploring their development as sexual and gendered human beings. Students may examine messages they received about sex at various stages of their lives, identify how their personal thoughts and feelings about sex affect their future practice, and reflect on how their intersecting identities impact their attitudes and values about sex (e.g., how one's faith identity impacts their value regarding monogamy).	Professionalism • Reflective Practice • Individual and Cultural Diversity
Sexuality treatment presentation	Instruct students to develop a presentation addressing the treatment of a sexuality-related concern in psychotherapy. Encourage them to choose a topic that may evoke discomfort or challenge a bias. Informed by scholarly literature, have students describe the history and contemporary methods of treatment and how these approaches fit within the values of health service psychology and their personal theoretical framework. Invite creative delivery methods including interviews with professionals and development of psychoeducational materials (e.g., infographics).	Application • Evidence-based practice • Intervention
Scientific approach to sexuality	Have students identify a frequently misunderstood area of sexuality, one steeped in myth or misinformation (e.g., abortion). Have them explore, individually or in small groups, what they learned about this topic, from what source(s), how it impacts their values, and the scientifically accurate information.	Science • Research/Evaluation • Scientific knowledge Professionalism • Reflective practice

Integrating Sexuality Across Training Settings

For programs unable to dedicate a course to human sexuality, we identify ways to incorporate sexuality training into existing, foundational courses, which can be adapted to trainers involved across psychologists' education, such as predoctoral internship supervisors. When engaging in case conceptualization, for example, trainers can generate cases that centralize the sexual concerns of potential clients. For example, students could conceptualize the case of a college-aged woman's concern that her once-weekly pornography use and masturbation is a form of addiction or create a treatment plan for a client hoping to increase sexual satisfaction in their long-term romantic relationship with their partner. Such exercises position the treatment of sexual issues as the work of all psychologists, rather than only sex therapists.

In discussions about ethics, educators and supervisors can address students' ethical obligation to provide medically accurate information about abortion and facilitation of access to local providers, support and assessment for gender-affirmative medical treatment and procedures, and clinical practice with people in polyamorous relationships. When discussing psychopathology, instructors can devote time to covering sexual and paraphilic disorders, an area we have often found overlooked in training. In sum, trainers can increase the intentionality with which they integrate human sexuality across existing curriculum by adapting lessons and activities likely addressed as part of their curricula.

Consistent with recommendations for the infusion of social justice training in psychology (Burnes & Singh, 2010), trainers and educators can foster relationships with local organizations specializing in sexual health and reproduction to offer opportunities for students to engage in clinical and social justice practica, outreach, and consultation experience in the community. Faculty can encourage students' sex-positive research interests and mentor them in best practices. Clinical supervisors can move beyond covering sexuality only as it pertains to navigating sexual attraction or sexually harassing behavior in the supervisory relationship or with clients (Ladany et al., 2005; Thompson, 2020) and model inviting and attending to sex and sexuality as it relates to clients' well-being. Finally, given that educators in health service psychology often report little sexuality education in their own training (Mollen, Burnes, et al., 2018), which may inhibit their ability to facilitate trainees' education, faculty and trainers can pursue continuing education via professional organizations including American Association for Sexuality Educators, Clinicians, and Trainers (AASECT) or the World Association for Sexual Health (WAS).

Conclusion

Well-informed, sex-positive health service psychologists can influence policy at all levels through advocacy, education, and positioning sexual rights as human rights. We argue that the prioritization of human sexuality training and competence among psychologists will improve sexual health among people in the US, facilitate access to sexual and reproductive health services, and reduce health disparities, consistent with objectives established by APA's current strategic plan (American Psychological Association [APA], 2019) and with the APA Commission on Accreditation's Standards of Accreditation (American Psychological Association [APA] & Commission on Accreditation, 2015). We, therefore, call for training programs to integrate sexuality into their curriculum via dedicated sexuality coursework, infusion across existing curricula, clinical supervision, and service-learning opportunities.

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