

# Sexuality Training for Psychiatry Residents: A National Survey of Training Directors

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*The current status of training in human sexuality is relevant to all health care professionals. The purpose of the current study was to determine the extent of sexuality training offered in psychiatric residency programs. The training directors of psychiatry residencies were surveyed with regard to the number of expert faculty in sexuality training as well as resident exposure to seven related curricular areas. Of the 69 respondents, the majority reported expert faculty in sexual dysfunctions, sex therapy, therapy with gay/lesbian patients, and HIV/AIDS. For each sexuality topic, approximately 80% of programs reported curricula offerings through either didactics or clinical rotations. For didactics, most topics were presented in the context of a broader course. With the exception of HIV/AIDS, it was rare for programs to offer a clinical rotation involving sexuality issues. In conclusion, the majority of training programs in psychiatry provide curriculum offerings in sexuality training, primarily through didactic education. Results are discussed with regard to comparison to training in professional psychology and the need for assessment of sexuality training in health care professions generally.*

Health professionals commonly are seen by the public as experts in human sexuality (i.e., the professionals to whom one turns when sexual difficulties arise). Accordingly, many would consider sexuality training for health pro-

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professionals imperative (Leino & Ojanlatva, 1994). However, the extent to which health professionals currently receive exposure to training in human sexuality remains an ambiguous issue. In their review of the literature, Weerakoon and Stiernborg (1996) noted that many of the relevant surveys and analyses of medical school curricula were conducted in the 1970s, a period during which there seemed to be increased emphasis on sexuality training in the health professions. However, more recent examinations of medical school curricula relating to human sexuality have focused primarily on issues related to homosexuality (Stein, 1994; Townsend & Wallick, 1996; Wallick, Cambre, & Townsend, 1992) or HIV/AIDS (Boyd, 1994; Carter, Greenfield, & Kenkre, 1997; Caruso, Nieman, & Gracely, 1993).

In addition to the unclear status of training in human sexuality among health professionals, several recent writers have noted that interventions for sexual dysfunction, or sex therapy, have become increasingly more biomedical or medicalized (Rosen & Leiblum, 1995; Tiefer, 1994, 1996; Wiederman, 1998). Accordingly, some professionals have raised concerns that the field of sex therapy, or even psychological intervention with individuals experiencing significant sexual dysfunction, is in jeopardy, particularly as pharmacological interventions proliferate (Schover & Leiblum, 1994; Tiefer, 1994).

The one health profession poised at the intersection of psychological and pharmacological perspectives in human sexuality is psychiatry. However, it is unknown to what extent psychiatrists-in-training currently receive exposure to information about sexuality and related issues. A previous study that examined this issue did so in rather limited ways. Verhulst (1992) surveyed residency training programs in psychiatry during 1991. He reported that more than one half of the programs indicated the existence of clinical rotations related to sexual problems, but one fourth of programs had no supervisors with special interest in sexuality issues. It is interesting to note that at least one half of training directors believed that such topics as homosexuality, HIV/AIDS, child sexual abuse, sexual assault, and the effects of mental illness on sexuality needed *more* attention in their curricula.

The current study was undertaken to further investigate the extent of human sexuality training currently offered to psychiatry residents. Specifically, we explored to what extent residency programs have faculty with expertise in various aspects of sexuality, didactic training in sexuality, and access to clinical experiences involving human sexuality issues. The specific sexuality topics we focused on were sexual dysfunctions, sex therapy and counseling, therapy with gay and lesbian patients, HIV/AIDS, typical and healthy sexual functioning, gender disorders, and paraphilias. The methodology was patterned after Wiederman and Sansone (1999) to allow informal comparison to their results, which were obtained from training directors in clinical and counseling psychology doctoral programs and predoctoral internships.

## METHOD

### Participants and Materials

Potential respondents were the training directors of all psychiatry residencies ( $N = 192$ ) as listed in the *Graduate Medical Education Directory 1996–1997* (American Medical Association, 1996). Training directors were sent a one-page questionnaire that explored two areas: description of the training program and curriculum content as it relates to training in human sexuality. With regard to the description of the training program, respondents were asked about the number of full-time faculty in the program as well as the number of residents. Additionally, respondents were asked to provide the number of faculty with identified expertise—based on certification, publishing, research, or extensive professional experience—in each of the following six areas: sexual dysfunctions (e.g., premature ejaculation, anorgasmia, low sexual desire), sex therapy (i.e., treatment of sexual dysfunction), therapy with gay men and lesbians, therapy with patients with HIV/AIDS, gender disorders (e.g., gender dysphoria, transsexualism), and paraphilias (e.g., pedophilia, transvestism, fetishism, sadism).

With regard to curriculum content, both didactic and clinical, respondents were asked to indicate, with an “X,” any or all of the training experiences currently offered to residents in their respective programs. We clarified in the questionnaire that we assumed residents receive individual or group clinical supervision when they encounter these issues with specific patients. The seven listed curricular areas were: (1) assessment of sexual dysfunction, (2) sex therapy/counseling, (3) therapy with gay men and lesbians, (4) HIV/AIDS, (5) typical or healthy sexual functioning, (6) gender disorders, and (7) paraphilias. Respondents were asked to indicate whether these topics received exposure in the curriculum: (1) through an entire didactic course, (2) as a topic within a didactic course, (3) as a seminar or grand rounds, and (4) through a clinical rotation. Respondents were also asked whether there were department plans to develop additional training experiences in human sexuality for residents either at the didactic or clinical level. Finally, respondents were asked to rate the importance of human sexuality training for residents using a seven-point scale, from “unimportant” (1) to “very important” (7).

### Procedure

The one-page questionnaire was accompanied by a brief cover letter explaining the purpose of the survey, assuring anonymity, and clarifying that results would be reported in aggregate, not individual, responses. Each mailing packet contained a postage-paid return envelope. Respondents were given the opportunity to request a report of the results. The one-time mailing occurred in March 1997.

## RESULTS

Of the 192 questionnaires sent to viable training programs, 69 (35.9%) were returned completed. Rates of response did not differ as a function of geographic regions of the country,  $\chi^2(3, N = 192) = 3.22, p < .36$ . The 69 surveys upon which the current study is based represent a total of 2,413 psychiatry faculty and 1,833 psychiatry residents. Basic information regarding the participating programs and the faculty comprising these programs is presented in Table 1. Note that, with the exception of gender disorders and paraphilias, the majority of respondents indicated faculty with expertise in each of the areas of sexuality.

Curriculum offerings are presented in Table 2. It was relatively rare for an entire course to be devoted to one of the listed sexuality topics, but the majority of the residency programs covered each topic in the context of a course. With the possible exception of working with patients infected with HIV/AIDS, it was rare for programs to offer a clinical rotation involving human sexuality issues. The last column in Table 2 indicates the percentage of residency programs that indicated that the listed topic was *not covered* in any way. Only about one out of five to seven programs failed to offer any form of training with regard to each particular facet of clinical sexuality.

As an index of the extent of sexuality training offered, we calculated the total number of ways that the seven listed sexuality topics were covered within each program. That is, if a program covered each of the seven topics in each of the four ways (entire course, topic within a course, seminar/grand rounds, clinical rotation), then the score for that program would be 28. A program that failed to offer any training in any of the seven areas would have a score of 0. We found that the mean number of curriculum offerings for the residency programs was 7.16 ( $SD = 3.24$ ), which did not differ as a function of geographic region of the country,  $F(3,64) = .08, p < .98$ . It is interesting that the total number of curriculum offerings was unrelated to the number of psychiatry faculty ( $r = .12, ns$ ) or the total number of residents ( $r = .13, ns$ ). However, there was a positive relationship between the number of different curriculum offerings in human sexuality and the total number of faculty with expertise in sexuality ( $r = .46, p < .01$ ).

**TABLE 1.** Description of Participating Psychiatry Residencies and Faculty ( $N = 69$ )

Mean number of faculty	36.02	( $SD = 31.81$ )
Mean number of residents	26.96	( $SD = 14.01$ )
Have expert faculty in:		
Sexual dysfunction	68.1%	
Sex therapy	62.3%	
Therapy with gay/lesbian patients	59.4%	
HIV/AIDS	62.3%	
Gender disorders	43.5%	
Paraphilias	43.5%	

**TABLE 2.** Curriculum Offerings in Participating Residency Programs ( $N = 69$ )

Topic	Entire course	Topic in a course	Seminar/ grand rounds	Clinical rotation	Nothing offered
Assessment of sexual dysfunction	20.3%	59.4%	18.8%	0.0%	13.0%
Sex therapy/counseling	23.2%	52.2%	23.2%	2.9%	14.5%
Therapy with gay/lesbian patients	4.3%	59.4%	26.1%	4.3%	21.7%
HIV/AIDS	17.4%	63.8%	26.1%	17.4%	14.5%
Typical/healthy sexual functioning	23.2%	62.3%	23.2%	5.8%	8.7%
Gender disorders	8.7%	65.2%	17.4%	1.4%	18.8%
Paraphilias	8.7%	59.4%	20.3%	1.4%	20.3%

*Note.* Row values can sum to more than 100% because some programs offered multiple sources of training for each sexuality topic.

With regard to curriculum planning, only 1.4% of programs reported plans to augment the current level of didactic training in sexuality. Only 5.8% of programs indicated plans to augment clinical experiences related to sexuality.

Last, we examined the ratings provided by training directors regarding the perceived importance of human sexuality training for psychiatric residents. The mean rating was above the midpoint of the 9-point scale ( $M = 6.44$ ,  $SD = 1.58$ ), and these ratings of importance did not differ as a function of geographic region of the country,  $F(3,64) = .98$ ,  $p < .41$ . The ratings of perceived importance of sexuality training were unrelated to the total number of faculty ( $r = .20$ ,  $ns$ ) as well as the total number of residents within the program ( $r = .18$ ,  $ns$ ). However, the total number of such faculty with expertise in the various sexuality areas was positively related to ratings of importance of sexuality training for residents ( $r = .26$ ,  $p < .05$ ). Also, these ratings were positively related to the total number of different curriculum offerings in sexuality ( $r = .25$ ,  $p < .05$ ). One respondent wrote, “[I] would rate {sexuality training} higher except that too many things are important.”

## DISCUSSION

The results of the current study indicate that of those programs surveyed about two thirds had expert faculty in sexual dysfunctions, sex therapy, therapy with gay and lesbian patients, and HIV/AIDS. Nearly one half reported expert faculty in gender disorders and paraphilias. In other words, according to respondents, a majority of the psychiatric programs had at least one faculty member with some expertise in a topic related to human sexuality.

With regard to curriculum offerings in sexuality, residents most frequently were exposed to sexuality topics within a course; the least-endorsed curricular format involved exposure through a clinical rotation. On average, approximately 16% of programs indicated that “nothing” was offered in one of seven areas of sexuality (i.e., a decided majority of programs provided curriculum offerings to residents).

In a previous study exploring sexuality training in psychiatric residency programs, Verhulst (1992) reported that 25% of respondents indicated that they had no supervisors with expertise in human sexuality. In the current study, we are unable to determine a comparable figure because of different wording in our survey, but for a given sexuality topic, more than 30% of programs reported no faculty with expertise. Verhulst (1992) also reported that 57% of surveyed programs identified available clinical rotations involving patients with sexual problems. The current data indicate that clinical rotations are fairly limited, the highest endorsement being for rotations related to HIV/AIDS (17.4%).

Wiederman and Sansone (1999) used a very similar survey to examine the sexuality training experiences of psychologists at the predoctoral level. In comparing trainee groups, the mean percent of "nothing offered" for each of the seven curricular areas noted in Table 2 is as follows: for psychiatric residents 15.9%, for psychology doctoral programs 34.1%, and for predoctoral internships 58.5%. This comparison suggests that psychiatric residents may be exposed to meaningfully more sexuality training than are psychologists, which has implications for the issue of whether sexuality assessment and treatment is becoming more medicalized. Regardless of the degree of reported exposure to sexuality training, however, we are aware of no studies that explore trainees' comfort level in effectively handling the sexual problems of patients. In other words, is there a relationship between amount of curricular exposure and comfort level with patients? Are there variables independent of exposure that temper comfort (e.g., expertise of the instructor, method of teaching, patient's type of sexual difficulty, personal background of the trainee)?

The current survey contained certain methodological limitations that should be considered when interpreting the results. For one, it is unknown to what extent sexuality topics are covered within a didactic course, the degree of experience residents gain on clinical rotations with a purported sexuality component, and whether residents share the impressions of training reported by training directors. Also, a minority of programs provided data, leaving the possibility that the results overestimate the extent of sexuality training available to psychiatry residents. It is plausible that those residency programs that offered very little sexuality training were least likely to provide data, because the survey may have appeared irrelevant to the training directors in those programs.

The current data only reflect human sexuality training among psychiatry residency programs; the extent of sexuality training in the primary care specialties is virtually unknown (Weerakoon & Stiernborg, 1996). A number of authors have expressed concerns about the need for adequate training in sexuality for all health professionals (Carter, Greenfield, & Kendre, 1997; Leino & Ojanlatva, 1994; Wilson, Manoff, & Joffe, 1997; Yarris & Allgeier, 1988), and others have provided direction for doing so. Boyd (1994) suggested that each medical school establish a policy to coordinate teaching

about HIV/AIDS, particularly in the areas of communication skills and ethics. Caruso et al. (1993) developed an experiential, interactive workshop for medical students to develop their skills in conducting an HIV-risk-assessment interview. D'Ardenne (1986) described the development of a one-day sexual dysfunction workshop for medical students. Book (1987) described an approach to sexual issues that uses the resident's countertransference that arises during psychotherapy with the patient. Despite efforts to train health professionals, however, Meyer (1976) expressed the legitimate concern that training in sex therapy is unregulated and not standardized. Indeed, given the controversies and diversity of opinion inherent in topics such as homosexuality (Townsend & Wallick, 1996), determining universal curriculum fundamentals would be a challenge.

In closing, the current study indicates that the majority of residency programs in psychiatry expose trainees to sexuality training, most often as a didactic topic within a course. Few programs plan to augment current levels of sexuality training for residents. In comparison with psychology trainees, psychiatry residents appear to receive meaningfully broader training in sexuality, or at least greater exposure to a range of sexuality topics. The extent of sexuality training among the other medical specialties remains empirically unknown and is an area for future study. Whether these data are an indication of the increasing medicalization of sexuality treatment remains an additional question for further study.

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