The Family Practice Resident as Sexual Counselor

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Little research has been done on family practice residents and their sexual counseling attitudes, knowledge, and abilities. This study sought answers to five broad questions about family practice residents' perceptions of sexual counseling. Subjects were 132 residents and 21 faculty members from eight family practice training units in Minnesota, which were affiliated with the University of Minnesota.

Residents regard sexual counseling as important and say they desire more training to deal with sexual problems encountered in family practice. They tend to raise the subject of sex with patients not routinely but only if there appears to be a psychosocial problem. Respondents indicate a lack of ability as well as discomfort with several areas of sexuality, notably frigidity and homosexuality. Family practice residents need to develop their skills in specific areas of sexual counseling. While these findings are most applicable to the eight units involved, the diversity in respondents' backgrounds and differences between units suggest that the results may be relevant to other residency programs.

Thousands of troubled marriages might be saved each year if so many physicians were not so uncomfortable about female nudity, afraid to discuss emotional problems – and more are embarrassed about sex than their patients are . . . . But, there is dismaying evidence that when it comes to the diagnostics of sex, the average doctor is "an embarrassed, incompetent bungler."[1]

While this may be an exaggerated conclusion, an examination of medical literature discloses data to support its basic proposition: physicians are often ill-equipped to recognize and manage their patients' sexual problems. Several writers document the frequency of sexual problems presented to doctors in family practice and show that physicians often are not adequately trained to assist patients with such problems.[2-6]

Counselors and physicians alike attest that sexual concerns frequently trouble their clients. Masters and Johnson estimate that 50 percent of all married couples have sexual problems at some time in their marriage.[7] Their estimate considers only married people. What of the many unmarried persons who are most assuredly sexually active? Conservative estimates from family practice place the prevalence of patients with sexual problems at 10 to 15 percent.[4,5] Treating common diseases, as well as dis-eases, is the proper responsibility of family physicians. Since sex-related distress so frequently occurs, training the family physician should include developing his or her competency in sexual counseling.

Fortunately medical educators have become sensitive to the need for developing such competence. There are many articles on training medical students in human sexuality;[8-12] the sexual counseling activities of practicing physicians are well recorded also.[2-6] However, a review of the literature reveals only one article on training family practice residents in human sexuality.[13] Clearly in this latter area further work is needed. To help fill this gap, this study is reported.

Inquiry is focused on how the residents in the family practice program at the University of Minnesota perceive their sexual counseling attitudes and competencies. Since family practice faculty do most of the resident training in sexual counseling, their attitudes and competencies in this area were also studied. Only family physicians among the faculty were surveyed. Five general questions were asked:

1. How important do residents feel sexual counseling is in family practice?
2. Do residents feel they need further training to be able to deal with the sexual problems they will encounter in their practices?
3. How likely are residents to ask various types of patients about sexual problems?
4. How do residents perceive their counseling abilities in some specific areas of sexual counseling?
5. How do residents perceive their comfort levels in some specific areas of sexual counseling?

Answers to these questions could be valuable in shaping residency training programs.

Methodology

Participants were family practice residents and faculty from eight training units, six of which make up the University of Minnesota Affiliated Hospitals Training Program in Family Practice and Community Health, while the remaining two are county hospital programs in the Minneapolis/St. Paul area of Minnesota. There were 172 residents in the eight units of which 77 percent (132) participated in the study. Fifty-seven percent (21) of the 37 faculty members participated. Since this study was done in June and July 1975, four groups of residents were surveyed: incoming first year residents and those residents who had just completed their first, second, and third years of the training program.

Each participant in the study was sent a testing packet which consisted of a 67-item objective questionnaire, a preaddressed and stamped return envelope, and a preaddressed postcard with the participant's name on it. The participant was asked to return the postcard and the questionnaire

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Table 1. Likelihood of Resident or Faculty Asking Patients About Sexual Problems*

Patient Category	Faculty (N=21)		Resident (N=132)	
	$\bar{X}$**	S***	$\bar{X}$	S
Married female	2.00	.92	2.28	.95
Single adult female	2.40	.84	2.38	.87
Married male	2.10	.99	2.44	.91
Single adult male	2.45	.93	2.53	.84
Adolescent female	2.70	.97	2.75	.89
Adolescent male	2.80	.96	2.92	.88
Senior female	2.90	.98	3.43	.91
Senior male	2.75	.96	3.35	.89

*Each patient was rated on a 5-point scale from 1 (very likely) to 5 (very unlikely)
**$\bar{X}$ = mean
***S = standard deviation

separately. Thus we could monitor who had not returned the questionnaire while maintaining the anonymity of those who had. At weekly intervals after the questionnaire was first mailed, those who had not responded were sent reminders in the mail. After the third reminder those who did not respond were sent a new packet. We did not pursue subjects after mailing the packet a second time.

The questionnaire was developed by constructing a preliminary questionnaire and analyzing it with a pilot study. The data obtained from the pilot study were used to refine the questionnaire, results from which are reported in this article. The final questionnaire was found to have a reliability of .89 as determined by the test-retest method.

Beginning with basic demographic data, the questionnaire then asked residents to supply the following information:

1. How important do you think sexual counseling is to family practice?
2. How do you rate your understanding of human sexual behavior?
3. From what source(s) did you gain this understanding?
4. How likely are you to ask patients – both in general and in categories by age – if they have sexual problems?
5. What percentage of patients in your practice have sexual problems?

In addition to these questions, residents were also asked to rate their feelings of comfort when faced with specific sexual problems and to rate their feelings of ability when asked to deal with these same sexual problems. The list of 13 sexual problems thought to be common in family medicine was adapted from a similar list, developed by Burnap and Golden, of sexual problems in general medical practice.[4]

Results

Importance of Sexual Counseling

Eighty-five percent of the residents and 95 percent of the faculty consider sexual counseling important in the context of family practice. Within the four groups of residents, new residents and third year residents place the most importance upon sexual counseling followed by the second and first year residents. However the only difference found to be statistically significant using one-way ANOVA is the difference between the first and third year residents.

Need for Further Training

Three questions explored a perceived need for further training of the faculty and residents. In the first question, respondents were asked to indicate their need for further training to deal with sexual problems encountered in practice. The second question asked them to rate the accuracy of their understanding of human sexual behavior. Lastly, subjects were to show the importance of different types of education to their overall understanding of human sexuality.

Eighty percent of the residents indicate they need more training to deal with the sexual problems encountered in practice. This need for further training is only slightly less among third year residents than the other three groups of residents, although the differences between resident groups are not statistically significant. Of the faculty, 45 percent indicate they also need further training to deal with the sexual problems encountered in practice.

"Less than adequate" is the way 50 percent of the residents describe their understanding of human sexual behavior. Among resident respondents, third year residents rank their understanding the highest, followed in descending order by the residents with fewer years of training. Among all respondents, the faculty rating of their understanding of human sexual behavior is highest overall with only 20 percent of the faculty considering their understanding to be less than adequate.

As for the importance of various educational experiences to the understanding of human sexuality, the residency program itself ranks near the bottom. However, the considered importance of residency training does increase as the residents progress through the program. All respondents rate personal experience as most important to their understanding of human sexuality.

Who is Asked About Sexual Problems

Two questions focused on asking patients about sexual matters. The residents were asked first how often they raise the subject of sex with patients. The most typical response (40 percent) was that they ask "only if there appears to be a psychosocial problem." Twenty-five percent ask routinely, 20 percent ask only if the problem was brought to their attention by someone other than the pa-

Table 2. Resident and Faculty Ratings of Their Own Counseling Abilities*

Problem	Faculty (N=21)		Resident (N=132)	
	$\bar{X}$**	S***	$\bar{X}$	S
General information	1.52	.68	1.81	.65
Frequency of intercourse	1.67	.58	1.92	.69
Masturbation	1.90	.62	2.01	.69
Premarital intercourse	1.95	.50	2.03	.65
Premarital counseling	1.62	.59	2.07	.76
Extramarital intercourse	2.00	.55	2.26	.78
Dyspareunia	1.95	.74	2.39	.78
Premature ejaculation	2.14	.91	2.40	.81
Lack of orgasm	1.90	.44	2.50	.79
Impotence	2.05	.74	2.50	.80
Sexual problem secondary to disease	2.00	.84	2.57	.86
Frigidity	2.14	.57	2.70	.77
Homosexuality	2.52	.98	2.86	.87

*Each problem was rated on a 5-point scale from 1 (very able) to 5 (very unable)
**$\bar{X}$ = mean
***S = standard deviation

tient, and 15 percent seldom or never ask.

Participants were also asked how likely they are to raise the topic of sex with various types of patients. Table 1 shows answers to this question. Examining these results, one is tempted to pity the adolescent or senior citizen with a sexual problem since these groups are least likely to be asked. The faculty show a similar trend: however, they are more likely to ask senior citizens about sexual problems.

The residents and faculty were also asked to estimate the number of their patients with sexual problems or questions. Both groups indicate that 18 to 23 percent of their patients have sexual problems or questions.

Perception of Counseling Abilities

The residents and faculty were asked to rate their counseling abilities in 13 areas using a five-point scale from very able to very unable. Table 2 reports these results. The faculty rate their ability higher than the residents for all 13 areas. On the average, residents rate themselves above "able to counsel" in only 2 of the 13 problem areas (general information and frequency of intercourse). Residents feel least able to counsel patients with problems of frigidity and homosexuality. (The authors recognize that the phrase "general sexual dysfunction" is beginning to replace the term "frigidity" in medical writing.) Eighty percent of the residents feel less than able to counsel in 6 or more of the 13 areas listed. Residents report their counseling ability as increasing as they progress from new residents through the third year. However, a large portion of even third year residents (60 percent) and faculty (50 percent) feel less than able in six or more counseling areas.

Perception of Comfort Level

In the same 13 areas mentioned above, respondents were asked to rate their comfort levels using a five-point scale from very comfortable to very uncomfortable. These results are shown in Table 3. Faculty indicate a higher comfort level than do residents in all areas. The residents rate themselves very comfortable in five of the 13 areas with comfort level in other areas increasing with time spent in the program. However, 60 percent of the third year residents rate six or more areas below comfortable; 66 percent of the second year, 70 percent of the first year, and 80 percent of the new residents rate at least six areas below comfortable. Both faculty and residents are least comfortable with homosexuality.

Discussion

The questionnaire used in this study produced a self-rating of attitudes and abilities. Actual observation of both would have been preferable but the authors were unable to devise an instrument for codifying and measuring such observation. However, the fact that the test-retest reliability of the questionnaire is high indicates at least that resident perceptions of their attitudes and abilities are consistent when measured over a short time.

After the study the results were discussed with several junior residents who, in retrospect, qualified their questionnaire responses. The residents said (1) they tended to underestimate the importance of sexual counseling in family practice, and (2) they tended to overestimate their comfort and ability to deal with sexual problems. These afterthoughts from a portion of the respondents should be kept in mind when analyzing the data.

A 77 percent response to the questionnaire was achieved, and this testing method is recommended to other researchers. The authors speculate that the nonresponders (23 percent of the total residents) were the least interested in sexual counseling. If this is true, 100 percent of the residents might then have appeared less comfortable and less able when required to counsel patients with sexual problems.

Table 3. Resident and Faculty Ratings of Their Own Comfort Level with Sexual Problems*

Problem	Faculty (N=21)		Resident (N=132)	
	$\bar{X}$**	S***	$\bar{X}$	S
General information	1.38	.59	1.64	.59
Frequency of intercourse	1.43	.51	1.72	.58
Premarital intercourse	1.67	.58	1.81	.64
Masturbation	1.67	.73	1.89	.75
Premarital counseling	1.43	.75	1.90	.75
Dyspareunia	1.52	.75	2.04	.72
Lack of orgasm	1.48	.51	2.11	.79
Impotence	1.71	.85	2.13	.81
Premature ejaculation	1.81	.81	2.14	.73
Sexual problem secondary to disease	1.52	.60	2.17	.85
Extramarital intercourse	1.86	.79	2.18	.91
Frigidity	1.62	.59	2.32	.81
Homosexuality	2.29	1.10	2.68	1.04

*Each problem was rated on a 5-point scale from 1 (very comfortable) to 5 (very uncomfortable)

**$\bar{X}$ = mean

***S = standard deviation

These results show that family practice residents and faculty consider sexual counseling important in the practice of family medicine. With one exception, the longer a resident has been in training the more importance he or she places on sexual counseling. The exception to this trend is the group of incoming, first year residents. They rate the importance of sexual counseling as highly as do third year residents. There are several possible explanations for this similarity. The high rating among new residents might reflect increased sexual education in medical school. It might also be that the new residents have not been exposed to as much organic medicine as the older residents so their attention is not yet drawn away from the behavioral sciences. Finally, the old first and second year residents might have underestimated the importance of sexual counseling (as some mentioned in the discussion afterward) since most of their time is spent on inpatient, organically oriented services.

It is interesting to note that the oldest physicians surveyed, the faculty, place the most importance on sexual counseling. Most of these people were in private practice before entering academic medicine. Increased time in the practice of family medicine may therefore contribute to a move away from a strict organic view of medicine toward a view that recognizes the importance of psychosocial-sexual problems. On the other hand, this result may indicate that teaching physicians place more importance on sexual counseling than do practicing physicians. A study of responses to the questionnaire from a group of non-teaching family physicians could test these possible explanations for the faculty response.

These results also indicate that residents feel they need more professional sex education. Such training, however, is not absent from the program. Resident training in sexual counseling currently consists of a one-quarter, weekly seminar in marriage and family counseling and two optional weekend workshops. In addition, there are varying day-to-day clinical experiences. Each unit has, as well, a person experienced in sexual counseling with whom the resident can consult. But even with these experiences the residents place the training program among the least important contributors to their overall knowledge of human sexuality.

By contrast, residents rate personal experience as one of the most important contributors to their knowledge of human sexuality. Many sex educators stress the importance of integrating one's own sexuality into his or her training as a sexual counselor.[2,9,10] In fact, being comfortable with one's own sexuality appears to be the *sine qua non* of effective sexual counseling. Discomfort with one's sex-

uality hinders the sexual counseling relationship. Because both residents and sexual therapists acknowledge the importance of personal experience in understanding human sexuality, the authors feel that the training of family practice residents in sexual counseling must include both factual knowledge and personal attitude assessment. Family physicians/counselors ideally should be knowledgeable about and comfortable with their own sexuality and comfortable with sexual life-styles that differ from their own.

While previous researchers[4,5] have documented the importance to case findings of asking routinely about sexual problems, the respondents in this study persist in asking less than routinely. In particular, adolescents and senior citizens are not asked if they have sexual problems or questions. This failure to encourage patients to express their sexual concerns is unfortunate. Ignoring the sexual lives of adolescents and senior citizens is of special concern. Persons in both these groups experience changes in their sexuality and all the uncertainty these changes bring. Because many patients are reluctant to bring up the subject of sexual health, physicians must learn to take the lead on this topic if they want to care for the whole person.

Residents estimate that, on the average, 21 percent of their patients have sexual problems or questions. This figure is higher than previous reports by Burnap and Golden[4] and Pauly[5] who cite a figure of about ten percent. Burnap and Golden also found that physicians discover double the number of sexual problems discomforting their patients if they inquire routinely about them rather than only "when indicated." If this result holds true for the residents in this study (were they to ask routinely about sexual problems), their estimate of percentage of patients with sexual problems would increase too, coming close to the 50 percent figure reported by Masters and Johnson.[7]

On the average, residents say they are able to deal with only 2 of 13 common sexual problems (general information and frequency of intercourse). They feel less than able to deal with the rest. Similarly, residents express some discomfort when patients present 8 of the 13 common sexual problems. Frigidity and homosexuality are the problems residents are least able to deal with and about which they feel least comfortable. Unlike the residents, faculty members generally feel more able to handle and more comfortable with patients with sexual problems. However they too feel least comfortable and competent when faced with a homosexual patient.

Frigidity is one of the most common female sexual complaints and homosexuality, Kinsey[14] estimates, is the sexual orientation of about ten percent of a physician's patients. It is disturbing that residents feel both ill at ease and unconfident about treating sexual problems which affect significant numbers of their clients.[15] If family physicians are not to be like the doctor described at the start of this article, they must be able to deal with common sexual problems. Residents must acquire a sensitivity to their patients' reticence to bring up sexual concerns, skill in creating an open atmosphere for discussing them, and the habit of regularly asking if patients want to talk about sexual matters.

The authors believe that the residents who participated in this study need skill development in specific areas of sexual counseling. Although it is true that many subjects compete for time during the family practice resident's training, the authors' bias is clear: sexual problems are a very common dis-ease among patients. Ideally, physicians should be comfortable discussing them. Family physicians should be able to treat or appropriately refer patients with sexual problems. Training in sexual counseling deserves a high priority in residency training programs.

Of all the sexual problems included in the questionnaire, one is conspicuously absent: incest. Since the questionnaire was designed, the authors have become increasingly aware that family physicians must deal with this problem. It is hoped that future research will not overlook this sensitive issue.

To conclude with a word about the general applicability of these results: even though the respondents were drawn solely from family practice training programs in Minnesota, they are not a homogeneous group. They represent many different medical schools and are currently associated with different types of medical centers. The diversity in residents' past and present situations suggests that their responses will not be unique to this study, although research on other resident groups is needed before these findings can be generalized.* At the very least it is felt that the questionnaire employed in this study is useful for examining resident strengths and weaknesses in sexual counseling. When used to assess these abilities, it becomes a tool for logically planning the human sexuality component of a residency training program.

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*The questionnaire used in this study is available from the authors to anyone wishing to do further research in this area.