EDITORIAL

SEX EDUCATION FOR PSYCHIATRY RESIDENTS?

In a climate of self-examination in psychiatry where recruitment of residents is at an all time low and public demand for emotional and behavioral help increases daily, is there value in reviewing the "standard" didactic curriculum of U.S. Residencies in Psychiatry? The balance of emergency and basic inpatient, outpatient, individual, group, family therapy is somewhat uniform today with psychopharmaco-therapy an essential, although emphasis varies greatly depending on faculty skill attitude.

What about sex therapy? (a) Too much; (b) enough; (c) some; or (d) none? Are there answers available? A May 1980 Medline library search revealed zero publications on sex education in psychiatry. There were some references on the role of sex education for family practice and gynecology residents.[1,2,3,5] It used to be a standing joke that psychiatrists were overinterested in sexual thoughts and symbolism and that sometimes a cigar simply meant a cigar! Why is it that psychiatry has lagged in teaching the wealth of scientific specific data on sexual medicine available since the 1960s?

A small A.P.A. Task Force on Sex Education met in Chicago, May 1979, under the Chairmanship of Ed Auer, who reported that of 260 inquiries to U.S. Psychiatry Departments, 90 (one-third) responded. Of the ninety programs, 80 said they taught 3 to 50 hours of sexuality. Few details were available of content or whether the course was required vs. elective. The members of the Task Force agreed that it would be desirable for Psychiatric Residents to have a Sexuality Course covering the biosocial sex development aspect, anatomy and physiology of male and female sexual responses, pathology and treatment strategies. Each person in the room knew that Task Force

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0363-1907/81/1400-0103$00.95

Reports gather dust and do not readily translate into action. However, having considered its task of inquiry, it dismissed itself. A panel dialogue at 1979 A.P.A. Chicago on "Sex Education in Medical School" drew an overflow and involved audience yet an evening panel "Psychiatry Residency Training in Human Sexuality" drew an audience of six people. Is it easier to talk about or teach medical students than psychiatry residents? Low priority? Bad night? Oversaturation? It is as difficult to speculate about the poor attendance as it is to obtain useful data on Psychiatry Resident's education in sexuality.

The State of California (as it has often done with other changes) took a strange leadership role in 1978 and legislated that as a condition of license renewal all physicians (including surgeons) needed to show proof of 6 hours per year C.M.E. on the subject of human sexuality—in July 1980 this ruling apparently includes Social Worker licenses. Community pressure for action upon its help-givers may be resented by professionals but clearly represents a perceived need to be met by responsive and responsible caregivers.

For eight full years I have worked with residents in Psychiatry, Family Practice, Gynecology, Urology in the Loyola Sexual Dysfunction Training Clinic 10 week Elective. The Program is once-a-week for five hours each. There are three weeks (15 hours) didactics then seven weeks of clinical work with a dual-sex therapy team and a patient couple. There is close "in process and on site" supervision. The five hour format is an enriched teaching technique using indepth, structured history-taking and program under supervision to assist linkage between antecedent patient experiences and current life or sexual difficulties. Residents learn to understand each person and the couple through a unique modality that optimally weaves applied anatomy, physiology, personal and interpersonal interactions and values into a coherent whole. Psychodynamics are interpreted during team supervision times of each 5-hour clinical session. Direction to the trainee therapist dyad may be given to each team as to treatment strategy with their couple.

Despite attacks on the research method, the reporting and personal responsiveness of Masters-Johnson to inquirers[6], yet potential wholeness and healing of couple's relationship plus symptom reversal through this method has been duplicated and does occur in a high percentage of cases.[4]

The Loyola Treatment (not Training) Program, in its entirety with minor local modifications has been "transplanted" successfully to Grand Rapids, Michigan; to Wellington, New Zealand and to Johannesburg, South Africa by out-of-country Loyola trainees. Despite training of numerous non-Loyola staff from other Medical

Schools growth of similar or modified training programs in other Departments of Psychiatry to date has not occurred. Over 50 medical students per year (Loyola plus other) also rotate along with Psychiatry and other residents for the 50 hours elective. They learn about listening, understanding, taking time to talk to patients, giving credence to the myriad of emotional stress factors reported. Nine percent of 233 medical students who have trained at the Loyola Sex Clinic have gone into Psychiatry as a specialty—this is, therefore, not a recruiting base for psychiatrists. The other 91% will be physicians much more sensitve to the complexity of underlying emotional factors in their everyday patients.[5]

After the pioneering medical school work of psychiatrists Harold Lief and Ed Tyler in the early 1970s, Human Sexuality was included as an essential part of the medical school curriculum in a majority of U.S. schools. However, it is being now loosely stated that the priority has changed and sexuality has again been extruded from the curriculum. A fresh survey may be indicated. However, surveys are easier to recommend than to do.

The core questions regarding Sex Education for Psychiatry Residents remain to be addressed. Questions like: (a) Why do we not teach Human Sexuality? (b) If taught what is the quality of teaching? (c) What is the content and the context of the teaching? (d) What is the comfort and training of psychiatry sex educators? (e) Are there objections to providing a required didactic course on sexuality? (f) Are there ideas/comments to share? These might well be addressed if the Journal of Psychiatric Education could provide a forum for both educators and the Resident "consumers" of our teaching through letters to the editor.

Despite abundant current available academic and clinical data (including postgraduate courses) indicating effective treatment methods for sex problems, referrals continue to flow to Loyola Sex Clinic from area psychiatrists who openly inform the patient: "I don't deal with sex problems." Will we as Psychiatry educators raise yet another generation of partially trained graduates who must say the same thing?

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