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Sexuality Training for Professional Psychologists: A National Survey of Training Directors of Doctoral Programs and Predoctoral Internships

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Addressing sexuality issues is an inherent part of being a professional psychologist. A survey of training directors revealed that, although about one half of the doctoral programs covered at least some sexuality topics within courses, 19% to 21% of programs did not offer any training with regard to sexual dysfunction, therapy with gay clients, and HIV–AIDS. Sexuality training was even less likely in predoctoral internships. Sexuality training was unrelated to size of the program but was a function of the number of faculty with relevant expertise. Psychologists with adequate knowledge and comfort regarding sexuality will be better able to serve clients and avoid ethical pitfalls. Suggestions for infusing sexuality training into the already-crowded curricula are offered.

Sexuality is an inherent part of being human, and problems in sexuality may be a cause or consequence of emotional and psychological distress (Charlton, 1996; Leiblum & Rosen, 1989; Wincze & Carey, 1991). Clinically, sexual disorders as a class may be second only to substance-related disorders with regard to prevalence (Spector & Carey, 1990). In the mental health setting, a lack of appropriate formal training in sexuality issues can result in problematic interactions between psychotherapist and client, including ethics violations (Koocher & Keith-Spiegel, 1998; Pope, Sonne, & Holroyd, 1993; Yarris & Allgeier, 1988).

Surveys conducted in the 1980s consistently showed that a minority of doctoral programs offered a course devoted to human sexuality (Campos, Brasfield, & Kelly, 1989; Nathan, 1986). Likewise, as of 1987, only 25% of doctoral programs offered any information on AIDS, and when such training was offered, it typically consisted of an isolated lecture, colloquium, or workshop (Campos et al., 1989; see also Pingitore & Morrison, 1993). Accordingly, it is not surprising that most practicing clinicians believe they were inadequately prepared for working with clients infected with HIV, although indeed most have had infected clients (Schmeller-Berger, Handal, Searight, & Katz, 1998). Similar conclusions have been drawn with regard to professional psychologists' preparation and ability to work with gay men and lesbian women, despite the fact that nearly all practicing clinicians encounter sexual orientation issues in delivering services (Buhrke & Douce, 1991; Garnets, Hancock, Cochran, Goodchilds, & Peplau, 1991; Pilkington & Cantor, 1996).

What about addressing sexuality issues during the predoctoral internship? Nathan (1986) found that many clinical psychology training directors believed that sexuality training was most appropriately offered on internship rather than during graduate school. The previous literature on predoctoral internships is dated with regard to many topics and does not include investigation of sexuality curriculum (Stedman, 1997). Accordingly, we surveyed training directors in clinical and counseling doctoral programs and predoctoral internships with regard to the extent of sexuality training offered to students and interns.

The Sexuality Training Survey

The one-page questionnaire inquired as to the size of the program, the number of full-time faculty with identified expertise ("based on certification, publishing, research, or extensive professional experience") in each of six content areas (see Table 1), and whether each of seven content areas was covered in each of four different ways (see Table 2). Respondents were also asked whether there were plans to develop additional training experiences in human sexuality. Last, respondents rated the importance of training in human sexuality issues for trainees using a 7-point scale (1 = *unimportant*, 7 = *very important*).

Potential respondents included the training directors of all American Psychological Association (APA)-accredited doctoral programs in clinical (n = 163), professional (PsyD, n = 26), or counseling (n = 70) psychology, as well as all APA-accredited predoctoral psychology internships (n = 430). The programs were identified using the December 1996 issue of *American Psychologist,* and the one-time mailing occurred during March and April of 1997. Of the 689 questionnaires sent to viable training programs, 323 (47%) were returned completed, with a higher response rate

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Table 1
Survey Results Presented as a Function of Type of Training Setting

Variable	Clinical PhD (n = 54)	PsyD (n = 14)	Counseling PhD (n = 27)	Predoctoral internship (n = 228)
No. of faculty				
M	9.48	13.29	6.70	11.89
SD	3.82	8.80	2.77	8.32
No. of students				
M	60.33	154.00	48.89	5.03
SD	51.25	156.37	41.67	4.92
Percentage having faculty with expertise in area				
Sexual dysfunction	40.7	50.0	40.7	35.1
Sex therapy–counseling	33.3	50.0	44.4	32.0
Therapy with gay clients	40.7	57.1	63.0	53.9
HIV–AIDS	44.4	57.1	51.9	53.9
Gender disorders	18.5	21.4	29.6	26.8
Paraphilia	20.4	28.6	18.5	24.1

for predoctoral internship sites (53%) than for the doctoral programs (37%), $\chi^2(1, N = 689) = 17.34, p < .0001$. The completed surveys represented a total of 860 full-time faculty and 6,436 full-time students in doctoral programs, as well as 2,688 full-time faculty and 1,141 full-time interns involved in predoctoral internship programs. Basic information regarding each type of program is presented in Table 1. Note that a substantial proportion of programs did not have a faculty member with expertise in sexuality or therapeutic issues related to HIV–AIDS and gay clients.

Curricular offerings as a function of training setting are presented in Table 2. It was relatively rare for an entire course to be devoted to one of the listed sexuality topics, but about one half of the doctoral programs covered each topic in the context of a course. The last column in Table 2 indicates the percentage of respondents who indicated that the specific topic was not covered in any way in their program. A substantial minority of doctoral programs failed to provide any training opportunities with regard to basic assessment or intervention with clients experiencing sexual dysfunction. More than one third did not provide any coverage of typical or healthy sexual functioning, and at least one half failed to provide any training with regard to gender disorder or paraphilia. The "slack" in these areas apparently is not taken up by predoctoral internships as the majority of these failed to provide any coverage of these issues in their curricula.

With regard to HIV–AIDS, training efforts are more comprehensive. Campos et al. (1989) found that only 25% of doctoral

Table 2
Curricular Offerings as a Function of Type of Training Setting

Curricular content area	Form of curricular offering: Entire course	Topic in a course	Seminar	Practicum	Nothing offered
	Doctoral programs[a]				
Assessment of sexual dysfunction	9.5	49.5	16.8	41.1	21.1
Sex therapy–counseling	7.4	42.1	13.7	33.7	31.6
Therapy with gay clients	10.5	50.5	26.3	42.1	18.9
HIV–AIDS	7.4	51.6	26.3	36.8	21.1
Typical–healthy sexual functioning	5.3	48.4	10.5	28.4	37.9
Gender disorders	1.1	49.5	8.4	17.9	42.1
Paraphilia	2.1	41.1	7.4	14.8	49.5
	Predoctoral internships[b]				
Assessment of sexual dysfunction	0.9	11.8	13.6	12.3	66.2
Sex therapy–counseling	0.9	12.3	17.5	18.4	63.6
Therapy with gay clients	2.2	24.6	40.8	28.1	28.5
HIV–AIDS	2.6	23.2	40.8	28.5	31.6
Typical–healthy sexual functioning	0.9	11.4	13.2	14.5	70.6
Gender disorders	0.0	8.8	13.6	11.4	71.5
Paraphilia	0.9	7.9	10.1	11.0	77.2

Note. The values shown represent the percentage of programs offering the indicated form–content combination.
[a] $n = 95$. [b] $n = 228$.

programs offered any information on AIDS as of 1987. Ten years later, 68.4% of the doctoral programs covered HIV–AIDS through didactic means, and nearly 80% of the doctoral programs and nearly 70% of the predoctoral internships offered some training opportunities regarding HIV–AIDS.

In addition to the inclusion of HIV–AIDS information in curricula, coverage of therapeutic issues with gay men and lesbian women apparently has proliferated in training programs in professional psychology. Respondents from more than 80% of doctoral programs and more than 70% of predoctoral internships surveyed indicated some training opportunities regarding intervention with gay and lesbian clients (including two thirds of doctoral program respondents who indicated didactic coverage of these issues). Interestingly, however, we noticed an apparent link between coverage of HIV–AIDS and coverage of therapeutic issues with gay clients. Indeed, two thirds of doctoral programs that did not provide any coverage of issues inherent in working with gay clients also did not provide any coverage of HIV–AIDS. Similarly, 70.8% of internships that did not provide coverage of therapy with gay men and lesbians also did not provide any coverage of HIV–AIDS. Unfortunately, to the extent that HIV–AIDS is being paired exclusively with gay and lesbian issues, the stereotype that HIV–AIDS affects only gay men may be exacerbated among psychologists in training.

From the comments directors provided on the questionnaires, we sensed that training directors of doctoral programs and training directors of predoctoral internships may each believe the other will provide what is needed. For example, a training director for an internship wrote, "The assumption is that they [interns] will have received this [sexuality] training prior to coming to internship." Another internship training director commented, "This [sexuality training] should occur in the academic department training." Of course, not all training directors believed that graduate training was the appropriate setting for sexuality training. A training director in a clinical psychology doctoral program wrote, "Specialized—perhaps better at a post-doc level" beneath his or her rating of the importance of sexuality training for graduate students. Similarly, a training director for a predoctoral internship wrote, "[Sexuality is] important as a specialty skill after learning basics of therapy and assessment." Other training directors appeared to put the burden for recognizing the need for additional training on the students or interns. For example, a training director for a predoctoral internship wrote, "If interns require sexuality training, we will attempt to provide it."

As an index of the extent of sexuality training offered, we calculated the total number of ways the seven listed sexuality topics were covered within each program. If a program covered each of the seven topics in each of the four ways (see Table 2), 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 number of curricular offerings for doctoral programs ($n = 95$) was substantially higher ($M = 7.03$, $SD = 4.38$) compared with that for predoctoral internship programs ($n = 228$, $M = 3.82$, $SD = 3.20$), $F(1, 321) = 53.72$, $p < .0001$. Also, even after partialing out the total number of faculty, there were positive relationships between the number of curricular offerings and number of expert faculty in doctoral programs ($pr = .43$, $p < .01$) and internships ($pr = .37$, $p < .01$).

Dramatic improvement in sexuality training did not appear likely as only 17.9% of doctoral program respondents and 11.0% of internship respondents reported plans to augment didactic training. Even fewer doctoral program (6.3%) and internship (4.8%) respondents indicated plans to augment relevant practicum opportunities.

Last, we examined the ratings provided by training directors regarding the perceived importance of sexuality training for those in the directors' charge. Because the training directors personally provided these ratings, they may not have reflected the general attitude of other faculty in the program. As one respondent wrote beneath the importance rating, "But I am the only faculty [member] concerned about this." Still, mirroring differences in actual curriculum offerings, training directors in doctoral programs rated sexuality training as more important ($M = 5.72$, $SD = 1.53$) than did training directors in predoctoral internship programs ($M = 5.29$, $SD = 1.53$), $F(1, 320) = 5.15$, $p < .03$.

The total number of faculty with expertise in the various sexuality areas was positively related to ratings of importance of sexuality training for psychology interns ($r = .17$, $p < .05$), and these ratings were positively related to the total number of different curricular offerings in sexuality at the internship site ($r = .29$, $p < .05$). Similarly, among doctoral programs, ratings of importance were positively related to both the number of faculty with sexuality expertise ($r = .42$, $p < .01$) and the total number of different curriculum offerings in sexuality ($r = .45$, $p < .01$). Whether sexuality training is seen as important and is offered to trainees may be driven, at least in part, by whether the training site includes faculty with expertise in sexuality. What would happen to sexuality training for psychologists if training programs were forced to downsize? Will the economic climate in academia cast a more dismal shadow on sexuality training? Also, if relatively few psychologists are exposed formally to sexuality issues, who will become the next generation of faculty to provide such training?

Our discussion thus far has implied that psychology trainees should be provided with extensive training related to clinical aspects of human sexuality. However, we recognize that programs are already following a dense, largely APA-prescribed curriculum (Belar, 1998). There are only so many resources to go around, and these concerns were echoed in some of the comments training directors wrote on the questionnaires. For example, a training director in a clinical psychology doctoral program wrote, "The importance rating is lower because I must put this need in the context of multiple training needs with fewer resources." A training director in a predoctoral internship wrote, "[Sexuality] is important, but other training must take priority." Similarly, another internship training director wrote, "In my opinion, these [topics] seem like specialties. One year is barely enough time to teach generalist skills."

The portrait we have painted of sexuality training offered to professional psychologists may not be entirely accurate. As not all eligible programs responded, it is possible that those who did overrepresent the programs that emphasize sexuality training. Another limitation of the current survey involves the fact that we used fairly lenient criteria for determining whether sexuality training is offered to students or interns. The extent to which students actually participate in such training remains unknown. As a training director in a clinical psychology doctoral program wrote on his or her questionnaire, "All of these topics are covered in one graduate

course on human sexuality but it has only been offered once in the last 8 years!" Also, we did not ask about training opportunities offered outside the psychology department or internship program. One training director of a clinical psychology doctoral program wrote, "Our program is part of a large university with expertise in other departments in many if not all of these [sexuality] topics. The focus here [in the survey] just on [our] program misses the big picture."

Implications for Training and Practice

It is easy to point out a topic in professional psychology that receives relatively little attention in formal training (e.g., disabilities, gerontology, death and dying). Given the constraints on time and other resources, are there negative consequences to not specifically addressing sexuality issues during training? Does sexuality need to be paid special attention?

As one internship director wrote on our questionnaire, "Most of these issues can be competently dealt with by any moderately respectful, compassionate, well-trained clinical or counseling psychologist." The assumption behind this statement is that sexuality issues elicit the same types of reactions from clients and psychologists as do issues involving drug use, death, suicidal ideation, or any one of a host of potentially sensitive topics. However, sexuality is a deeply personal, and often taboo, topic in Western culture and is liable to engender anxiety and uncertainty on the part of both the client and the psychologist (Risen, 1995).

One's view regarding the nature of sexuality as a clinical issue has important implications for how one will view the issue of training. If adequate sexuality training simply consists of acquiring information, one "solution" to inadequate training is for practitioners to seek out their own resources. Indeed, this appears to be one of the most common approaches to acquiring needed knowledge regarding HIV–AIDS among practitioners (Robiner, Parker, Ohnsork, & Strike, 1993; Schmeller-Berger et al., 1998). Print resources exist with regard to clinical aspects of HIV–AIDS (Goldfinger, 1990; Kalichman, 1995; Winiarski, 1991), psychotherapy with gay and lesbian clients (Dworkin & Gutierrez, 1992; Falco, 1991; Gruskin, 1998; MacDonald, 1998), and assessment and treatment of sexual dysfunction (Charlton, 1996; Leiblum & Rosen, 1989; Wincze & Carey, 1991), as well as sexual deviation (Laws & O'Donohue, 1997; I. Rosen, 1996), typical sexual functioning (Daniluk, 1998; Francoeur, Koch, & Weis, 1997; Laumann, Gagnon, Michael, & Michaels, 1994), and general sexual topics (Bullough & Bullough, 1994; Francoeur, 1995).

Our position is that, although accurate information is necessary, competency in handling clients' sexual issues may not be as simple as having adequate knowledge. Indeed, experiments have revealed that therapists' own sexual attitudes and comfort level with regard to sexuality affect whether client disclosure of sexual issues is handled appropriately (Schover, 1981). To remedy such problems with comfort, others have offered specific direction regarding curricula and course material designed to address sexuality training for mental health professionals (e.g., Freeman, 1989; Jensen & Schover, 1988; Walters, 1994; Werth & Carney, 1994; Whitman, 1995).

There exist different levels of comfort and expertise with regard to client sexual issues, and it is unlikely that psychology students enter graduate training at an advanced point along this continuum. As one training director in a clinical psychology doctoral program wrote on his or her questionnaire, "Therapists in training are very reluctant to even discuss sexual issues with clients!" Thus, psychologists in training are not likely to develop comfort and expertise simply through experience seeing clients. Developing comfort with sexuality issues takes time and deliberate effort. How can the needs of trainees be accommodated given existing constraints?

To start, for those programs that currently do not have faculty with relevant expertise, recruiting professionals from outside the program to conduct workshops would be a viable solution to the problem of providing information and initial exposure to clinical aspects of sexuality. Otherwise, perhaps there are ways in which sexuality training, involving both information and experience, can be integrated into existing curricula. There has been an impetus to emphasize appreciation of, and exposure to, diversity during clinical training (Iijima Hall, 1997; Lonner, 1997; Pope-Davis & Coleman, 1996). Typically, the word *diversity* brings to mind ethnic or racial differences. However, as part of this diversity initiative, we should encourage inclusion of sexual and gender orientations as aspects of the diversity professional psychologists will encounter in their careers.

With regard to existing course work, sexuality issues should be used, at least on occasion, when introducing illustrative or hypothetical material for class consideration and discussion (e.g., see Werth & Carney, 1994). For example, in discussing issues surrounding couples therapy, it would be easy to include the experience of low sexual desire by one partner in the hypothetical case used in the classroom. Similarly, discussions of professional ethics can include issues surrounding therapist sexual attraction to a client, a client who is infected with HIV but refuses to inform his or her partner, a client who wishes to work on sexual performance problems but who currently does not have a partner, and so forth. These are scenarios practicing psychologists are more or less likely to encounter, yet few psychologists-in-training are exposed to them.

Information and cursory exposure are an important first step. However, to foster comfort and competency in handling client sexual issues, psychologists need to have personal experience addressing these issues in a training setting. For example, trainees might be asked to perform a sexual history (Risen, 1995) or explain to a client how to perform a particular homework assignment involving a sexual behavior (Charlton, 1996; Leiblum & Rosen, 1989; Wincze & Carey, 1991). Our point is that there is a substantial difference between learning the areas to be assessed in a sexual history and actually asking another person about this aspect of his or her life. The training issues that are liable to surface during such an exercise are many, especially if students perform such interviews with members of the opposite sex as well as the same sex and with gay, lesbian, and bisexual people as well as heterosexual individuals.

We recognize that not all training programs include substantial proportions of clients who present with sexual issues (clients rarely do, even if such issues are primary to them). However, the likelihood of a program's being able to provide such practical experience can be increased by advertising that sexual issues are among those handled at the counseling center or "in-house" psychological clinic. Even if public advertisement is deemed too extreme, increasing the comfort and readiness of trainees to broach sexuality issues will send the message to clients (and those with whom they

share their experience) that sexuality is a legitimate therapeutic topic. Even when early graduate students do not have clinical practicums (so that "real" clients are not available), exercises in taking a sexual history could be performed with volunteers, perhaps even students from an introductory psychology research participant pool.

Thus far, we have implied that improving sexuality training would result in better clinicians in that practitioners would be better able to address sexuality issues that arise. What implications would increased sexuality training have for actually expanding the scope of clinical practice?

It appears that the dominant approach to treatment of sexual dysfunction has become increasingly biomedical (R. C. Rosen & Leiblum, 1995; Tiefer, 1994), and this is likely to continue with the introduction of several medications for male erectile disorder (Riley, 1998; Stahl, 1998). Accordingly, others have raised concerns that the field of sex therapy, or even psychological intervention with individuals experiencing significant sexual dysfunction, is in jeopardy (Schover & Leiblum, 1994; Tiefer, 1994). Psychological treatment for sexual problems is an area of potential practice whose demise is imminent if psychologists ignore it. Conversely, deliberate emphasis on sexuality training would facilitate psychologists' access to an additional domain of practice.

In summary, the results of the current survey represent both good news and bad news. We have attempted to make the case that deliberate attention to sexuality issues during training is required for development of competent professional psychologists. Ideally, such training would involve accurate information, graded exposure, and firsthand experience. The net result would be clinicians better prepared to address client concerns, less prone to ethically problematic dilemmas, and poised to expand their scope of professional practice.

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