Training Family Planning Personnel in Sex Counseling and Sex Education

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ACCURATE KNOWLEDGE of the extent of human sexual problems has been incomplete for several reasons. Our society has discouraged open examination and discussion of sexual activities. With the exception of a few intrepid investigators such as Ellis (*1*), Dickinson (*2*), and Kinsey (*3, 4*), no solid empirical studies of human sexual behavior were available before the work of Masters and Johnson (*5, 6*), who estimated that up to 50 percent of married couples have some significant sexual problems. Other efforts to establish the real incidence of sexual problems have followed.

Direct observation of human sexual functioning is rarely possible in a research setting. Consequently, data must be obtained by asking people whether they have sexual problems, and frequently, it is first necessary to define a problem. Despite these complicating considerations, a variety of populations have been examined (*7*). One neglected group has been the relatively poor—members of racial and ethnic minorities, who are seen as patients in family planning clinics. A recent study demonstrated that sexual problems are common in the patient population served by family planning clinics (*8*).

We studied four family planning clinics in the Los Angeles area by submitting a written questionnaire to patients and clinic staff members who volunteered to participate. Additionally, many of the patient volunteers were interviewed. The results of the survey of 578 patients and 68 staff members indicated that about 4 of 10 family planning patients would like to have help with their sexual problems. Since most of the patients were women, problems in experiencing pleasure and orgasm in sexual activities were most common. Premature ejaculation was the common problem among men. Both sexes suffered from a lack of information, poor communication skills, and unrealistic expectations about their sexual roles.

Although the staff personnel tended to underestimate the incidence of problems among their patients, many indicated an interest in learning how to help patients with sexual problems. The patients also reported, in answer to the survey, that they would like to receive help at the family planning clinics if it were available. The next problem was the development of a program that would provide treatment to a large group of relatively poor patients, primarily women from racial and ethnic minorities, at a manageable cost. An effective program, in terms of patient satisfaction and costs, required that the existing staff personnel be trained

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Ginger Douglass, data analyst for Los Angeles Regional Family Planning, assisted in analysis of the data.

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in the techniques of treating their patients' common problems. A training program developed to meet this need is described here.

The Pilot Project

In January 1976, the Los Angeles Regional Family Planning Council funded a 1-year pilot project for sex education and sex counseling. The project staff consisted of one full-time coordinator and six part-time consultants. The primary objectives of the project were to train physicians, nurses, counselors, health educators, and volunteers to routinely ask patients if they had sexual problems, to provide accurate sex education and brief sex counseling, and to refer patients who needed more sex counseling or relationship counseling to the appropriate resources for help.

Sex education, as part of a regular office visit, includes providing patients with information about anatomy, physiology, and sexual response cycles and discussing common myths and unrealistic expectations. Sex counseling includes suggesting methods to help patients with sexual problems and concerns, such as lengthier foreplay and the use of direct manual stimulation of the clitoris for women who complain of lack of desire and enjoyment of sex; the use of lubricants and various positions for intercourse for women who experience painful intercourse; and various methods to delay ejaculation, and so on. Sex counseling can be a part of a regular office visit, but may require repeated visits with "homework assignments" in which the patients attempt new activities at home and then meet with a counselor for feedback and discussion. Patients who are unable to benefit from brief education and suggestions for improving their sexual problems would be referred to other clinics that provide more traditional sex therapy.

Since low-cost sex education and sex counseling programs were virtually nonexistent in Los Angeles County, a major emphasis of the project was to train the existing staff within the participating agencies to provide education and counseling services, and then to encourage the newly trained staff to be trainers, supervisors, and consultants in their agencies when the pilot project ended. To develop this internal capability, a five-stage training model for the family planning staff was developed.

Five-Stage Training Model

The five stages of the training program consisted of: Stage 1—a 2-day introductory program, stage 2—a 10-lecture series, stage 3—case supervision, stage 4—presentation of a sex education program, and stage 5—presentation of a lecture or provision of case supervision, or both.

Stage 1. Trainees attended a 3-hour evening program in which the project staff were introduced and the pilot program was described. Explicit sex films were shown, followed by group discussions in which trainees were encouraged to examine their personal attitudes about the broad range of sexual behaviors depicted in the films. The following day (8 hours),

the project consultants provided information about sexual anatomy, physiology, and male and female sexual response cycles; the diagnosis and brief treatment of sexual problems, common myths, and unrealistic expectations about sex. The participants practiced by taking a brief sex history and making a referral. Films that illustrate brief behaviorally oriented treatment programs for common sexual problems were shown and followed by group discussions.

The 2-day introductory programs were given at six family planning agencies. They were attended by 270 staff members and spouses. Staff from related services such as obstetrics-gynecology, urology, psychiatry, and social services were included in these programs and invited to attend future training programs.

Stage 2. Project staff provided a series of 10 lectures, approximately 2 hours per lecture, to 4 agencies participating in the project. The objectives of the lecture series were to provide a more detailed introduction to the diagnosis and brief treatment of sexual problems, to describe and demonstrate through role playing the various techniques for counseling and referring patients, and to encourage agency staff to become involved in some form of sex education or sex counseling under supervision of a project consultant.

The lectures, attended by 76 trainees, were given at 4 agencies. Briefer lecture series were provided to two freestanding clinics, because they had limited capability to provide education and counseling services.

Stage 3. Project consultants provided weekly or bimonthly case supervision to agency staff who were interested in counseling clients. Trainees asked patients questions about their sexual problems, provided information and suggestions for improving these problems, and then met with a project consultant for corrective feedback and suggestions. Whenever possible, project staff would schedule counseling appointments and invite trainees to join them as co-therapists for additional training and feedback. Supervision was provided on a regular basis for 17 trainees at 3 agencies.

As trainees became more proficient in assessing and treating common sexual problems, the project staff began to encourage the trainees to proceed to the next stage—presentation of an educational program to staff or patients within their agency.

Stage 4. The purposes of having trainees present education programs were threefold: (*a*) to encourage the trainee to master the information presented in previous stages of training, (*b*) to develop internal staff capability to continue these educational programs, and (*c*) to elicit public recognition for trainees who had volunteered many hours of their time to become involved in the pilot project. Project staff helped the trainees to plan and rehearse their presentations and provided corrective feedback and encouragement.

By the end of the program year, 16 trainees from 5 participating agencies had presented a variety of educational programs to more than 300 staff members and patients. These educational programs included training workshops and case presentations for staff members and a variety of programs for patients, including teen rap groups, programs for parents, and discussions of sexuality and common sexual problems following the regular contraception counseling programs provided for patients in the waiting room. The responses of the staff members and patients were positive and proved to be an invaluable source of reinforcement to the trainees.

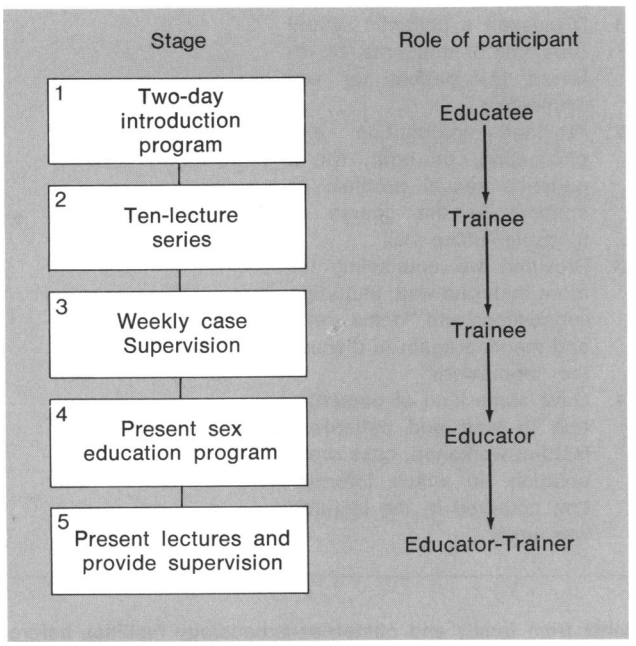
Stage 5. To maximize the impact of the year-long pilot project, trainees who had gained a wide range of supervised experience in sex education and counseling programs, were encouraged to conduct lecture series and supervision programs within their own agencies. Some of the agency staff from family planning and psychiatry-psychology-social services had had considerable counseling experience previously, and with the training and supervision provided by the project staff, they were qualified and capable to take on the new role of trainer. Project staff were available for consultation and supervision.

By the end of the project year, trainees in two agencies had planned lecture series and training workshops for their own staffs and planned to provide case supervision to new trainees. Staff from family planning and mental health services in these two agencies joined to develop sex therapy clinics to train staff and to provide sex counseling for family planning patients. Thus, as a result of the initial training provided by the project and the dedication of trainees who continued to volunteer their time, two new resources for low-cost sex counseling were established in the Los Angeles community.

In summary, the five-stage training model involved a stepwise progression from the passive role of

trainee to the active, autonomous role of educator-trainer (see figure). The model has several distinct advantages for training in family planning agencies. First, it allowed each trainee to determine the stage of training and involvement that would be most appropriate, based on his or her level of interest, skill, comfort dealing with sexuality, and time available. Thus, some staff could feel free to make a

Five-stage model for sex education and therapy training



limited commitment to learning about available treatment programs and making referrals, while other staff could become actively engaged in counseling and the educational programs. Further, since most of the training could be conducted in group settings, it was possible to include representatives from obstetrics-gynecology, urology, mental health services, and the clergy. In large hospital settings, the flexibility of this training model facilitated the development of an interdisciplinary team approach to the treatment of sexual problems that proved to be beneficial to both the trainees and the patients.

Followup of Training Program

At the end of the program year a questionnaire was sent to trainees who participated in at least stage 2, the lecture series. The questionnaire was designed to assess the trainee's performance following the lecture series on four outcome variables: (*a*) whether the trainee had discussed a patient's sexual problems or concerns or referred a patient for sex therapy, (*b*) whether a trainee had provided information or counseling, or both, as part of a regular office visit, (*c*) whether a trainee had provided sex counseling for more than one visit, including "homework assignments" (suggestions for sexual activities to try at home, designed to reduce sexual problems and increase sexual satisfaction) and meeting with the patient to discuss the "homework," and (*d*) whether a trainee gave some type of presentation to staff or patients, or both, in which they used the information and techniques provided in the 10 lectures.

Of 67 questionnaires mailed, 49 (73 percent) were completed and returned. Twenty-five respondents were from family planning and obstetrics-gynecology (7 physicians, 9 nurses, 3 counselors, 3 health educators, 2 social workers, and 1 volunteer) and 24 were from a variety of services, including urology, psychiatry, psychology, social service, and clergy.

Analysis of the data from family planning and obstetrics-gynecology staffs (N=25) showed that after the lecture series, 96 percent had discussed a patient's sexual problems or made a referral, 96 percent had provided sex information or counseling as part of a regular office visit, 52 percent had provided sex counseling which included "homework assignments" and meeting with the patient to discuss the "homework assignments" and 36 percent had conducted a workshop, case presentation, or lecture, and so on, in which they used information and techniques provided in the lectures. The percentages of all respondents and family planning and obstetrics-gynecology staff only who achieved each of the four outcome variables are presented in table 1, which shows that similar percentages were achieved by both groups. By the end of the program year more than 90 percent of the respondents had discussed a patient's problem or made a referral and had provided sex information and counseling as part of a regular office visit.

The percentages of participants who achieved the trainee outcome variables (table 1) become more meaningful when the trainees' level of prior experience in providing sex education and sex counseling is considered. As shown in table 2, the 25 trainees from family planning and obstetrics-gynecology reported that, before the lecture series, when a patient's sexual concerns were brought to their attention as part of a regular office visit 36 percent reported they "never or rarely" provided sex education or counseling; 32 percent reported "sometimes"; 16 percent reported

"frequently"; and 16 percent reported "always." Table 2 also shows the percentage of respondents who achieved each of the four outcome variables and the respondent's corresponding frequency of providing sex education and sex counseling before the lecture series. Of the 36 percent of the respondents who reported that before the lecture series they "never or rarely" provided sex education or sex counseling, 100 percent reported they had discussed a patient's sexual problems or concerns or had referred a patient for sex counseling, and 88 percent provided sex information and counseling, or both, during a regular office visit. Thus, high percentages of the most inexperienced trainees did use the information gained in the lecture series.

Table 1 shows that smaller percentages of trainees from both family planning and obstetrics-gynecology, as well as the total sample, achieved the trainee outcome variables that required the highest levels of skills and knowledge—providing sex counseling with "homework assignments" (variable 3) and giving a presentation to staff or patients, or both (variable 4). Analysis of data for the total sample (N=49) suggests that the weekly case supervision in addition to attendance at the lecture series was necessary for trainees to acquire the skills and confidence to provide these more demanding services.

As shown in the following tabulation, 76 percent of the 17 trainees who received case supervision provided sex counseling with "homework," as compared to the 52 percent of those who did not receive case

Table 1. Percentage of respondents who achieved the four outcome variables

Trainee outcome variables	*Total respondents (N = 49)*	*Family planning, obstetrics-gynecology only (N = 25)*
1. Discussed a patient's sexual problems or concerns, or referred the patient for sex counseling	86	96
2. Provided information and counseling, or both, for a patient's sexual problem or concern in the course of a regular office visit	90	96
3. Provided sex counseling for more than one visit, including suggestions and "homework" and meeting again to discuss the "homework"	60	52
4. Gave some kind of presentation to staff and patients—lecture, workshop, case presentation, in which information acquired in the lectures was used	33	36

Table 2. Provision of sex education and counseling by respondents from family and obstetrics-gynecology facilities before and after series of 10 lectures

Trainees' achievements of 4 outcome variables after lecture series	*Frequency that 25 trainees provided sex information or counseling before lecture series*			
	Never or rarely 9 (36 percent)	*Sometimes 8 (32 percent)*	*Frequently 4 (16 percent)*	*Always 4 (16 percent)*
1. Discussed a patient's sexual problems or concerns or referred patient for sexual counseling:				
Yes	100 percent	100 percent	100 percent	75 percent
No				25 percent
2. Provided information and counseling or both, for a patient's sexual problems or concern during regular office visit:				
Yes	88 percent	100 percent	100 percent	100 percent
No	12 percent			
3. Provided sex counseling for more than 1 visit, that included suggestions, homework assignments, and meeting again to discuss homework:				
Yes	44 percent	44 percent	50 percent	100 percent
No	56 percent	56 percent	50 percent	
4. Gave presentation to staff and patients using information acquired in lecture series:				
Yes	22 percent	22 percent	50 percent	75 percent
No	78 percent	78 percent	50 percent	25 percent

supervision. This relationship was not statistically significant. A chi-square analysis showed that relationship between receiving case supervision and giving a presentation was significant ($P<.01$). The tabulation also shows that 59 percent of the trainees who receive case supervision gave a presentation, while only 19 percent of those who did not receive supervision gave a presentation. These results suggest that future training programs for sex counseling that include giving "homework assignments" and meeting for more than one office visit and giving education programs for staff and patients, should include weekly case supervision. Weekly case supervision was the most costly component of this training model, but the costs for case supervision were reduced in our project by using group supervision. One consultant provided supervision to two to eight trainees at each agency, for approximately 2 hours per session weekly. The family planning agencies were required to absorb the cost of staff attendance to the supervision, and some agencies could not afford the added expense.

Counseling and presentations

	Received case supervision	
	Yes (17)	*No* (31)
Provided counseling with homework: [1]		
Yes	76	52
No	24	48
Gave presentations: [2]		
Yes	59	19
No	41	81

[1] Significant at $p < .17$, as measured by Chi-square test of significance.

[2] Significant at $p < .01$.

Unfortunately, we were unable to assess systematically our trainees' competence in delivering the various educational and counseling services. At present the fields of sex education and sex counseling lack systematic procedures for assessing a counselor's competence to deliver services. Because this was only a 1-year project, there was neither time to develop new assessment tools nor to develop sufficient rapport with the trainees to systematically assess their level of competence. Our initial attempts to assess the trainees' level of comfort with sexuality and the ability to counsel people with sexual problems before beginning the training programs met with a great deal of resistance. Trainees said they felt comfortable and competent to handle patients' sexual problems, but they "didn't have time" to provide sex education and counseling. As rapport developed, trainees disclosed that they were uncomfortable talking to patients about sex and felt considerable concern about their own sexual problems. To build the rapport that was necessary to maintain this brief project, we limited our followup assessment of the trainees to surveying the types and frequency of services delivered. Whenever possible, however, our consultants would observe trainees as they delivered services, either as a co-therapist for a trainee who was counseling, or by attending an education program presented by a trainee. Our observations suggested that most of the trainees were able to deliver services in a competent manner, and we did not receive any reports of incompetent or unethical behavior from other trainees or from patients who were receiving the services.

To help plan for future training programs, the questionnaire also requested the kinds of information and suggestions actually given by family planning and obstetrics-gynecology staff to their clinic patients who had sexual problems and concerns. The questionnaire provided a list of 15 topics typically included in sex education and counseling programs. Analysis of the data showed that of the 17 staff members who responded, more than 50 percent had included each of the following topics in their discussions with patients: male and female anatomy and sexual response cycles, the "normal" range of the female orgasmic response, how to do a self-genital examination, and permission for self-stimulation, sensate focus or mutual pleasuring exercises to practice with partners, the use of fantasy and various techniques for increasing arousal such as clitoral stimulation during intercourse, techniques for reducing pain and discomfort during intercourse, such as the use of a lubricant and longer foreplay, and basic communication skills to improve the sexual relationship. (Detailed descriptions of these topics have been published (*6,9*).) These results suggested that by the end of the training program the trainees had incorporated a wide range of sex information and specific suggestions for improving sexual relations into the services provided to family planning patients.

Most staff members spent 15–45 minutes counseling patients on a one-to-one basis, usually for one or two sessions. No serious negative reactions to the counseling were reported during the program; at worst, a few patients expressed disinterest in trying an activity suggested by a counselor or stated that he or she had tried the activity before and it had failed. Most patients expressed initial surprise and then delight to discover that staff were now willing and able to discuss sexual problems openly and to provide specific information and suggestions for relieving many common problems and concerns.

The investigators considered the program a success. Feedback from the family planning staff and the

patients who participated confirmed our impressions. Nevertheless, there were problems. Initially, the structure of the funding agency, the Los Angeles Regional Family Planning, Inc. (LARFP), contributed to the difficulties. Several facilities make up LARFP, ranging from general hospitals to "free clinics." The personnel who work at the various facilities are heterogeneous in training, attitudes, and comfort with providing sexual health care services. Public representation on the LARFP board of directors assures that all decisions reflect a consensus of the participating agencies. As a result, it was difficult to get some representative LARFP facilities to agree to participate in the demonstration project.

Heterogeneity was the investigators' desirable goal, and fortunately, the agencies that participated were different. In most cases, the unique characteristics of the institution influenced the types of sexual counseling, education, or treatment provided by the institution's staff. For example, a general hospital program in the central city was composed of representatives of the departments of psychiatry and obstetrics-gynecology. The psychiatry participants wanted to learn to perform sex therapy for couples and individual patients during a number of visits—up to 15 or 20 in some cases. Provision of such training to the psychiatry staff and other interested trainees was time consuming, expensive, and relatively inefficient in terms of our original goal—providing sexual health care services to many people, cheaply. But, if the training provided to staff of that particular institution had not included "traditional sex therapy," the institution may not have agreed to participate in the project.

Other facilities were located in communities that were considered conservative about sexual matters, at least by the directors of those clinics. Where these community representatives contributed to the policy-making of the facilities by membership on their boards, the clinic directors were reluctant to participate. Much of our project staff's time and effort initially was expended to educate, reassure, and encourage the directors of some facilities to take the risk of providing sexual education and counseling.

When cooperation was obtained, other problems appeared. Cutbacks of funds led to staff turnover in many of the participating agencies. The need for patience, flexibility, and dedication in our project staff was crucial. Many of the early trainees left or became disheartened by the changes taking place in family planning agencies, and new recruiting was necessary. All of these problems were surmountable, but they added to the expense of initiating this unique addition to family planning services.

Conclusion

A flexible and relatively cost-efficient training model was designed and used in a number of family planning agencies to train staff to provide accurate sex information and brief sex counseling to patients with sexual problems. Trainees reported that participation in the various training programs had had considerable influence on their current approach to counseling patients with sexual problems. Trainees reported increased comfort and openness about their own sexuality, an increased sensitivity to patients' problems, and the ability to initiate discussions about previously taboo sexual topics, increased knowledge and skill in providing information and counseling, and a desire to continue to practice their newly learned skills and acquire further training.

The availability of reliable forms of birth control has the potential for improving the quality of sexual relationships. However, many patients suffer from a lack of accurate information and poor sexual and interpersonal skills. Many otherwise viable relationships are seriously undermined by sexual problems, and particularly for low-income patients there are few sources of help. In most family planning settings, discussions of birth control are kept separate from discussions of sexuality, and frank discussions of sexual problems and concerns are typically neglected. The findings in this project suggest that family planning physicians, nurses, counselors, educators, and volunteers can be trained in a relatively short time to provide a wide range of sorely needed sex information and counseling to the patients with sexual problems and concerns.

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