SEXUALITY IN CLINICAL PRACTICE

A CONTINUING MEDICAL EDUCATION PROGRAM FOR FAMILY PRACTICE PHYSICIANS

By

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ABSTRACT

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This study was concerned with the training of medical practitioners who were products of medical schools that had no coursework in human sexuality beyond its anatomy and physiology. The purpose of the study was to develop and present a model human sexuality workshop to be offered to family practice physicians and other health care professionals.

The model was developed in rough form, field tested in a course for osteopathic medical students, refined, and then presented to the family practice residents and staff at seven of the nine major family practice concentration areas in the United States Army. The physicians at these seven hospitals comprised 80 percent of the family practice residents and physicians on active duty in the United States Army at that time.

Two objective pre- and post-course test instruments, post-course student evaluations and the researcher's clinical

observations were utilized to evaluate the effectiveness of the workshop presentation.

All evaluative methods tended to validate the workshop as effective and adaptable. Participants in the study were influenced positively in the areas of both knowledge gain and attitudes. The student course evaluations reflected a high level of interest, enthusiasm and support for the program which was reinforced by the researcher's clinical observations.

To my wife, CHERYL,

my partner and companion,

whose love, support and caring

are the foundation for this achievement

-and-

To my children,

DANIELLE and MICHELLE,

whom I love dearly

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CHAPTER I

THE PROBLEM

Introduction

Since the introduction of Masters' and Johnson's book, Human Sexual Inadequacy,[1] in 1970 the treatment of sexual dysfunction has not only come more into the open, but has essentially received public acceptance. Increasingly, men and women are realizing that their sexual problems are not hopeless and can be treated. The widespread media coverage has contributed to a large increase in the numbers of patients appearing in primary care practitioners' offices with a sexual dysfunction, sometimes with a history of many years.

In any field as young and rapidly growing as this, an educative process needs to be implemented to teach both new and experienced primary care practitioners how to evaluate, diagnose and, in some cases, treat sexual problems. Just as important is knowing when and to whom to refer their patients if short-term methods prove unfruitful. This process needs to take place on two major levels: 1) the training of medical students, and 2) continuing medical education (CME) for physicians already in practice.

Much pioneer work has already been done at the first

level; that of incorporating human sexuality coursework into the medical school curriculum, at least as an elective. In 1963, only three medical schools in the United States had any formal coursework in this area (the University of Pennsylvania,[2] Washington University in St. Louis and Bowman-Gray).[3, 4, 5] Coombs[6] surveyed twenty-nine medical schools in 1968 and found that five had required, and eight had elective courses in human sexuality. Lief,[7] in 1974, estimated that about ninety medical schools had organized courses in this area. Even today, much of this coursework is spotty and uncoordinated. However, the need is now being recognized and most medical schools are seeking ways to meet it.

Statement of the Problem

This study attempts to deal with what is seen as an educational vacuum, the training of those medical practitioners who are products of medical schools with no coursework in human sexuality beyond the anatomy and physiology of sexuality. This has been referred to as the second major level of human sexuality education, and has two subsections: 1) incorporating human sexuality training programs into the various residency training programs, and 2) offering continuing medical education (CME) to those physicians already practicing medicine, whether a residency training program has been completed or not.

In the past, discussion of sexual thoughts, feelings, attitudes and values, and dealing with patient concerns in

this emotionally laden area, were neglected by most medical schools and professional training programs. Sexual dysfunction was seen as a psychological or emotional disorder to be treated by the analyst or psychotherapist. The physician's role was to verify or rule out physiological etiology.

Sheppe points out that "Excluding that part of human sexuality related to physiology, endocrinology and genetics, the average American physician may be less knowledgeable about human sexuality than his patients are."[8] Yet, as McCary points out, "It is typically to the physician that people first turn when there are sexual problems."[9]

Physicians, by their lifestyle, are often sheltered and naive about many of life's issues. Winnicott writes:

> The doctor's long and arduous training does nothing to qualify him in psychology and does much to disqualify him. It keeps him so busy from 18 to 25, he finds he is middle-aged before he has the leisure in which to discover himself. It takes him years of medical practice and the struggle to find time to live his own life before he can catch up on his fellow creatures, many of whom have lived a lot by the time they are 25.[10]

Lief (et al.) has stated that "The personality type found most frequently in medical school (more than 50 percent of our students) is the obsessive compulsive."[11]

> The obsessive compulsive personality is one in which mastery, control, thoroughness, safety and self-restraint are dominant attributes. The obsessive is the sort of person who puts intellectual matters above emotions, security above pleasure, service to others above self-service (at least at conscious levels), exactitude above fantasy. He is the student who works harder for good grades even in subjects he cares little about. This is a far cry from the popular stereotype of the student as sexually experienced and unrestrained, but it is in keeping with the public's view of the doctor.[12]

These roles and values become reinforced over time, producing a physician who may be conservative with traditional values, limited self-experience and a natural defensiveness about dealing with areas in which he has limited knowledge and/or experience.

Purpose of the Study

The purpose of this study is to develop and present a model program to be offered to family practice residents, staff physicians and other health care professionals within a CME framework intensively over two working days. The purposes of this program are twofold: 1) to help the health care practitioner to attain more knowledge, skills and techniques in the field of human sexuality so that he/she will be better prepared to assist patients in dealing with their sexual problems, and 2) to enable him to increase his personal comfort level, allowing him to get more in touch with his own thoughts, feelings, biases and values and to answer some of his personal concerns so that he may be more receptive to the problems of his patients.

Although new texts directed at medical students and nurses are appearing on the market, no one has yet published either a model CME workshop or a training manual to assist those already in practice. It is the purpose of this study to present and evaluate such a program.

Design of the Study

The workshop will be presented to all available family practice physicians located in each of the major family practice concentrations in the United States Army.

The model will be assessed through several separate means: 1) two pre-existing instruments (the SKAT test and Miller Test) will be utilized to compare pre- and post-course scores to determine the model's influence on sexual knowledge and attitudes, 2) course evaluation summaries are filled out by the course participants to provide subjective written input, and 3) the researcher's clinical observations are included to provide further subjective input, since statistics are an inadequate measure of clinical data.

Population and Sample

Although this study focuses on a specific population, that of family practice residents and physicians within the United States Army, it can be presented to any group of health care practitioners concerned about the sexual problems of their patients. Family practice was chosen as the specialty of primary focus due to its concern with the total person, taking into consideration both emotional and physical components of disease and how that person reacts within the family system. Human sexuality is an individual, couple, family and societal concern. The family practice physician may be in the best position to detect and treat sexual problems before they become sexual dysfunctions. The United States Army provides an ideal specific population

because of the increasing shift toward family medicine and the usual effective and appropriate utilization of the family practice physician as a primary care practitioner. In addition, the nature of military medicine allows for presentation of the CME workshop to the majority of family practice physicians on active duty. For the purposes of this study, seven of the nine family practice concentration areas were visited and the sample consisted of all the family practice residents and staff physicians available at the time of workshop presentation. This provided an overall sample of approximately 225 family practice physicians, which was approximately 80 percent of the total number in the United States Army at that time. The SKAT and Miller questionnaires were given to all course attendees, both before and after the workshop presentation, with primary concern for knowledge evaluation and comparison of pre- and post-course results.

Limitations of the Study

The model will be tested initially in two groups only, osteopathic medical students and family practice physicians.

Although the SKAT test is a viable instrument for measuring sexual knowledge and attitudes, a post-test given two days after the pre-test may not be completely representative of the benefits derived from the workshop presentation. The sexual knowledge section of the SKAT may represent a portion of new knowledge gained, but attitudinal change may only be slight. The attitudinal effects of a

program of this type are increasingly evident as the physician returns to his patient care role, deals with the sexual problems of his patients and gradually incorporates his new knowledge and ideas into his practice of medicine. When dealing with material which is emotionally laden for many people, retention is inevitably selective and different from person to person.

The clinical observations of the researcher will be incorporated as a part of the procedure for testing the model, and are subject to the limitations on the degree of objectivity that can be involved in this type of process.

Definition of Terms

The following terms are used in the context of this research:

1. CME. Acronym for continuing medical education, a program of ongoing coursework to assist the physician in keeping up to date with medical advances and new information.

2. AASECT. Acronym for the American Association of Sex Educators, Counselors and Therapists, the national organization in this field, and the one concerned with certification and training of sex educators, counselors and therapists.

3. SKAT. Acronym for the Sexual Knowledge and Attitude Test, by Harold Lief, the major research instrument employed to test the model's effectiveness.

4. Family systems theory. A theory which is concerned with the family as a system. Emphasis is placed on the effect of each member or part of the system on every

other member or part. In a couple, for instance, a sexual problem is viewed as a shared problem and not just a problem of one member. Both members then work together toward problem remission.

5. Couple Communication. A twelve-hour course developed by the University of Minnesota, which is taught by certified instructors to couples or partners, with the goal of helping them learn the skills and techniques which will facilitate them sharing their thoughts, feelings and intentions clearly and more accurately.[13]

6. Family practice physician. A term referring to physicians who are either residents or fully trained in the residency of "Family Practice," rather than the general practitioner who might label himself as a family practice physician yet has no residency training in this specialty.

7. Sexual dysfunction. A term referring to sexual problems in a relationship, including everything from general dissatisfaction to severe physiological trauma. An important and inseparable consideration in all sexual dysfunction are the thoughts, feelings, fears and concerns of the persons involved--the emotional component.

Overview of the Study

This study will be reported in the following sequence. Chapter I will include the introduction, statement of the problem, purpose of the study, design of the study, population and sample, limitations of the study, definition of terms and overview of the study. Chapter II will contain a

review of the related literature. A more exact look at population and sample, the evolution of the model through its various developmental stages, and presentation of the testing and evaluation methods will comprise Chapter III. Chapter IV will present the data obtained through the pre- and post-course instruments, post-course evaluations (both clinical and written) and the analysis thereof. Summary, conclusions and recommendations will be provided in Chapter V.

CHAPTER II

REVIEW OF THE LITERATURE

An extensive review of the literature failed to identify any research studies explicitly concerned with remedying the gaps in the training of medical practitioners graduated by schools of medicine, which in those years offered no coursework in human sexuality.

At the same time, there is a growing body of literature underlining the need for medical students and practicing physicians to be more effectively equipped to deal with the sexual problems of their patients. A sampling of authors of books and journal articles concerned with this need includes Appel,[14] Branch,[15] Burnap and Golden,[16] Calderone,[17] Coombs,[18] Hunt,[19] Lief,[20, 21, 22] McCary,[23] Mudd,[24] Pauley and Goldstein,[25] Rubin,[26] Sadler,[27] Tyler,[28] Vincent[29] and Woods.[30] The great majority of these references explore the importance of preparing medical students to understand and treat patients' sexual difficulties helpfully and comfortably. The authors note that most medical schools now offer such courses, and in many schools the courses are part of the core curricula.

These and other authors acknowledge the possibly even greater need for already practicing physicians to be

brought up to date in their knowledge of human sexuality; they also state that the majority of physicians have never received formal education in human sexuality during or since their medical schooling.

Bloom[31] reports that Helen Kaplan, M.D., Director of the Sex Therapy and Education Program at New York Hospital's Payne Whitney Clinic, insists that most primary care physicians have not been prepared to deal effectively with sexual problems, despite the fact that such problems are the most common medical complaint in the world. The new sexual freedom has allowed patients to be more comfortable in verbalizing their sexual difficulties.

Kent[32] argues that most practicing physicians are lacking in knowledge of human sexuality, even though they may have a thorough grounding in reproductive physiology. When a patient comes to a physician with a sexual problem, the physician may find that his own attitudes and anxieties about sex prevent him from helping his patient.

Kent believes that comprehensive programs in sexuality are needed, including two-day seminars requiring physicians to come to terms with their feelings about sex and sexuality. He outlines a University of Minnesota program, the Sexual Attitude Reassessment (SAR) seminar, designed to increase physicians' knowledge and skills in human sexuality. The seminar's three basic components are large group discussions, multimedia presentations and small group discussions. The large group discussions are primarily for dissemination

of and reaction to information. The multimedia presentations are designed to bring out the participants' inner attitudes and anxieties. In the small group, participants are helped to express reactions and to listen to those of others. The resulting interchange is intended to put feelings into perspective and foster a new understanding of sexuality.

In his identification of the need for such two-day seminars and workshops, Kent is one of several thoughtful writers who is moving beyond lamenting these gaps in earlier medical education and is asking that remedies for this situation be developed. A leader in this emerging movement is Harold Lief, M.D., Director of the Center for the Study of Sex Education in Medicine at the University of Pennsylvania School of Medicine, and co-designer of the Sex Knowledge and Attitude Test (SKAT). In 1976, he and Karlen[33] published an overview of the then current needs and programs in sex education in medicine. He noted that the teaching of human sexuality is becoming an integral part of medical school curricula, but that practicing physicians have had little opportunity to receive such formal instruction.

Lief, as well as Werkman, Mallory and Harris,[34] states that physicians want and are beginning to seek lectures, seminars and workshops geared to helping them gain greater competence in treating patients with sexual dysfunction. He urges medical schools and professional associations to develop continuing education approaches and

programs, including short-term intensive workshops, to meet such needs.

In discussing the growing role of the physician as sex counselor, Mason[35] believes that many medical practitioners are ill-informed and uneasy in such a doctor-patient relationship, and that they need retraining to be effective in this role. He feels that the physician should appreciate the trauma caused by sexual problems and understand human sexuality as a complicated topic involving feelings, attitudes and prejudices.

Renshaw argues that all physicians, especially psychiatrists, "through continuing medical education should be adequately trained to deal with a patient's questions about sex in order to dispel guilt, distortions, misunderstanding and misinformation regarding human sexuality."[36]

Pauley and Goldstein[37] conducted a survey of 947 physicians to obtain information about the physicians' perceptions of their understanding, training, experience, competence and attitudes in dealing with the sexual problems of others. Despite the physicians' generally high ranking of themselves, other data collected by the authors indicated that the physicians' positive self-perceptions related to the organic aspects of human sexuality rather than to the emotional or psychological aspects. Pauley and Goldstein conclude that more sexual knowledge is needed by the majority of physicians currently practicing medicine.

The foregoing situation is of international rather

than simply national magnitude. Smith[38] presents an overview of family planning programs in Great Britain, West Germany, Denmark and Sweden, and notes that in these countries, as well as in his native Canada, physicians are inadequately prepared to offer effective help to persons with sexual problems. He believes that one solution, being organized strongly in the Scandinavian countries, is the development of offering of practice-oriented continuing education seminars and workshops in human sexuality.

James and Lord[39] write in a similar vein of the need for upgrading knowledge and competence in human sexuality, for practicing physicians in Great Britain and New Zealand. They believe that medical education and clinical practice have not kept pace with increased liberality and changing mores, and cite several studies which indicate that physicians feel incompetent to deal with sexual problems and are inadequately trained to do so.

From the relevant literature, then, at least five inferences may be drawn:

1. There is clear and present need for medical students and practicing physicians to be knowledgeable and competent in dealing with patients' sexual problems.

2. Most medical schools in the United States now offer coursework in human sexuality, and in many schools the courses are an integral part of the core curricula.

3. Most practicing physicians have never received formal education in human sexuality, during or since their

medical schooling.

4. Because of increasing numbers of patients with sexual problems, and growing awareness of their inadequate preparation for dealing with same, physicians are beginning to seek educational help in learning to use themselves more effectively and comfortably in meeting the needs of such patients.

5. Short-term intensive seminars and workshops can be highly effective in helping physicians to develop knowledge, skills and attitudes which will enhance their ability to offer effective help to patients with sexual problems.

CHAPTER III

METHODOLOGY

POPULATION AND SAMPLE

There are nine major family practice centers in the Army, seven of which have family practice residency training programs. One of these centers, Fort Ord, California, was deleted from the proposed list because the family practice staff had recently participated in a human sexuality workshop. Fort Ord's chief of family practice decided that a second presentation so soon would be redundant. A second small center, Fort Polk, Louisiana, did allow eight of their doctors to participate in a small one-day seminar, but the two-day workshop was not practical. A second problem at Fort Polk was the general unresponsiveness and uncooperativeness of the doctors themselves. Intra-clinic problems at this center apparently interfered with their investment of time and energy in the seminar. Even though the group was non-responsive and atypical, an attempt was made to give the pre- and post-research instruments, but the doctors neglected to return the post-test; hence, no data could be collected.

This study, then, was concerned with the seven major hospital centers where the full two-day workshop was

presented, was well received, and where pre- and post-data were gathered. These seven centers comprise approximately 80 percent of the family practice physicians and residents currently on active duty with the United States Army. Table 3-1 summarizes the numerical breakdown of the participants on a hospital-by-hospital basis.

EVOLUTION OF THE MODEL

As indicated in Chapter I, the primary focus of the study was to develop a model for a short-term, intensive workshop dealing with sexuality in clinical practice for family practice physicians--in this instance practitioners in the United States Army. The discussion which follows in this section is concerned with the activities that led to a conceptualization of the model, as well as the field testing of it.

Fort Belvoir, Virginia

The first experimental continuing medical education (CME) workshop in human sexuality began in the summer of 1976. Colonel Henry C. Reister, Chief of the Department of Family Practice at Dewitt Army Hospital, Fort Belvoir, asked the writer, who was the hospital's sex therapist, to assist him in developing a one-day workshop for his family practice residents to assist them in gaining basic knowledge and skills in human sexuality.

The course (see Appendix A) was based on five papers, each dealing with a different approach in the treatment of

TABLE 3-1

WORKSHOP PARTICIPANT BREAKDOWN

Post	Number of Participants
Fort Bragg, North Carolina	24
Tripler, Hawaii	32
Fort Belvoir, Virginia	33
Fort Lewis, Washington	26
Fort Sill, Oklahoma	34
Fort Benning, Georgia	40
Fort Gordon, Georgia	36
TOTAL	225

patients with sexual dysfunction. The speakers were experts and presented their papers effectively. The principle criticism was that, while whetting the appetites of the residents for further information and guidance, the workshop gave them little to use in their direct practice. While the workshop presented a series of opening lectures--introductions to various methods and/or techniques--there was limited consideration of concrete or tangible steps to take in the treatment of patients. With near unanimity the residents recommended that a longer course be presented the following summer. The response was so strong that the hospital approved funding for a presentation by the national organization, the American Association of Sex Educators, Counselors and Therapists, henceforth referred to as AASECT.

AASECT Sex Therapy Skills Workshop

The AASECT course was effort number two (see Appendix B) and the first major human sexuality seminar funded by the military. The course was constructed by staff of AASECT, and involved a teaching staff of eight nationally renowned experts. Despite the knowledge and competence of the staff, the course was evaluated by the residents as ineffective. Its major weakness, assessed by both staff and students, was a lack of cohesiveness, organization, coordination and complementarity. Each expert spoke on his or her area of expertise, but there was no explicit linkage between one paper or approach and the next. Finally, in an effort to "save"

the course, a series of sex films was shown. Unfortunately, the audience was not advised how or for what purposes each movie could be used; hence, for some the movies were stimulating and pleasurable, and for others they were repulsive and threatening. Interestingly, although the response from the physicians tended to be one of frustration, it was nonetheless positive. They knew that the area of sexuality was one of weakness in their practices, and they still wanted to learn. All participants indicated a desire for further learning, and most indicated that they wanted to learn some basic skills and techniques that they could use with their patients.

It seemed to the writer that one expert could have taught all the basics in one twelve- to sixteen-hour class to such a group of physicians. With only one instructor, the problems of slippage, needless repetition and lack of cohesiveness could have been avoided or at least reduced. The physicians could have been taught by a military sex therapist, thus facilitating optimal use of military case examples to increase understanding. Movies could have been integrated into the course where appropriate to vary the teaching method, and basic skills and techniques--practical knowledge--could have been taught. Such a workshop could have been presented to all military family practice residency training programs as a part of the curriculum. From the above reasoning, planning and development of this two-day CME workshop emerged.

Post-AASECT Course Assessment

Prior to finalization of the workshop, additional feedback was sought from the physicians who took part in the summer 1977 AASECT course concerning their ideas, impressions and recommendations one full year later. A questionnaire (see Appendix C) to seek their reactions was devised and sent to all participants. AASECT approved a paper presenting the results to the Twelfth National Sex Institute in April 1979 in Washington, D.C.

The general response of the physicians to the questionnaire was positive, there being agreement that they enjoyed the course and that it filled, in part, a large gap in their medical education. They indicated strong interest in participating in a course which had a direct, practical approach they could use in treating patients. They expressed need for more knowledge before they could feel capable of conducting even basic sex counseling with their patients. Particularly, the respondents believed that courses in human sexuality should become a permanent part of both the resident training program and of their ongoing medical education. Further, they expressed conviction that the course provided new insight in their personal lives and/or alleviated anxiety they felt in dealing with sexual issues. Finally, they reported a high percentage of sexual problems in their caseloads and acknowledged feelings of inadequacy in helping their patients deal with these problems.

The writer spent much time researching and evaluating

potential course content, keeping recommendations and suggestions in mind. A basic core curriculum was developed, consisting of minimal essential material. This was expanded with issues of particular concern in a clinic setting. Care was taken to insure that the course did not assume a high degree of prior knowledge about human sexuality, and that it was sufficiently flexible to allow a certain amount of "flow" in areas of particular audience interest or concern.

Field Testing the Model

Next came the need to fieldstudy the course, "polish" it and make final revisions. The writer was able to give the course a trial run, by offering it in a somewhat expanded version, to second year medical students in the College of Osteopathic Medicine at Michigan State University. Although this population was less knowledgeable and experienced than the family practice doctors and residents for which the course was being developed, it was felt that the level of knowledge and degree of sophistication was similar in both groups. Most family practice physicians and residents queried indicated that the human sexuality content in their medical school training had been minimal or absent beyond the anatomy and physiology of sexuality. The course was constructed so that more complex questions and concerns could be explored if appropriate.

The course information and outline is enclosed (see Appendix D). The experience with these osteopathic medical

students was invaluable in that it provided the writer with a highly-motivated, intelligent audience with which a new course could be tested, refined and improved.

The first three weeks of the class were concerned with introduction, presentation of sex education content, and discussion of attitudes and values. From this segment it became clear that one cannot assume that medical students or physicians are knowledgeable about sex. Although they seemed knowledgeable about the anatomy and physiology of sexuality, understanding of related skills, techniques and behavior was naive and often absent. The students could draw charts and explain in medical detail the impact of the various systems on sexuality and the secretions of the various glands, but found it difficult to discuss feelings, emotions and interpersonal behavior. Specifically, when they related the discussion to their own feelings, values and attitudes and the effect they might have on their patients, they shared feelings of fear, defensiveness and confusion. The need for a behavioral science approach to human sexuality became increasingly evident. However, it was also clear that the behavioral science framework needed to be oriented to a medical and physiological foundation in order for it to be heard and incorporated. This gradually became a frame of reference for both the class and the workshop to follow. Growing conviction of the importance of this segment prompted the writer to retain most of it and incorporate it into the workshop in a four-hour block, a third of the total program.

The fourth week was spent discussing the family and family systems theory. A segment of the University of Minnesota's "Couple Communication Course"[40] was presented to the class so that the students could get a feel of and participate in this experience of communication growth. In the workshop to follow, the family systems theory approach was interwoven into the entire presentation, rather than being presented as a separate component. The Couple Communication Course, however, was seen as particularly valuable, and so was retained and presented in a one-hour block in the workshop.

The fifth week was spent discussing the special problems associated with adolescence. This segment was considered important enough for one hour of the workshop to be devoted to it. The movie About Sex[41] was utilized in both the class and the workshop and it proved to be a good catalyst for discussion and feeling-sharing.

Alternate sexual preferences were discussed during the sixth week of the course. A two-hour movie, entitled Word is Out,[42] was used as a part of this presentation. Although the movie was an authentic presentation of "real people" who have chosen homosexuality as their sexual preference, it was too long and at times redundant. The class reacted with boredom and loss of interest. The students were receptive to the post-movie discussion on homosexuality and alternate sexual preferences, and were particularly interested in current theories of etiology. Because of some

emerging concern in the military, the writer decided to include a discussion of this issue in the workshop, but not to show the movie. Due to limitations of time, the decision was made to minimize the amount of attention given to homosexuality in order to maximize time spent on teaching the physicians skills and techniques they could use with their patients. Homosexuality is not a common problem encountered by military physicians, since current military policy leans toward discharge of homosexuals, once recognized, rather than coexistence.

The seventh and eighth weeks of the course were spent teaching the students assessment and primary level treatment techniques. The interest and motivation levels of the students were high during this phase of the course. They eagerly learned and asked for more. When each class ended, most students stayed to ask additional questions. The importance of this section was such that most of it was retained and incorporated into a three-hour-plus block of instruction in the later workshop. The continuing objective was to help them to develop skills, techniques and knowledge for use in helping their patients. A seldom verbalized message was that this information was also helpful to them as individuals, in their personal as well as professional relationships. The movie The Sexological Exam[43] was not, as its title implied, a graphic illustration of the sexological exam; hence, its purpose was not met. The movie was not included in the workshop presentation.

The ninth week of the course presentation was on the topic of sexuality in the later years. Geriatric sexuality is an area which is seldom discussed, often misunderstood, and concerning which many students tend to lean toward myths and stereotypes. The writer considered this segment to be critical for any health care practitioner, especially because of the general misunderstanding and lack of knowledge, and it was included in the final phase of the workshop presentation.

The Assistant Dean for Educational Research of the College of Osteopathic Medicine reported that the post-course evaluations were the highest of any course taught by any of their faculty that term. They further reported that the course was viewed by the students as an essential part of their medical education, and that such a course should be incorporated into the required medical school curriculum. (The evaluation summary is included in Appendix E.)

In the presentation of the model, the decision was made to avoid changing the content of the model, allowing modification of the time involved in certain subject areas and/or the method of presentation when appropriate, based on the needs and knowledge of the specific groups.

Based on the foregoing planning and development, the two-day workshop was now ready for implementation. The model was presented to and approved by the family practice consultant to the Surgeon General, Colonel Henry "Clay" Reister. (The course information and outline is included in

Appendix F.)

EVALUATION OF THE MODEL

Two objective pre- and post-course test instruments, post-course student evaluations and the researcher's clinical observations were utilized to evaluate the effectiveness of the workshop presentation.

Sexual Knowledge and Attitude Test

The primary instrument was the "Sex Knowledge and Attitude Test," commonly called the "SKAT," developed in its second edition by Harold I. Lief and David M. Reed of the Center for the Study of Sex Education in Medicine.[44] The SKAT has four parts: 1) attitudes, 2) knowledge, 3) demographic data, and 4) personal sexual behavior data. It has been administered to over 14,000 people of whom more than 8,000 are medical students. This study utilized the SKAT as a pre- and post-test with major emphasis on knowledge evaluation and a secondary emphasis on attitude assessment. Within the attitude portion of the SKAT, there is a further breakdown into four assessment scales. Lief describes the four scales as follows:

> The Heterosexual Relations Scale. This deals with an individual's general attitude toward pre- and extramarital heterosexual encounters. Individuals with high H-R scores (above 34) regard premarital sexual relations as acceptable or even desirable for both men and women. These individuals view extramarital relations as potentially benefiting rather than harming the marital relationships of those involved. Low scores (below 23) imply conservative attitudes in this area.

The Sexual Myths Scale. This deals with an individual's acceptance or rejection of commonly held misconceptions. High S-M scores (above 39) indicate a rejection of misconceptions. Low scores (below 30) indicate the acceptance of popular misconceptions.

The Abortion Scale. This deals with an individual's general, social, medical and legal feelings toward abortion. High A scores imply an orientation that treats abortion as being acceptable. Low scores suggest an orientation that treats abortion as unacceptable. Scores above 36 are considered high, and scores below 24 are viewed as low.

The Autoeroticism or M Scale. This deals with general attitudes toward the permissibility of masturbatory activities. Individuals with high scores (above 30) view autoerotic stimulation as healthy or acceptable. Low scores (below 22) imply an orientation that treats masturbation as an unhealthy practice.[45]

Part two of the SKAT consists of seventy-one questions of which fifty are designated test items. The remaining twenty-one questions are related to specific interest areas to allow the tester to check out certain lecture areas for class presentation.

The SKAT test has much data available for comparison of various populations or groups if desired. Although the SKAT was initially constructed for use in evaluating medical students before and after human sexuality coursework material, the questions are such that it can be used with maximal effectiveness within the CME course framework.

Miller Test

The secondary instrument was a twenty-question multiple-choice sexual knowledge test. It was developed by Dr. Paul R. Miller as a before-and-after test to be used in conjunction with his sound-slides module, entitled "Human Sexuality--Its Anatomy, Physiology and Psychology,"[46] which

was an integral part of the CME workshop presentation.

Course Evaluation Form

A third method of evaluation, the course evaluation form, was given to the participants at the end of the workshop presentation (see Appendix G). The format used for this evaluation was a slight revision of the student course evaluation form in use at Michigan State University in the College of Osteopathic Medicine. This form allowed direct feedback from the participants as to their assessment of the course content and the teaching style and presentation.

Clinical Observations of the Researcher

A fourth method of evaluation, clinical observations of the researcher, was included. In dealing with people in a classroom situation involving emotionally charged content, the researcher identified the importance of including this subjective, yet vital input as a part of the assessment procedures.

Analysis of the Data

The objective data were examined in terms of the hypotheses stated below. These hypotheses were developed for testing on the basis of pre-established SKAT and Miller test scoring format and the experiences of the researcher described in previous chapters.

Statistical Hypotheses:

Null Hypothesis I - There is no difference between pre- and post-test scores of family practice physicians concerning the attitude measured by the Heterosexual Relations scale (SKAT).

Null Hypothesis II - There is no difference between pre- and post-test scores of family practice physicians concerning the attitude measured by the Sexual Myths scale (SKAT).

Null Hypothesis III - There is no difference between pre- and post-test scores of family practice physicians concerning the attitude measured by the Abortion scale (SKAT).

Null Hypothesis IV - There is no difference between pre- and post-test scores of family practice physicians concerning the attitude measured by the Autoeroticism scale (SKAT).

Null Hypothesis V - There is no difference between pre- and post-test scores of family practice physicians concerning the sexual knowledge gain measured both by the SKAT and Miller tests.

Both the Miller and SKAT tests were analyzed with repeated measures analysis of variance, utilizing David J. Wright's program, "Profile."[47] The .05 level of significance was used as the criterion to reject null hypotheses.

The course evaluation forms were assessed using percentages and descriptive analysis, both individually by

hospital and as a total group.

The subjective clinical observations were purely descriptive reflecting the researcher's own personal views. They did however, add to the written data an additional dimension of both expressed and non-verbal attitudes on the part of the respondents, and therefore were considered when drawing any conclusions about the efficacy of the model which was developed.

CHAPTER IV

ANALYSIS OF DATA

This chapter will deal with assessment of the workshop experience. The written objective data will be presented first, incorporating the results of the two instruments employed in this study. The next section will present written subjective data obtained through the use of student course evaluation forms. Next, the clinical observations of the researcher will be presented and discussed. And finally, the researcher presents his summary and conclusions.

ANALYSIS OF OBJECTIVE DATA

As presented in Chapter I, the Miller and SKAT tests were given to every participant before and after the workshop. "Profile--A Fortran IV Program for the Analysis of Split-Plot Factorial or Groups by Repeated Measures Designs," by David J. Wright,[48] was the program utilized to facilitate statistical analysis of the test results. This program was particularly appropriate, as it concerned itself primarily with analyzing the differences between pre- and post-data within each hospital, and within the group of family practice physicians as a total group. Hence differences between hospitals were identifiable, as well as the statistical significance or non-significance of each measured factor within the

group as a whole.

Sexual Knowledge and Attitude Test

In addition to measuring knowledge, the SKAT test also measures attitudes. Four major attitudinal areas are assessed; heterosexual relations, sexual myths, abortion and autoeroticism. The respondents' conservatism or liberalism within these attitudinal areas is measured. In general, a high score in any of these four areas denotes a liberal, accepting attitude, whereas a low score indicates a more conservative or rigid view. Each of these attitudinal areas will be discussed separately, both as to their significance statistically and any possible indications.

Heterosexual Relations (HR).

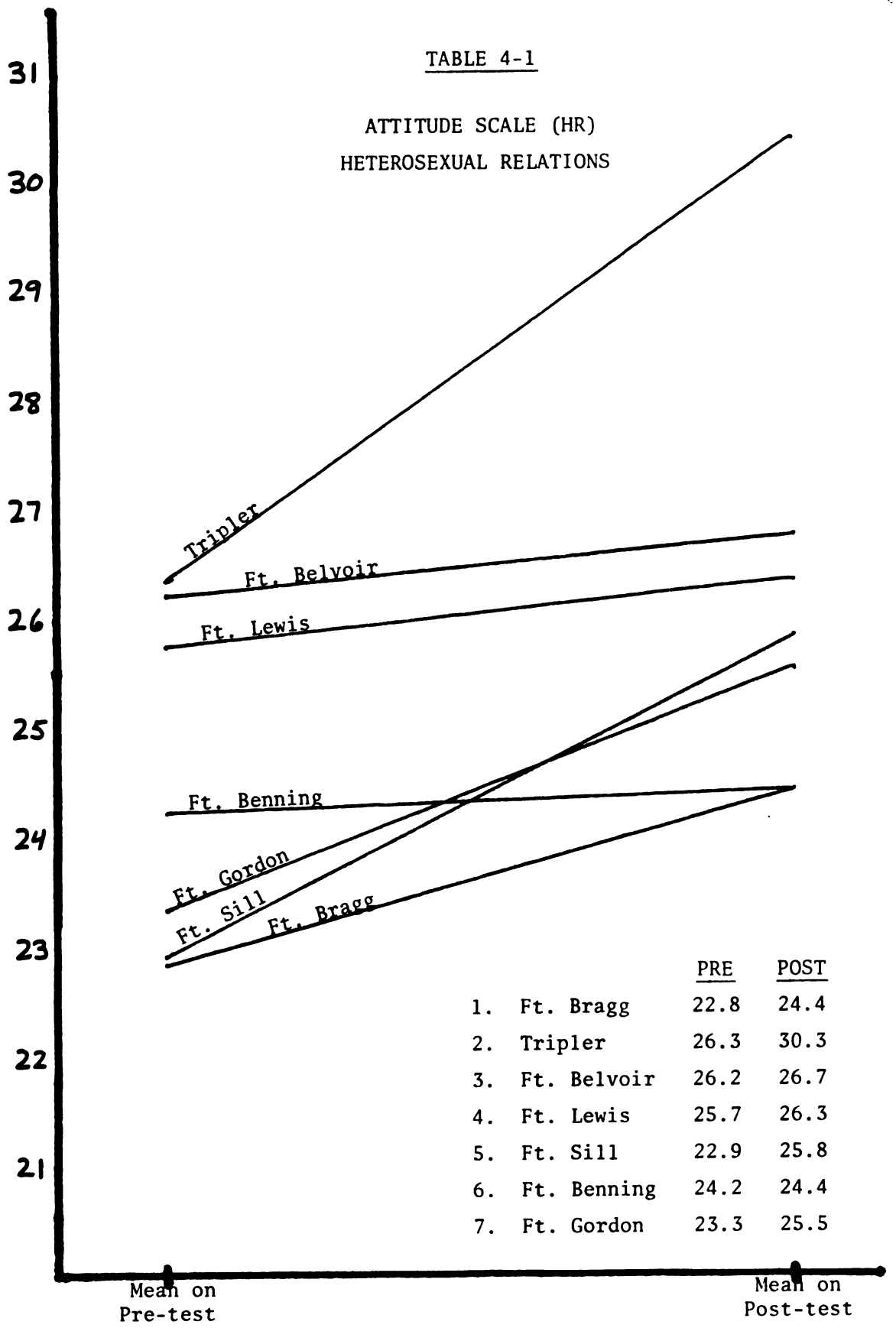
> The heterosexual relations scale deals with an individual's general attitude toward pre- and extramarital heterosexual encounters. Individuals with high H-R scores regard premarital sexual relations as acceptable, or even desirable, for both men and women. These individuals view extramarital relations as potentially benefiting rather than harming the marital relationships of those involved. Low scores imply conservative attitudes in this area.[49]

As can be seen in the HR graph (Table 401), although there is a difference in response from hospital to hospital, scores in each hospital did increase from pre- to post-test. Hence, an attitudinal change trending toward a more liberal outlook in this area did take place. The statistical breakdown (Table 4-2) illustrates the statistical significance of this difference, rejecting Null Hypothesis I.

Examining the graph on a hospital-by-hospital basis, it is noteworthy that the three hospitals located in the most

TABLE 4-1

ATTITUDE SCALE (HR)
HETEROSEXUAL RELATIONS



		PRE	POST
1.	Ft. Bragg	22.8	24.4
2.	Tripler	26.3	30.3
3.	Ft. Belvoir	26.2	26.7
4.	Ft. Lewis	25.7	26.3
5.	Ft. Sill	22.9	25.8
6.	Ft. Benning	24.2	24.4
7.	Ft. Gordon	23.3	25.5

TABLE 4-2

REPEATED MEASURES ANALYSIS OF VARIANCE
SUMMARY TABLE FOR ATTITUDE SCALE (HR)
HETEROSEXUAL RELATIONS

Source	df	MS	F	p - less than
Hospitals	6	176.1785	2.085	.10
Doctors within Hospitals	218	84.4987		
Post-test - Pre-test	1	332.8200	37.846	.01
(Post-test - Pre-test) x Hospitals	6	32.7648	3.726	.01
(Post-test - Pre-test) x Doctors within Hospitals	218	8.7940		
TOTAL	449			

liberal communities (Hawaii, Washington State and Washington, D.C. areas) started and finished with high scores, indicating a liberal and accepting response toward this attitude, in terms of the responses on the scale. The most liberal community (Hawaii) scored higher on the pre-test than most other hospitals on the post-test, and from that point made the greatest increase of any hospital. The most rigid hospital, Fort Benning, began in a conservative trend and remained at about the same level throughout the workshop. It is interesting that those groups of doctors residing in parts of the country tending to be more conservative are clustered at the lower end of the scale.

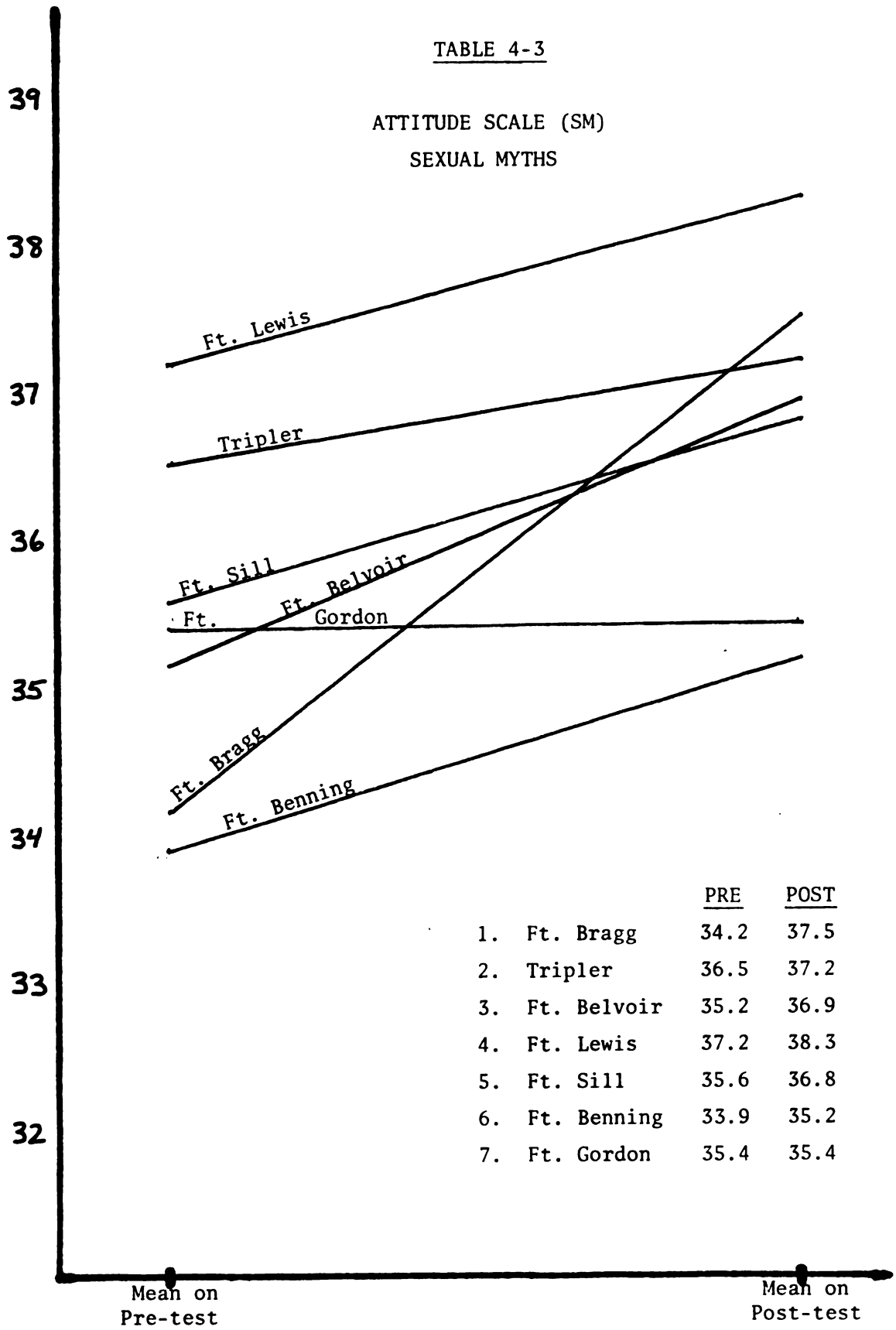
Sexual Myths (SM). "The sexual myths scale deals with an individual's acceptance or rejection of commonly held sexual misconceptions. High S-M scores indicate a rejection of misconceptions. Low scores indicate acceptance of popular misconceptions."[50] Again it is evident, when looking at the SM graph (Table 4-3), that although there is a difference in response from hospital to hospital, one hospital stayed the same and all other hospitals increased in their rejection of commonly held sexual myths from pre-test to post-test. The statistical breakdown (Table 4-4) illustrates the statistical significance of this finding, rejecting Null Hypothesis II.

Examination of the graph on a hospital-by-hospital basis reveals that the groups of doctors which tend to be located in liberal communities begin and end at a level above

TABLE 4-3

ATTITUDE SCALE (SM)

SEXUAL MYTHS



		PRE	POST
1.	Ft. Bragg	34.2	37.5
2.	Tripler	36.5	37.2
3.	Ft. Belvoir	35.2	36.9
4.	Ft. Lewis	37.2	38.3
5.	Ft. Sill	35.6	36.8
6.	Ft. Benning	33.9	35.2
7.	Ft. Gordon	35.4	35.4

TABLE 4-4

REPEATED MEASURES ANALYSIS OF VARIANCE
SUMMARY TABLE FOR ATTITUDE SCALE (SM)
SEXUAL MYTHS

Source	df	MS	F	p - less than
Hospitals	6	48.3574	1.785	.10
Doctors within Hospitals	218	38.2975		
Post-test - Pre-test	1	166.8356	26.088	.01
(Post-test - Pre-test) x Hospitals	6	14.6754	2.295	.05
(Post-test - Pre-test) x Doctors within Hospitals	218	6.3950		
TOTAL	449			

most of the others. The hospital at Fort Bragg, which was the lowest on the HR scale, both pre- and post-, showed a significant increase in knowledge in this important area. Sexual myths can be dispelled by knowledge. Fort Bragg is a good example of that fact. Interestingly, the majority of the hospitals (four out of seven) ended within a one-point spread at post-test. These same four hospitals had a 2½-point spread at pre-test.

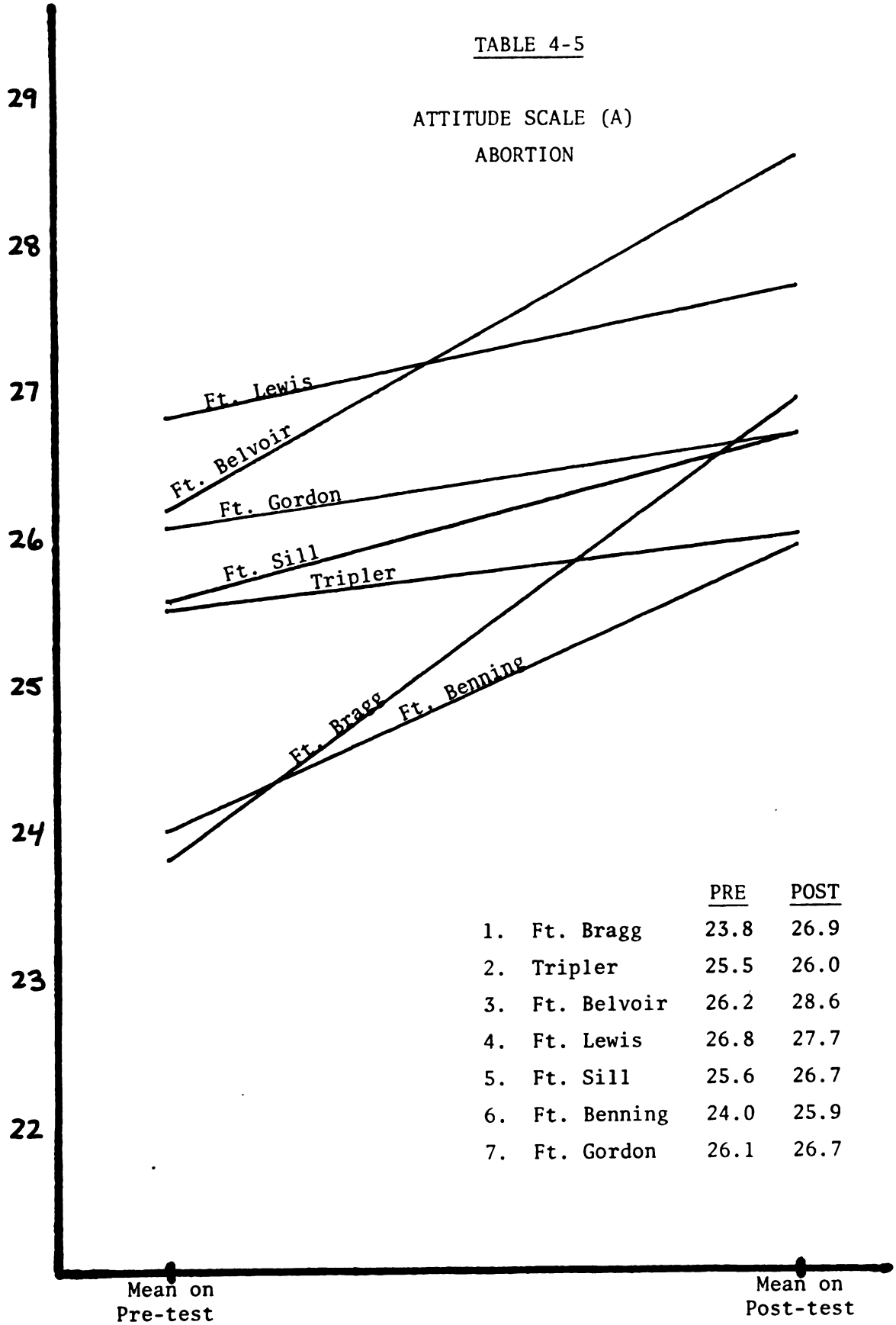
Abortion (A). "This scale deals with an individual's general social, medical and legal feelings toward abortion. High A scores imply an orientation which sees abortion as being acceptable."[51] Again, the difference in response from hospital to hospital is noted on the graph (Table 4-5), but all hospitals increase in their acceptance of abortion from pre-test to post-test. The statistical breakdown (Table 4-6) again illustrates the significance of this difference, rejecting Null Hypothesis III.

On a hospital-by-hospital breakdown, some interesting changes occurred with this attitude. Madigan (Washington State) and Belvoir (Washington, D.C. area) continued in their liberal, accepting attitude trend. Tripler (Hawaii), which had high scores on the last two attitudes, both began and ended in the low mid-range on this issue. Fort Bragg, which had low (conservative) scores on previous issues, was the most conservative on the pre-test, but increased to third from the top on the post-test. This follows the trend shown

TABLE 4-5

ATTITUDE SCALE (A)

ABORTION



		PRE	POST
1.	Ft. Bragg	23.8	26.9
2.	Tripler	25.5	26.0
3.	Ft. Belvoir	26.2	28.6
4.	Ft. Lewis	26.8	27.7
5.	Ft. Sill	25.6	26.7
6.	Ft. Benning	24.0	25.9
7.	Ft. Gordon	26.1	26.7

TABLE 4-6

REPEATED MEASURES ANALYSIS OF VARIANCE
SUMMARY TABLE FOR ATTITUDE SCALE (A)
ABORTION

Source	df	MS	F	p - less than
Hospitals	6	54.8986	1.715	.25
Doctors within Hospitals	218	32.0141		
Post-test - Pre-test	1	233.2800	37.666	.01
(Post-test - Pre-test) x Hospitals	6	13.9284	2.249	.05
(Post-test - Pre-test) x Doctors within Hospitals	218	6.1933		
TOTAL	449			

on the SM scale, indicating an impact on attitudes. Fort Belvoir (Washington, D.C. area) showed a similar increase from a high score (liberal) to the highest score.

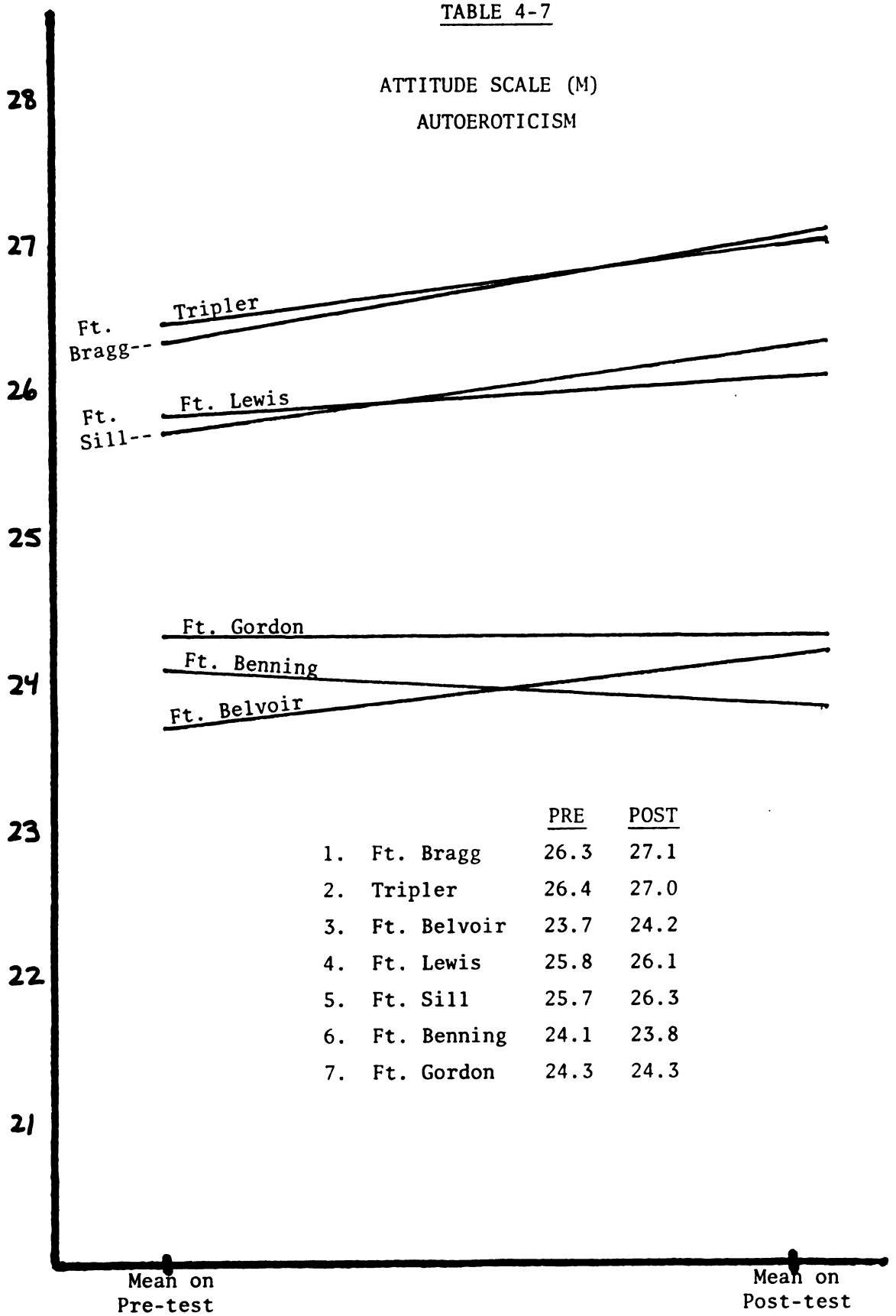
Abortion was not an issue discussed specifically during the workshop. More general areas, such as individual rights, acceptance of the needs and/or differences of others, an individual's right to his/her own sexuality, etcetera, were discussed and inevitably had a bearing on these responses. Physicians need to be able to deal with patients who are either conservative or liberal on this issue. The conservative physician might have some difficulty dealing with the liberal patient.

Autoeroticism (M). "The M scale deals with general attitudes toward the permissibility of masturbatory activities. Individuals with high scores view autoerotic stimulation as healthy or acceptable. Low scores imply an orientation which sees masturbation as an unhealthy practice."[52] As can be seen on the graph (Table 4-7), movement in either direction was minimal. The statistical chart (Table 4-8) also illustrates that due to the erratic up-and-down nature of the results, the finding for the group as a whole is not statistically significant. Null Hypothesis IV failed to be rejected. Throughout the workshop presentations this was an issue about which most physicians seemed to have rigid feelings; and whether those feelings were conservative or liberal, they were not negotiable. The stability of the responses from pre-test to post-test tends to confirm this

TABLE 4-7

ATTITUDE SCALE (M)

AUTOEROTICISM



		PRE	POST
1.	Ft. Bragg	26.3	27.1
2.	Tripler	26.4	27.0
3.	Ft. Belvoir	23.7	24.2
4.	Ft. Lewis	25.8	26.1
5.	Ft. Sill	25.7	26.3
6.	Ft. Benning	24.1	23.8
7.	Ft. Gordon	24.3	24.3

TABLE 4-8

REPEATED MEASURES ANALYSIS OF VARIANCE
SUMMARY TABLE FOR ATTITUDE SCALE (M)
AUTOEROTICISM

Source	df	MS	F	p - less than
Hospitals	6	102.5920	1.708	.25
Doctors within Hospitals	218	60.0572		
Post-test - Pre-test	1	11.5200	2.551	.05
(Post-test - Pre-test) x Hospitals	6	2.8519	.632	.5
(Post-test - Pre-test) x Doctors within Hospitals	218	4.5155		
TOTAL	449			

observation.

In every hospital the pre- and post-results were fairly constant, with little change. Autoeroticism seems to be an area, as mentioned above, that the workshop has not discernibly influenced either pro or con.

SKAT Sexual Knowledge (SK).

> Part II of the SKAT contains 71 questions; 50 of these questions are designated test items, the remaining 20 are lecture items. The 20 lecture items are not counted in the raw True/False score because they do not necessarily relate to the degree of sexual knowledge a person possesses. Lecture items are retained in SKAT, Part II because of their topical value in courses dealing with human sexuality.[53]

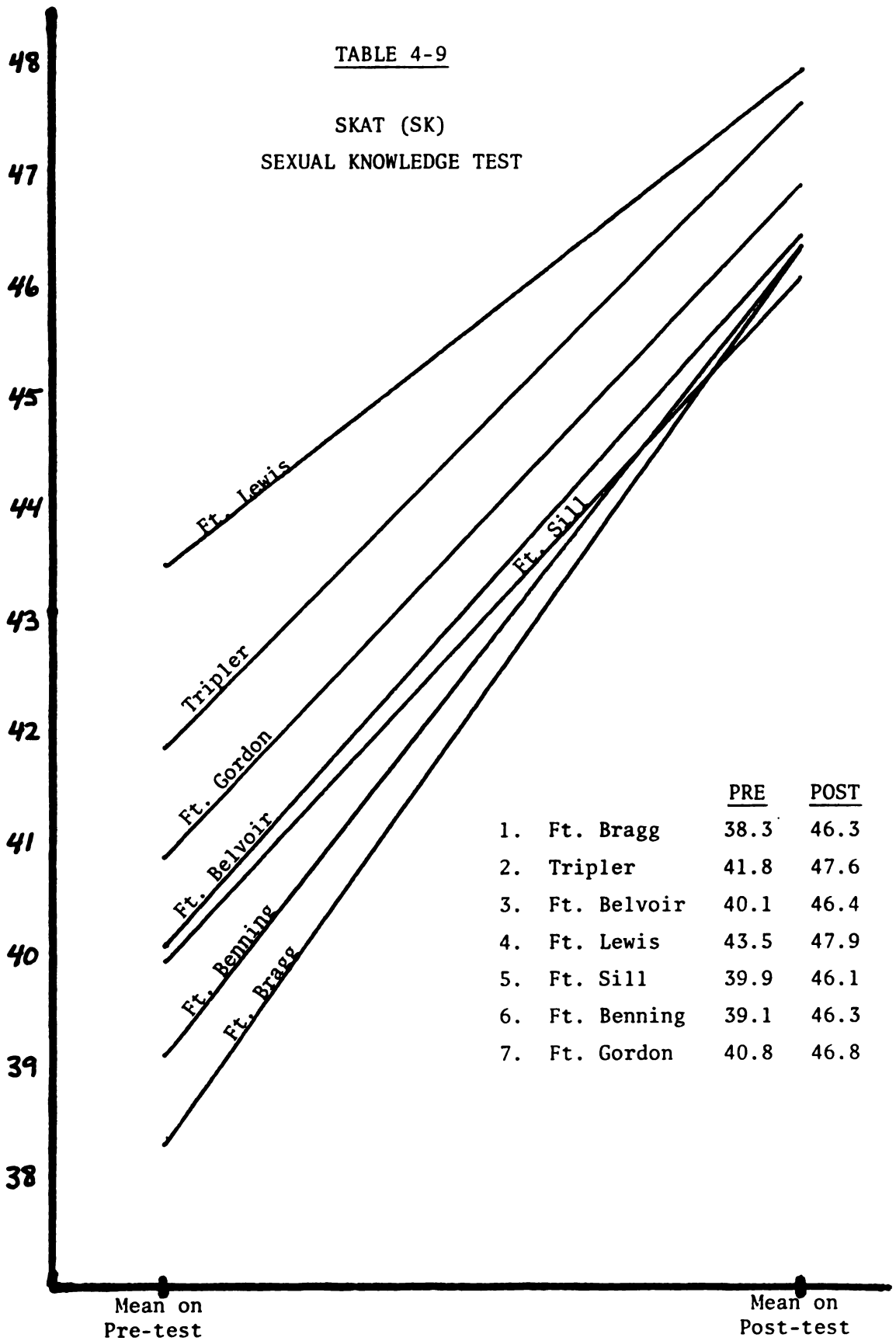
The graph (Table 4-9) and the statistical breakdown (Table 4-10) illustrate both the numerical and statistical significance of the sexual knowledge gained between the pre- and post-tests, rejecting Null Hypothesis V. All hospitals showed a consistent and measurable knowledge gain. This is particularly significant, since the lectures were not keyed to answering SKAT questions, but were instead concerned with meeting the needs and answering the questions of the family practice physician participants. This suggests that the workshop was a useful learning experience and the instrument was an effective measuring device.

Examination of the results on a hospital-by-hospital basis reveals Madigan Army Medical Center in Washington State scored higher than the other hospitals, both in pre- and post-course testing. Madigan is the one hospital which has ongoing consultation and teaching in the area of human

TABLE 4-9

SKAT (SK)

SEXUAL KNOWLEDGE TEST



		PRE	POST
1.	Ft. Bragg	38.3	46.3
2.	Tripler	41.8	47.6
3.	Ft. Belvoir	40.1	46.4
4.	Ft. Lewis	43.5	47.9
5.	Ft. Sill	39.9	46.1
6.	Ft. Benning	39.1	46.3
7.	Ft. Gordon	40.8	46.8

TABLE 4-10

REPEATED MEASURES ANALYSIS OF VARIANCE
SUMMARY TABLE FOR SKAT (SK)
SEXUAL KNOWLEDGE TEST

Source	df	MS	F	p - less than
Hospitals	6	84.6665	4.045	.01
Doctors within Hospitals	218	20.9333		
Post-test - Pre-test	1	4468.2756	491.655	.01
(Post-test - Pre-test) x Hospitals	6	17.7481	1.953	.10
(Post-test - Pre-test) x Doctors within Hospitals	218	9.0882		
TOTAL	449			

sexuality. Although the knowledge of the workshop participants at pre-course testing was at a higher level than that at the other hospitals, their level of learning was at the same rate of acceleration, placing them still higher at post-course testing. The next three hospitals, at both pre- and post-course testing, had some previous human sexuality input, either occasional lectures or from a previous staff member with some training in this specialty area. The three low-score hospitals had no previous input in the area of human sexuality, but showed significant gains as a result of this workshop. The figures show that the workshop influenced all participants with an increase in knowledge level.

Miller Sexual Knowledge Test (MK)

The Miller Sexual Knowledge Test is a small, twenty-question objective test provided by Dr. Miller as an adjunct to be used with his human sexuality sex education narrated slide series,[54] as a means of testing (pre- and post-) knowledge in the area which the slide presentation specifically addresses. The test is keyed directly to the narrated slide presentation and all questions asked on the test are answered during the presentation. The test measures knowledge level prior to the presentation and then measures how much of the new information and knowledge is retained by the participant. That all questions are answered during the presentation, is evident in the high score increase from pre-course to post-course testing. The value of this presentation as a learning instrument is further emphasized.

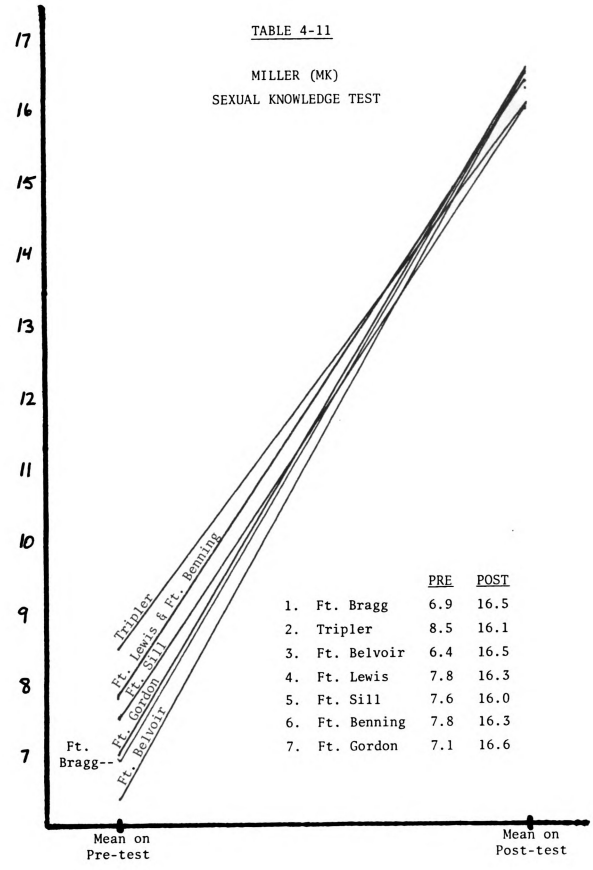
All hospitals averaged more than six, and less than nine right answers on the pre-test, while all averaged from fifteen to seventeen right answers on the post-test. The significance of this difference is illustrated by both the graph (Table 4-11) and the statistical breakdown (Table 4-12), which further rejects Null Hypothesis V. The scores are clumped so closely for both the pre- and the post-test, that caution suggests deducing only that the physicians had fairly consistent lack of knowledge of this material prior to the presentation, and then had fairly consistent knowledge gain as a result of the presentation.

Summary

Considering the workshop as a whole, it is clear from the results of pre-course and post-course testing that the presentation influenced the participants not only in the area of knowledge gain, which was reflected in the rejection of Null Hypothesis V, but also in the more sensitive and complex areas of sexual attitudes and awareness. Three out of four measured attitudinal issues showed statistically significant increases with resultant rejected null hypotheses, indicating increasing awareness and acceptance of these emotionally laden areas. The importance of acceptance of persons with differing ideas, behavior or alternate sexual preferences was an underlying theme of the workshop, with the accompanying implicit message that the physician's role is not one of judge and jury, but of helper and facilitator.

TABLE 4-11

MILLER (MK)
SEXUAL KNOWLEDGE TEST



		PRE	POST
1.	Ft. Bragg	6.9	16.5
2.	Tripler	8.5	16.1
3.	Ft. Belvoir	6.4	16.5
4.	Ft. Lewis	7.8	16.3
5.	Ft. Sill	7.6	16.0
6.	Ft. Benning	7.8	16.3
7.	Ft. Gordon	7.1	16.6

TABLE 4-12

REPEATED MEASURES ANALYSIS OF VARIANCE
SUMMARY TABLE FOR MILLER (MK)
SEXUAL KNOWLEDGE TEST

Source	df	MS	F	p - less than
Hospitals	6	4.9872	.388	.5
Doctors within Hospitals	218	8.5246		
Post-test - Pre-test	1	8844.5000	1746.388	.001
(Post-test - Pre-test) x Hospital	6	11.8249	2.355	.05
(Post-test - Pre-test) x Doctors within Hospitals	218	5.0645		
TOTAL	449			

ANALYSIS OF SUBJECTIVE DATA

Student Course Evaluation

A second manner of assessing the workshop presentation was in the form of evaluations by the participants. The format used at Michigan State University for student course evaluation was adapted (see Appendix G for evaluation form). Charts are included in this study, both hospital-by-hospital (Tables 4-13 through 4-19) and in summary (Table 4-20). Assessment was facilitated through the use of percentages and descriptive analysis. The evaluations were completed at the conclusion of each workshop. Written comments, when made, are also included.

Looking at the summary of all seven hospitals (Table 4-20), it is evident that the family practice residents and staff were pleased with the workshop presentation. Ninety-six percent of the physicians agreed that the workshop was useful to them personally, while 98 percent saw it as useful professionally. Many of the participants confided that it was very hard for them to look at and deal with their own sexuality, hence the difficulty in assisting their patients in an area with which they are personally uncomfortable. Ninety-two percent of the respondents indicated that the workshop was an important part of their residency training or continuing medical education. This figure could be higher, as several staff physicians mentioned afterward that they marked "disagree" on the paper because they were not residents. Ninety-eight percent felt that the program should

TABLE 4-13

COURSE EVALUATION SUMMARY
Womack Army Hospital - Fort Bragg, North Carolina

0 = Strongly Agree
1 = Agree
2 = Disagree
3 = Strongly Disagree

Number of Participants Responding: 24

Instructor: Major Ronald G. Aldridge

		Response in %			
		0	1	2	3
1.	The material presented in this workshop was useful to me as an individual.	50	42	8	0
2.	The material presented in this workshop was useful to me professionally.	54	42	4	0
3.	This workshop was an important part of my residency training program or my continuing medical education.	58	29	13	0
4.	Courses in this specialty area should be regularly offered as a part of the Army's CME program.	66	34	0	0
5.	This instructor's style of presentation was stimulating and interesting.	58	42	0	0
6.	This instructor provided us with incentive for further study and investigation.	62	25	13	0
7.	This instructor appeared to be concerned that workshop participants learn and gain from class presentations.	54	46	0	0
8.	This instructor seemed to be both competent and knowledgeable about the material covered.	87	13	0	0
9.	This instructor provided me with the opportunity to gain a broad knowledge base in this area on which to build.	54	42	4	0
10.	This instructor related well with the course participants.	71	29	0	0

COURSE EVALUATION

Womack Army Hospital
Fort Bragg, North Carolina

Written Comments

Important subject for military physicians, especially in respect to the increase of women to the military.

Very professional, open to gearing workshop to needs of group, very effective in his methodology. It would be well to have ongoing training to insure all significant groups in the helping fields opportunity for awareness and skill development. Extremely well done--outstanding presentation (variety) of material.

I personally believe this training needs to be widely available to other professionals in the Army besides Medical Corps doctors. Chaplain, social workers and counselors need this training and much more in the area of human sexuality to be able to help their clients in areas of their lives where they are really hurting. I believe the Army needs to train sex therapists. There would be more functional soldiers and happier families if these basic issues could be resolved.

TABLE 4-14

COURSE EVALUATION SUMMARY
Tripler Army Medical Center - Honolulu, Hawaii

0 = Strongly Agree
1 = Agree
2 = Disagree
3 = Strongly Disagree

Number of Participants Responding: 32

Instructor: Major Ronald G. Aldridge

		Response in %			
		0	1	2	3
1.	The material presented in this workshop was useful to me as an individual.	56	44	0	0
2.	The material presented in this workshop was useful to me professionally.	63	37	0	0
3.	This workshop was an important part of my residency training program or my continuing medical education.	63	37	0	0
4.	Courses in this specialty area should be regularly offered as a part of the Army's CME program.	50	50	0	0
5.	This instructor's style of presentation was stimulating and interesting.	75	22	3	0
6.	This instructor provided us with incentive for further study and investigation.	50	50	0	0
7.	This instructor appeared to be concerned that workshop participants learn and gain from class presentations.	63	37	0	0
8.	This instructor seemed to be both competent and knowledgeable about the material covered.	84	16	0	0
9.	This instructor provided me with the opportunity to gain a broad knowledge base in this area on which to build.	69	25	6	0
10.	This instructor related well with the course participants.	75	22	3	0

COURSE EVALUATION

Tripler Army Medical Center
Honolulu, Hawaii

Written Comments

Very good experience.

Enjoyed course very much. Local residency training program deficient in sexuality and sex R_x. Would like some form of ongoing training.

TABLE 4-15

COURSE EVALUATION SUMMARY
Dewitt Army Hospital - Fort Belvoir, Virginia

0 = Strongly Agree
1 = Agree
2 = Disagree
3 = Strongly Disagree

Number of Participants Responding: 33

Instructor: Major Ronald G. Aldridge

		Response in %			
		0	1	2	3
1.	The material presented in this workshop was useful to me as an individual.	67	30	3	0
2.	The material presented in this workshop was useful to me professionally.	64	36	0	0
3.	This workshop was an important part of my residency training program or my continuing medical education.	64	33	3	0
4.	Courses in this specialty area should be regularly offered as a part of the Army's CME program.	67	33	0	0
5.	This instructor's style of presentation was stimulating and interesting.	48	42	0	0
6.	This instructor provided us with incentive for further study and investigation.	55	45	0	0
7.	This instructor appeared to be concerned that workshop participants learn and gain from class presentations.	64	36	0	0
8.	This instructor seemed to be both competent and knowledgeable about the material covered.	79	21	0	0
9.	This instructor provided me with the opportunity to gain a broad knowledge base in this area on which to build.	61	33	6	0
10.	This instructor related well with the course participants.	76	24	0	0

COURSE EVALUATION

Dewitt Army Hospital
Fort Belvoir, Virginia

Written Comments

Most such conferences are a waste of time--yours was very good and I stayed!!

Try using more small groups to get discussion to open up at the beginning.

Thought the communication workshop material was especially useful.

Enjoyed the course very much. Possibly could be more treatment oriented, which would probably lengthen the course.

I think this is an extremely valuable personal and professional experience--which has not been presented in medical schools. I would strongly encourage a review like this at regular intervals, particularly for family practice residency and staff training.

TABLE 4-16

COURSE EVALUATION SUMMARY
Madigan Army Medical Center - Fort Lewis, Washington

0 = Strongly Agree
1 = Agree
2 = Disagree
3 = Strongly Disagree

Number of Participants Responding: 26

Instructor: Major Ronald G. Aldridge

		Response in %			
		0	1	2	3
1.	The material presented in this workshop was useful to me as an individual.	42	54	4	0
2.	The material presented in this workshop was useful to me professionally.	54	46	0	0
3.	This workshop was an important part of my residency training program or my continuing medical education.	58	38	4	0
4.	Courses in this specialty area should be regularly offered as a part of the Army's CME program.	65	31	4	0
5.	This instructor's style of presentation was stimulating and interesting.	42	46	12	0
6.	This instructor provided us with incentive for further study and investigation.	27	58	15	0
7.	This instructor appeared to be concerned that workshop participants learn and gain from class presentations.	58	38	4	0
8.	This instructor seemed to be both competent and knowledgeable about the material covered.	77	23	0	0
9.	This instructor provided me with the opportunity to gain a broad knowledge base in this area on which to build.	50	50	0	0
10.	This instructor related well with the course participants.	62	38	0	0

COURSE EVALUATION

Madigan Army Medical Center
Fort Lewis, Washington

Written Comments

My third course. Done well. Need some new flicks.

Good job!!

Presentation too slow at times, not to the point, otherwise well done.

Need mandatory attendance by all doctors, not just the courageous enlightened few.

TABLE 4-17

COURSE EVALUATION SUMMARY
MEDDAC - Fort Sill, Oklahoma

0 = Strongly Agree
1 = Agree
2 = Disagree
3 = Strongly Disagree

Number of Participants Responding: 34

Instructor: Major Ronald G. Aldridge

		Response in %			
		0	1	2	3
1.	The material presented in this workshop was useful to me as an individual.	59	32	9	0
2.	The material presented in this workshop was useful to me professionally.	59	38	3	0
3.	This workshop was an important part of my residency training program or my continuing medical education.	47	38	15	0
4.	Courses in this specialty area should be regularly offered as a part of the Army's CME program.	68	29	3	0
5.	This instructor's style of presentation was stimulating and interesting.	50	41	9	0
6.	This instructor provided us with incentive for further study and investigation.	47	44	9	0
7.	This instructor appeared to be concerned that workshop participants learn and gain from class presentations.	50	47	3	0
8.	This instructor seemed to be both competent and knowledgeable about the material covered.	62	38	0	0
9.	This instructor provided me with the opportunity to gain a broad knowledge base in this area on which to build.	44	50	6	0
10.	This instructor related well with the course participants.	56	44	0	0

COURSE EVALUATION

MEDDAC
Fort Sill, Oklahoma

Written Comments

Outstanding. Well done.

I particularly enjoyed the scope of the information covered. Thankfully now I have more of an idea of what I don't know.

Okay, well done--non-prejudiced and professional valuative presentation.

TABLE 4-18

COURSE EVALUATION SUMMARY
Martin Army Hospital - Fort Benning, Georgia

0 = Strongly Agree
1 = Agree
2 = Disagree
3 = Strongly Disagree

Number of Participants Responding: 40

Instructor: Major Ronald G. Aldridge

		Response in %			
		0	1	2	3
1.	The material presented in this workshop was useful to me as an individual.	38	57	5	0
2.	The material presented in this workshop was useful to me professionally.	50	47	3	0
3.	This workshop was an important part of my residency training program or my continuing medical education.	45	45	10	0
4.	Courses in this specialty area should be regularly offered as a part of the Army's CME program.	50	50	0	0
5.	This instructor's style of presentation was stimulating and interesting.	38	62	0	0
6.	This instructor provided us with incentive for further study and investigation.	30	53	17	0
7.	This instructor appeared to be concerned that workshop participants learn and gain from class presentations.	40	60	0	0
8.	This instructor seemed to be both competent and knowledgeable about the material covered.	57	43	0	0
9.	This instructor provided me with the opportunity to gain a broad knowledge base in this area on which to build.	35	65	0	0
10.	This instructor related well with the course participants.	53	47	0	0

COURSE EVALUATION

Martin Army Hospital
Fort Benning, Georgia

Written Comments

Very good. Many of SKAT questions are vague and hard to answer.

Would like more instruction on actual therapy for male and female dysfunctions.

Excellent workshop. Much needed! Would recommend continuation. I think a suggestion for future coordinators would be to hold the workshop outside the hospital, perhaps the O.C., this would cut down the traffic in and out, which was distracting. The temptation is to get some work done during breaks, then finding yourself come in late. I was disappointed the handouts were not available prior to the last afternoon. You do good work, Ron!!

TABLE 4-19

COURSE EVALUATION SUMMARY
Dwight D. Eisenhower Army Medical Center - Fort Gordon, Georgia

0 = Strongly Agree
1 = Agree
2 = Disagree
3 = Strongly Disagree

Number of Participants Responding: 36

Instructor: Major Ronald G. Aldridge

		Response in %			
		0	1	2	3
1.	The material presented in this workshop was useful to me as an individual.	64	33	3	0
2.	The material presented in this workshop was useful to me professionally.	53	47	0	0
3.	This workshop was an important part of my residency training program or my continuing medical education.	56	33	11	0
4.	Courses in this specialty area should be regularly offered as a part of the Army's CME program.	67	30	3	0
5.	This instructor's style of presentation was stimulating and interesting.	56	38	6	0
6.	This instructor provided us with incentive for further study and investigation.	51	38	11	0
7.	This instructor appeared to be concerned that workshop participants learn and gain from class presentations.	53	41	6	0
8.	This instructor seemed to be both competent and knowledgeable about the material covered.	69	28	3	0
9.	This instructor provided me with the opportunity to gain a broad knowledge base in this area on which to build.	50	44	6	0
10.	This instructor related well with the course participants.	64	33	3	0

COURSE EVALUATION

Dwight D. Eisenhower
Army Medical Center
Fort Gordon, Georgia

Written Comments

Program needs to be offered to nurses and nursing staff. Their interactions are more frequent and intense than that of the physician and other health providers.

Handout very appreciated--we too frequently don't get one. Good seminar. Good luck, Ron.

Super.

I enjoyed the presentation. I especially am awed and interested in the fact that this is one of the psych fields that boasts a large amount of cures.

The material presented is all very basic to everyone present. I don't feel I learned anything I didn't already know.

Well organized presentation. Very good!!

Well organized educational program that provided a significant amount of practical material. Instructor did an outstanding job relating to and involving the course participants. This type of program should be planned for every family practice program on a continuing basis.

TABLE 4-20

COURSE EVALUATION SUMMARY
All Seven Hospitals

0 = Strongly Agree
1 = Agree
2 = Disagree
3 = Strongly Disagree

Number of Participants Responding: 225

Instructor: Major Ronald G. Aldridge

		Response in %			
		0	1	2	3
1.	The material presented in this workshop was useful to me as an individual.	54	42	4	0
2.	The material presented in this workshop was useful to me professionally.	57	41	2	0
3.	This workshop was an important part of my residency training program or my continuing medical education.	55	37	8	0
4.	Courses in this specialty area should be regularly offered as a part of the Army's CME program.	61	37	2	0
5.	This instructor's style of presentation was stimulating and interesting.	53	43	4	0
6.	This instructor provided us with incentive for further study and investigation.	45	45	10	0
7.	This instructor appeared to be concerned that workshop participants learn and gain from class presentations.	54	44	2	0
8.	This instructor seemed to be both competent and knowledgeable about the material covered.	73	26	1	0
9.	This instructor provided me with the opportunity to gain a broad knowledge base in this area on which to build.	51	45	4	0
10.	This instructor related well with the course participants.	64	35	1	0

be regularly offered as a part of the Army's continuing medical education program.

The last six questions related to the instructor's style, motivation, competency and ability to teach and relate to the course participants. The only area which showed more than a 4 percent disagreement factor was question six, which says "This instructor provided us with incentive for further study and investigation." Motivation for further study should come from within more than from without, so this was probably a poor question. Even so, 90 percent of the participants marked "agreement" to this question.

The participants indicated verbally and on the anonymous course evaluations that they were both pleased and excited by the course presentation, and all hospitals indicated a desire to have the course presented again to the next group of family practice residents. Six of the seven hospitals requested either a repeat of the workshop for other disciplines within the hospital, or a follow-up course for the course participants themselves. The seventh hospital requested consultation to help the staff set up their own training program in this area.

Clinical Observations of the Researcher

Because of the nature of this program being clinical and both instructor and participants being clinicians, the researcher is departing from the usual third-person method of presenting data to present these observations in the more

personal first person.

Fort Bragg, North Carolina. The first hospital visited was Womack Army Hospital at Fort Bragg, North Carolina. The reception was warm and friendly, and the doctors seemed motivated and eager. The family practice clinic was totally shut down, except for emergencies, during the two-day workshop, which allowed consistency and minimal interruption. The workshop was held in the family practice clinic's conference room, which gave the doctors a familiar, comfortable and intimate surrounding, while allowing work to take place. The only "outsiders" involved in the conference were two chaplains and two social work specialists, all of whom had a direct role in support of the family practice program.

Major issues of concern at Fort Bragg were those of homosexuality and alternate sexual preferences. These were particularly pertinent to this group because its members were currently involved with a court case concerning an Air Force officer who was being evaluated for discharge due to his homosexuality preference. The physicians were interested in current theories of etiology and "normalcy." This was an issue that was emotionally laden for them. Other issues relating to values and beliefs were discussed; such as infidelity, open marriage, group sex, treating a married man or woman for venereal disease and the issues associated with this. The course seemed to provide an opportunity or vehicle within which the physicians could dialogue about issues that might have otherwise been difficult or impossible for them

to talk about. Fort Bragg is in an area where the general tone seemed to be one of conservatism.

This group seemed particularly interested in the segment within which the University of Minnesota's "Couple Communication Course" was presented. The staff was interested in this concept, to the point of asking if it would be possible to have the entire "CC" workshop presented to their staff at their expense. This first presentation of the workshop went well, and the course seemed to flow and achieve closure as designed.

Tripler Army Medical Center, Hawaii. The second major hospital visited was Tripler Army Medical Center in Honolulu, Hawaii. This was the largest hospital visited and the greatest distance traveled. The format of the presentation was, in general, the same but the course was split and taught over three shorter days, rather than two long days. The commander requested this change, as he felt he could not shut down the family practice clinic completely. The revised arrangement allowed doctors to attend sick-call each morning prior to the start of the workshop. There was no change in the number of hours or in the course content.

In addition to the family practice staff and residents, the course was opened to mental health staff and OB/GYN clinic staff. The OB/GYN clinic staff was present almost in total, adding twenty-two more participants. The mental health staff added only three participants. Although these two groups were tested, their data are not included

in this study.

The setting for this workshop was quite different, in that it was presented in a large auditorium similar to the typical movie theater. A difficulty I soon noted was in getting audience participation, which is an important part of my teaching style. It was necessary to reach out to them more, in order to involve them in the course presentation.

The "personality" of the OB/GYN staff at this hospital seemed more rigid and less holistic than that of the family practice staff. This difference was used to promote intra-audience participation, but it required additional energy and control on the part of the instructor.

The course content was well received by both groups, and the course material flowed well in spite of the three-day presentation instead of the normal two-day approach. The size of the audience made instruction more difficult, but the effect and result seemed the same when comparing this presentation to the previous one at Fort Bragg, and later to the presentations at other military hospitals which followed.

The staff at Tripler was less concerned with the issue of homosexuality, and more concerned with specific treatment techniques for reversal of sexual dysfunction. During the discussion session, most topics were clinical and empirical in nature. This group was more concerned with the "how-to" of problem resolution, rather than etiology or related

emotional trauma. This trend seemed due to the OB/GYN influence, as some behavioral science and holistic concerns came from the family practice staff. The expressed views of most health care staff members at this hospital reflected permissiveness and liberality, as opposed to those of the staff at Fort Bragg. The staffs of these two hospitals seemed to be at opposite ends of a continuum with respect to their attitudes and approaches to the workshop content, with the staffs of the other hospitals visited falling somewhere in between.

Fort Belvoir, Virginia. Hospital number three was Dewitt Army Hospital, located at Fort Belvoir, Virginia. Although a few of the staff had taken part in the AASECT course two years previously, the majority of the staff had left since then, and all of the residents were new.

The course was presented over two full days in the hospital's main conference room. The general atmosphere was one of closeness and informality, promoting active and relaxed discussion. Participation in the workshop was limited to family practice staff, including two civilian family practice physicians, as well as two members of the mental health clinic who were not support members of the family practice residency.

During the discussion period, the group was principally concerned with the issue of homosexuality. They cited many of their own cases, seeking consultation. The discussion hour became more of an open forum and case conference. Homosexuality and the Army's method of reacting to and

dealing with it was of general concern. The one-hour presentation on adolescence became another area of high interest, particularly with respect to sexual acting out and dissemination of birth control materials. This workshop seemed to flow particularly well, due in large part to the relaxed surroundings and the comfort level of both the instructor and the participants.

Fort Lewis, Washington. Madigan Army Medical Center at Fort Lewis, Washington was hospital number four. This is a very large hospital similar to Tripler in patient population, with each clinic or hospital section in a different building, as are the wards. The workshop was held in the family practice clinic classroom, which was small but both intimate and convenient. Participation was limited to family practice residents and staff, assigned nursing personnel and social work support staff. The members of the group knew each other well and were comfortable with the subject matter, the environment and each other. The general tone of this physician group seemed to be one of openness and acceptance. A high level of intra-clinic esprit de corps was particularly evident at this hospital.

Concerns during the open discussion hour centered more around social and moral issues, particularly within the military. Homosexuality, again, emerged as an issue, this time with emphasis on the rights of homosexuals as individuals. Discussion also developed around the treatment of

families as units, rather than the treatment of family members as individuals. It became evident that this group of physicians had received human sexuality seminars in the past, and was able to build on that previous knowledge. The level of questions was advanced and reflected skill in dealing with sexual dysfunction, which was not present at other hospitals. The staff was both friendly and hospitable.

Fort Sill, Oklahoma. Reynolds Army Hospital at Fort Sill, Oklahoma was the fifth hospital to take part in the workshop. It became apparent that Fort Sill's geographic isolation is a major morale factor at the hospital. Many staff members have said, however, that they soon gradually become accustomed to the slower lifestyle and lower standard of living. At the end of my stay there, I found myself actually assessing Fort Sill as a potential future assignment, a possibility I would have discounted my first day there.

The workshop was held in the main hospital conference room, which was a medium-sized room with good location, good lighting and excellent audio-visual equipment. The workshop was well advertised and had at least representative participation from most clinics, with the family practice staff and residents present in total. The multi-disciplinary makeup of the group seemed to enrich the discussion, but was more difficult to control. The course, however, flowed well and was evaluated as a highly positive experience by the participants.

The discussion hour was spent discussing a variety of sexually related difficulties, many of which had to do with hospital and clinic concerns. Issues such as, "What do you do if you walk into a patient's room while he is masturbating?", "What about the fourteen-year-old kid who is sexually active and wants to take the pill?", "How about the spinal cord injury patient and his returning sexual desires?" and "How does a physician handle being sexually propositioned by a patient?" The staff seemed very dedicated to their work and their patients, which was apparent throughout the workshop.

Fort Benning, Georgia. Hospital number six was located at Fort Benning, Georgia. Fort Benning is known as "the home of the infantry," and is a post which emphasizes military bearing and discipline. This resulted in some additional concerns which came out particularly during the open discussion, and generally throughout the workshop.

The workshop was held in the family practice conference room, which was a medium-sized classroom. The chairs were movable, but uncomfortable. Attendance at the workshop was primarily by family practice staff and support personnel. Also in attendance were members of the social work service and the community mental health center. The participants seemed highly motivated to participate in the classroom situation. This was the only workshop during the series where all participants were assembled and ready to begin on time. This was probably related to the higher level of discipline

in this hospital. The tone of the geographic community was that of Southern Baptist conservatism and patriotism. The community's support of the military was evident and was seen by the residents as an extremely important morale factor for them.

During the discussion session most of the time was spent discussing military role expectations and their relation to sexual dysfunction (see Appendix H). The importance of "being a man" and being "macho" is particularly evident in line-fighting units such as those trained and stationed at Fort Benning. Unrealistic superman expectations are strived for and, when not reached, may result in depression, lowered self-image, self-questioning and/or sexual dysfunction. Even the physicians and hospital staff buy into these expectations, to a degree, and often reinforce them. The workshop went well, and both attendance and participation were maximal.

Fort Gordon, Georgia. The last hospital studied was the Dwight D. Eisenhower Army Medical Center at Fort Gordon, Georgia. This hospital is also located in a conservative Southern Baptist community. The pace of living is slow, and the hospitality is southern at its best. Patriotism is strong and the prevalent belief seems to be that it is definitely "American" to be a soldier. The costs of living and of housing are minimal, so the average soldier and his/her family can live comfortably on income.

The course was held in a small auditorium that had

the latest audio-visual equipment. Anything needed was immediately made available and the warmth and congeniality of the staff were noteworthy. Participation was a joint event between the hospital social work service and the family practice clinic. In addition, physician members of both the OB/GYN and urology clinics were in attendance, as well as residents.

During the discussion session the group was particularly concerned with specialized methods of treatment for specific sexual dysfunctions. The session was primarily clinical in nature and patient care oriented. Homosexuality within the military was a topic of minor concern. Additional questions were related to the chronic long-term inpatient and his or her sexual needs. The group was verbal, responsive and involved fully in all sessions. This hospital had a nationally certified sex therapist as chief of social work service until two years prior to the workshop, and many of his programs and ideas were still in use. This group's openness, comfort and knowledge level seemed greater than that of the other hospitals visited.

Summary. The course content was essentially the same at all hospitals where the workshop was presented. Specific focus and approach were modified according to the needs of the participants and the learning of the instructor during the fieldstudy itself. At each hospital, the workshop was received in a positive manner. At the end of each visit I was asked to return in a year or two to present the workshop

to the next "crop" of residents. Three hospitals asked that the same workshop be presented to their nursing services. The social work consultant to the Surgeon General requested that I present the workshop at Walter Reed Army Hospital in Washington, D.C., and three civilian groups have since sought the same arrangement.

The workshop was assessed by the attendees as effective because it was apparently tuned into the needs of the participants. It was concerned with providing direct knowledge, skills and techniques for helping people, rather than with imparting theories. Finally, it flowed well due to the presentation of a total workshop and learning experience by one instructor both familiar and comfortable with the military and Army medicine.

SUMMARY

On the basis of the above, it was found that modifications were minor and that the model was confirmed as being effective in achieving the objectives for which it was developed. It was shown that this model can be employed effectively for both medical students and family practice physicians already in practice, both as a two-day intensive workshop or further developed into a three-credit course. Further, the model was presented in June, 1980 to two groups of registered nurses at Fort Benning, Georgia with positive results. There is evidence to support the presentation of this model to any group of health care professionals with similar positive outcomes.

CHAPTER V

SUMMARY, CONCLUSIONS AND IMPLICATIONS

SUMMARY

This study was directed toward a perceived educational vacuum, the training of medical practitioners who were products of medical schools with no coursework in human sexuality beyond its anatomy and physiology. The purpose of the study was to develop and present a model human sexuality two-day workshop to be offered to family practice physicians and other health care professionals.

The model was developed in rough form, field tested in a course for osteopathic medical students, refined, and then presented to the family practice residents and staff at seven of the nine major family practice concentration areas in the United States Army. The physicians at these seven hospitals comprised 80 percent of the family practice residents and physicians on active duty in the United States Army at that time.

The model was tested four ways. The primary instrument was the Sex Knowledge and Attitude Test (SKAT) which has four parts: 1) attitudes, 2) knowledge, 3) demographic data, and 4) personal sexual behavior data. The study utilized the SKAT as a pre- and post-test, with major emphasis on knowledge evaluation and a secondary emphasis on attitude

assessment.

The secondary instrument was a twenty-question multiple-choice sexual knowledge questionnaire. It was developed as a before-and-after test to be used in conjunction with Dr. Paul Miller's sound-slides module, entitled "Human Sexuality--Its Anatomy, Physiology and Psychology,"[55] which was an integral part of the CME workshop presentation.

Both the SKAT and Miller tests were analyzed with repeated measures analysis of variance, utilizing David J. Wright's program, "Profile."[56] The .05 level of significance was used as the criterion to reject null hypotheses.

A third method of evaluation, the student course evaluation form, was given to the participants at the end of the workshop presentation. This form allowed direct feedback as to the course content and the teaching style and presentation. This method was analyzed using percentage responses and descriptive analysis, both individually by hospital and as a total group.

Finally, the researcher's clinical observations were included to provide subjective data on the human and behavioral facets of the study.

FINDINGS

Findings confirmed the applicability of a short-term intensive workshop model for instruction concerning sexuality in clinical practice for family practice physicians in a military setting. This general finding was derived from the following:

1. Comparison of pre- and post-test scores of the two instruments which were employed for this purpose indicated significant growth in learning. Participants in the study were influenced positively in the areas of both knowledge gain and attitudes.

2. Student course evaluations reflected a high level of interest, enthusiasm and support for the program.

3. The researcher's clinical observations reinforced the above findings, adding to them a dimension of expressed attitudes on the part of the respondents which, while subjective, were very supportive.

All evaluative methods tended to validate the content and presentation of the workshop as being effective and sufficiently adaptable and flexible.

CONCLUSIONS

On the basis of the objective and subjective findings, there is very good reason to believe that this model not only worked in the seven military family practice centers, but should also be effective with other populations and groups of health care professionals.

Since the completion of the family practice workshops, this model has been utilized twice at Fort Benning for the hospital's nursing service. Fifty registered nurses participated in the two workshops and showed even greater gains than the physician groups did. Course evaluations were comparable with those of the highest physician group in positiveness of response.

In each of the seven workshops presented in the study, other health care professionals were present. Physicians of all specialties, nurses, social workers, psychologists, etcetera, were active participants. Data for non-family practice physicians were not included in the study, since the focus was on the family practice physician. It was clear, however, that these other health care professionals enjoyed and benefited from the workshop presentations.

Further indications of the interest of health care professionals in the model are the invitations the researcher has received to present future workshops. Three different nursing services, the social work consultant to the Surgeon General, and several civilian groups have already requested a workshop presentation. In addition, many of the workshop participants from other medical specialties have inquired as to the possibility of return presentation. Also, the majority of the Army family practice residency training programs are requesting future workshops.

IMPLICATIONS FOR FURTHER RESEARCH

Directions for further research stemming from this study include the following:

1. Longitudinal follow-up one year later, either subjective in format, similar to the post-AASECT questionnaire presented in this study, or objective, utilizing the same instruments (the SKAT and Miller Test) used in this study. Comparison of test scores with the post-course scores of a year previous.

2. Research the extent of "application" of skills, techniques and knowledge gained by workshop participants. How many patients do they actually work with and treat for sexual problems after taking the workshop, compared with before?

3. Presentation of the model to other health care professional groups, with the evaluative results compared with those of this study's family practice physicians.

4. Comparison of SKAT scores, available in the literature, of physicians recently graduated from medical school, with the post-scores reported in this study.

5. Development of an advanced workshop as a follow-up to the model presented in this study. Pre- and post-workshop scores of the basic and advanced courses could be compared, with a separate comparison of scores obtained by individuals who had been enrolled in both courses.

This is the first major human sexuality CME workshop to be presented at hospitals within the United States Army medical service. It is the hope of the researcher that the model will stimulate knowledge and therapeutic skills in human sexuality on the part of health care professionals both in civilian and military practice.

APPENDICES

APPENDIX A

FIRST EXPERIMENTAL CME WORKSHOP

OCTOBER 1976

SEXUAL DYSFUNCTION AND

THE FAMILY PHYSICIAN

PROGRAM

Wednesday, October 13, 1976

0800	Registration
0820	Opening Comments - COL Lloyd McCabe, Hospital Commander
0830	Overview of Sex Therapy - MAJ R. Aldridge
0920	Sex Counseling Therapy in Medicine: Can the Busy Family Physician Function Effectively as a Sex Counselor or Therapist? - Dr. Patricia Schiller
1020	Coffee and Doughnuts
1035	The Solo Sex Therapy Approach - Dr. Patricia Schiller
1120	Questions and Answers
1145-1300	Lunch - Hospital Mess Hall
1300	"Masters & Johnson - The Dual Sex Therapy Approach" Diagnosis and Treatment of Sexual Dysfunction - Dr. and Mrs. DeMoya
1430	Questions and Answers
1445	Coffee and Doughnuts
1500	Task Oriented Approach to Sex Therapy - COL Frank J. Carmody
1550	Questions and Answers
1600	Closing Comments - COL Clay Reister

PROGRAM (cont'd)

GUEST SPEAKERS

MAJ Ronald G. Aldridge, ACSW
Chief, Social Work Service
U.S. DeWitt Army Hospital
First Nationally Certified Sex Therapist
in the Army (AASECT)

COL Frank Carmody
Chief, Social Work Service
Walter Reed Medical Center
Washington, D.C.
Field Instructor to Graduate Students in Social
Work, University of Maryland

Armanda DeMoya, M.D., FACOG, and
Dorothy DeMoya, MSN
Masters and Johnson Trained; Classical Model;
Members of Certificate Committee for Sex
Therapists

Dr. Patricia Schiller, M.A., J.D.
Trainer of Sex Therapists;
Assistant Professor, Howard University,
College of Medicine, Department of OB/GYN;
Director of Human Sexuality Program;
Executive Director, American Association of Sex
Educators, Counselors and Therapists
Washington, D.C.

APPENDIX B

SECOND EXPERIMENTAL CME WORKSHOP

JUNE 1977

"FORT BELVOIR WORKSHOP

"AASECT was invited by Col. C. Kleanthous, an AASECT member and physician in charge of the Family Practice Service, Department of the Army, U.S. Dewitt Army Hospital, Fort Belvoir, Virginia, to sponsor a training program. Dr. Kleanthous had attended several workshops conducted by AASECT staff and was impressed with the work being done.

From June 2-6, 1977 a program was conducted on the Post for 40 physicians, nurses, and social workers in sex education and counseling based on our course programs. This model program was very well evaluated by those attending and will hopefully lead to continued work with Army staff.

The following subjects were included in the program: (1) organic problems, male and female relationship to sexual dysfunction; (2) sex identity and interpersonal relations systems; (3) dyad experience by group members charting their sex roles, expectations of partners, and areas of conflict and agreement; (4) live short sex history demonstration--task oriented--non-orgasmic women--treatment methods; (5) sexual counseling--individual and group pre-marital, abortion, problem pregnancy, therapy with homosexual adolescents; (6) the Masters and Johnson system and its modifications; (7) taking a sex history; (8) the detailed physical examination; (9) the therapeutic foursome, two therapists and the two patients interaction; (10) discussion of special treatment techniques for vaginismus, impotency (primary and secondary), non-orgasmic female, menopause female; and (11) behavior modification techniques.

Faculty included: Patricia Schiller, M.A., J.D., Director; Major Ronald Aldridge, M.S.W., Fort Belvoir; Brian Campden-Main, M.D., Sex Therapist, private practice; Ernest Hopkins, M.D., Professor, Department of OB/GYN, Howard University College of Medicine; Alicia Hastings, M.D., Chairman, Department of Physical Medicine, Howard University College of Medicine; Barry McCarthy, Ph.D., Professor, Department of Psychology, American University; Thomas Wise, M.D., Chairman, Department of Psychiatry, Fairfax Hospital; and Nancy Woods, R.N., M.N., Faculty, School of Nursing, Duke University Medical Center."[1]

FOOTNOTES

[1]"Fort Belvoir Workshop," American Association of Sex Educators, Counselors and Therapists Newsletter, Vol. 9, No. 3 (June 1977).

APPENDIX C

POST-AASECT COURSE ASSESSMENT

QUESTIONNAIRE

Box 382
East Lansing, MI 48823

One year ago you attended the AASECT Sex Therapy Skills Workshop, either as a part of your residency training program or as a part of your ongoing professional education. I would like you to respond to these questions in terms of the effect or non-effect this course may have had on your life, your practice and/or your sexuality.

1. Did you view this course as having a positive or negative effect on your ability to assist your patients in dealing with any sexual problems they might have (explain)?

2. Did this course provide any insight into your personal life and/or alleviate any personal anxiety you might have had in dealing with sexual issues (explain)?

3. Should this course or a modified version of it be a mandatory part of a family practice residency training program (explain)?

4. In retrospect, what changes, additions or deletions would you like to see in the course framework (explain)?

5. What recommendations would you have regarding the length of the workshop and intensity of the material (explain)?

6. Would you see value in having follow-up workshops to update and increase your competencies in dealing with the sexual problems of your patients (explain)?

7. Should this training program be expanded to include other health care practitioners, or be further limited in any manner (explain)?

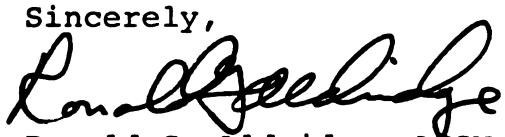
8. How often in your practice do your patients present sexual problems to you?

9. Should the Army be concerned with the treatment of sexual dysfunction?

10. Any further comments or reactions?

Thank you for assisting me in evaluating this program.

Sincerely,



Ronald G. Aldridge, ACSW
MAJOR, MSC

APPENDIX D

COLLEGE OF OSTEOPATHIC MEDICINE

SEXUALITY IN CLINICAL PRACTICE

COURSE INFORMATION

MICHIGAN STATE UNIVERSITY

COLLEGE OF OSTEOPATHIC MEDICINE
OFFICE OF THE DEAN • EAST FEE HALL

EAST LANSING • MICHIGAN • 48824

May 23, 1979

TO: COM Students

FROM: Allen W. Jacobs, Ph.D.
Assistant Dean

SUBJECT: Summer Term 1979 Elective Course

During the Summer Term 1979, Ronald G. Aldridge, ACSW, a certified sex educator and certified sex therapist, will offer an elective course entitled "Sexuality in Clinical Practice." This two-credit course is scheduled to meet on Tuesday from 7:00-10:00 p.m. in E-110 Fee Hall. The course enrollment will be limited to 25 students. Registration will be in OST 590 (Special Problems - Sexuality in Clinical Practice), Section 2.

The purpose of this course is to allow the medical student to build a set of competencies in dealing with the sexual problems of patients. The course is concerned with sexual function and dysfunction in all of the various life stages to include physiological, psychological, and emotional aspects. Sexual myths and taboos are explored, attitudes are discussed, and specific treatment methodologies are included. This course is recommended for any family health care provider.

The schedule and required textbooks are listed on the reverse side of the memorandum. Please contact the Office of Student Affairs if you wish to register for this course.

ksg

OST 590 (Sexuality in Clinical Practice)

MID-TERM PAPER - Trace the development of your own personal sexuality, including thoughts, feelings, experiences and the development of your current value system. Include your thoughts as to how your current values might impact on the work you do with your patients and how open you feel you are to patients with differing or alternate sexual practices or preferences. Be as open as possible and use this paper to get more in touch with yourself.

FINAL PAPER - This paper will provide you with the opportunity to research any topic you choose in the field of Human Sexuality. Again, I would like you to choose an area which is personally useful, relating it to yourself and/or your future medical practice.

A few examples:

Sexuality and the Paraplegic
Transsexuality
A Sexual Behavior Survey = Com Class 1981
Hypertensive Meds and Impotence
The Plissit Model and the Physician
Sexual Aversion
Sexuality in Nursing Homes
Sexuality and the Long-Term Inpatient
Etc., Etc., Etc.

COURSE POINTS -
Attendance - 30 pts. (3 per 3-hr. class period)
Mid-Term Paper - 30 pts.
Final Paper - 40 pts.

A passing grade will require 70 points.

OFFICE - Michigan Family Institute
Omni Building, Suite 202 351-4888
500 N. Homer, Lansing (Mondays & Tuesdays)

HOME - 351-2025

OST 590 (Sexuality in Clinical Practice) Aldridge

June 26 - Pre-course testing (for research purposes only)
Movie - "Love Toad"
Overview and feedback as to student needs and interests
Sexual problems in everyday living (discussion)

July 3 - Presentation of the Miller Sex Education Slide Series and discussion
Sex education as an integral part of ongoing patient care

July 10 - Sex Role Stereotyping - The Concept of Androgyny presented and discussed
Sexual Myths and Taboos Exposed
Our Values and Sexuality - their effect or non-effect on our patients

July 17 - Communication Dysfunction in Relationships: Presentation of the University of Minnesota's Couple Communication program
Guest Lecturer - Ms. Nancy Rinek, MSW (certified CC instructor)
An Overview of Family Systems Theory and Basic Relationship Theory
Guest Lecturer

July 24 - Adolescence - A Critical "Passage"
Guest Lecturer - Ms. Linda Waxman, RN, CPNP
Movie - "About Sex"
Mid-term paper due

July 31 - Homosexuality/Transsexuality - Alternate Sexual Preferences
Movie - "Word is Out" (130 minutes)

Aug. 7 - The Psychosexual History - its use and importance to the physician
Movie - "Pomeroy Takes a Sex History"
The Joint Psychosexual Physical Examination
Movie - "The Sexological Examination"

Aug. 14 - The Treatment of Sexual Dysfunction - techniques for assessment and treatment
Movie - "Sharing Orgasm" and discussion

Aug. 21 - Discussion of Sex in the Later Years
Movie - "A Ripple of Time"

Aug. 28 - Final papers due
Post-course testing (for research purposes only)
General discussion on areas of student concern.

APPENDIX E

COLLEGE OF OSTEOPATHIC MEDICINE

SEXUALITY IN CLINICAL PRACTICE

COURSE EVALUATION SUMMARY

STUDENT EVALUATION

OST 590 (Section 2) - Sexuality in Clinical Practice

Summer Term 1979

0 = Strongly Agree
1 = Agree
2 = Disagree
3 = Strongly Disagree

Number of Students Responding: 21

Instructor: Major Ronald G. Aldridge

		Response in %			
		0	1	2	3
1.	The material presented in this class was useful to me as an individual.	81	19	0	0
2.	The material presented in this class was useful to me professionally.	67	33	0	0
3.	This class was an important part of my medical school education and training.	71	29	0	0
4.	This course should be included as a permanent part of the medical school curriculum.	76	24	0	0
5.	This instructor's style of presentation was stimulating and interesting.	57	43	0	0
6.	This instructor provided us with adequate resources for further study and investigation.	71	29	0	0
7.	This instructor appeared to be concerned that students learn and gain from class presentations.	67	33	0	0
8.	This instructor seemed to be both competent and knowledgeable about the material covered.	76	24	0	0
9.	This instructor provided me with the opportunity to gain a broad knowledge base in this area on which to build.	67	29	4	0
10.	This instructor related well with the students.	71	24	5	0

COURSE EVALUATION

OST 590 - Section 2
Sexuality in Clinical Practice

Written Comments

An excellent presentation of material that will be valuable for me as a clinician. I appreciated Ron's willingness to teach, discuss, listen, and share ideas. Excellent person and very knowledgeable. I'm sorry to hear that this class isn't going to be offered next term. I think it was valuable and worthwhile, and other students would benefit from it.

I think this class is important and should be a permanent part of medical school education and training in every society. Personally I learned much from class. I came closer to grips with my own sexuality and I think I can relate more to others whose sexuality (behavior) may differ from mine. The class gave information on sexual dysfunction that each physician will face during practice.

More time needed to be spent on things the family physician could do in his/her own practice. It was instructive to see what agencies we can refer to, but more practical knowledge about our role as a "sex therapist" needed to be emphasized to make this a useful one in our curriculum. The overview of topics in sexuality was helpful and brought up issues that could then later be thought over in private thoughts. This "working through" was helpful.

Was very good, learned a lot, but especially became MORE RELAXED with topic. I wish we could have spent more time on various topics; i.e., R_X and sexual dysfunction (T_X and contra-dications), sexuality and chronically ill, i.e., paraplegics, etc., and various other related topics. Also, the lectures seemed very light and easy going. It seems (for the time spent) that we could have had some more meat during the times we were waiting to start, etc. Sometimes it seemed too slow of a pace (as compared to other medical school curriculum).

Course was valuable in helping me (and other students in the class I have talked to) feel more at ease with human sexuality. I feel this would help me be comfortable in talking with patients who have a sexual chief complaint. The class was nice and easy going. It was a pleasant change of pace from required curricula. One required paper covering student's sexual perceptions would have been adequate. Course should be fun and not pressured by writing papers.

Written Comments (cont'd)

The evaluation almost seems too good to be true, but in all honesty, Ron, the course was well organized and presented very professionally. It was a pleasure to come to class as the information forced me to deal with many areas of my own sexuality and how these attitudes would affect my performance with patients in the future. The course if by all means valuable, and without a doubt should be integrated into the curriculum. Best wishes and thanks, Bob Church, 8/21/79.

The class has helped me to take an important aspect which was embarrassing and intimidating, and made it so I can study it in a _____ realistic manner. This task would have been impossible without this class because if it were not in the curriculum, I would not had the time and not made the effort to go alternative routes.

The class was definitely useful to me personally which will also help me professionally. I feel much more comfortable and knowledgeable on the topic of sexual dysfunction and sexuality in general. I have already seen this as a credit in my work as the preceptor. I'm learning to take a sexual history more easily and more competently. I feel the class should definitely be part of the curriculum especially as it pertains to learning how to do a complete history and physical and forces the student to take a closer look at his/her views and the way it influences the doctor/patient relation.

Very valuable course - let's get the budget together to offer it again soon. I have had a similar graduate level course which was also well run. This course provided me with even more knowledge. I do not regret having invested the extra time.

The course was well presented and well organized by Ron. His approach fit in beautifully with the material being presented. The only major complaint about this course is that my goal to learn how to diagnose and treat sexual dysfunctions was never fulfilled. I was exposed to several topics in the field of human sexuality but the clinical aspects of the problems was not dealt with to any great extent. In order to be a more pertinent course in medical school, I think it would be beneficial to concentrate on the recognition of sexual dysfunctions and how to treat these people when they come into one's office. In other words, stress more clinical and less discussion about interesting but unrelated topics. Otherwise, the course was quite worthwhile.

Written Comments (cont'd)

I feel this is an extremely important class and should be added to our required curriculum. From my brief contact so far in preceptor's offices, I have found that sexual problems are very common complaints of patients. And I feel that physicians should be able to deal intelligently with these problems. Some fine points that would have improved the class for me ... have strict lecture, movies, etc., the first part of class and have students hold questions for last part. Thanx.

The Xeroxed material was excellent, and even more articles should have been provided. An interesting and varied subject matter which should be a part of the COM curriculum. Without this course as part of the standard program --maybe incorporated into OB-Gyn system it is impossible to be a holistic family practitioner. This course has been a useful adjunct to my medical education and the 3 hours/week was more than a worthwhile investment of my time. Ron's style was o.k. but the material presented - films, readings, etc., were all excellent.

(This wasn't proofread, so please excuse the grammatical errors.) This class provided information which no other class included in the osteopathic class curriculum. The material covered was relevant and could be quite useful during my medical career. Through taking this class I feel that I do possess some competent skills for treating a patient with some kind of sexual dysfunction. I also am more aware of my limitations in the field. Therefore, if the best therapy for a patient were a referral, I could better recognize that their problems(s) were beyond my scope of knowledge. If the class were offered or if this instructor (Ron Aldridge) was treating a continuation of this course or another course, this would be a good reason to enroll and attend that class.

An excellent course. Major Aldridge presented a complete course covering sexuality in clinical practice as well as relating our attitudes and behavior to our work with patients problems. This was one of the few courses I've had in medical school dealing with family therapy, marriage counseling, and problems in the life cycle. I think this course filled a gap in my education and our curriculum. Major Aldridge is a friendly, resourceful, and sensitive instructor, one of the best I've had in medical school. I'm sorry to hear the course won't be offered again.

Maj. Aldridge seems to enjoy what he is doing; he presents the material well and even introduces and dispells well festered myths. This course is necessary for medical students. Maj. Aldridge is an admirable person.

Written Comments (cont'd)

Reference materials are very valuable, especially the Guide to Office Counseling. Besides the general knowledge gained about sexual issues, the atmosphere in class was important in decreasing the discomfort I felt in thinking and talking about sex. I would like to see a little more organization to each lecture with more content, but the multi-media materials were important in "desensitizing" feelings. All the speakers were excellent. A great job, considering especially the time (uncompensated) you had to put the course together.

Knowing many of my classmates, I think it is unfortunate that this course is not going to be given again. Medical students need this exposure badly - need to think about dealing with a wide range of people and problems concerning sexuality. Not only were we provided with good practical material, we were given numerous resources to refer to in the future, and an awareness of how to get further information. The course was non-threatening, low key, and open to any input by students. Maj. Aldridge was able to provide many case histories as well as bring in colleagues to interact with us. How stupid that such a useful course will not be available. It's too bad that Dr. Kurtz didn't come to class but rather had us all tape-recorded.

This course was an enrichment and definitely a learning experience regarding individual's sexuality. It should be a required course for all medical students.

This class was very useful to me professionally and personally. It provided a broad overview of human sexuality and I think this exposure is invaluable to us as future physicians, as sexuality is such a basic and important part of life which is often, unfortunately, ignored. The class would be a positive addition to the curriculum - at least as an elective - but should be in a small group format (20-25 people) as this class was, and not as a huge lecture. Ron is a very competent and concerned teacher, and took the time to discuss anything that came up in the class periods - as well as having office hours here in Fee for our convenience. This type of experience is sorely lacking in our medical school education and I know I have benefited from this class and hopefully my patients will also.

A very good course to help a physician (especially a family physician) relate to the marital problems of the patients. The instructor handled the course content in a professional manner suitable to a medical school training.

Written Comments (cont'd)

An excellent addition to the curriculum. I'm not sure it should be a required portion of the curriculum, but I really appreciated the opportunity to take the course. The discussion format was helpful, though some more lecture time would have been appreciated. Perhaps a lecture followed by discussion would have been nice, though granted, difficult due to the interest of the group and the multitude of questions raised. Guest lecturers were good, films were good though the one regarding homosexuality was quite the opposite . . . TERRIBLE. I think the 3½ hours could have been better spent dealing with this topic. Otherwise, the course was great, and I really feel much more confident, not only in my knowledge of the subject matter, but also in my willingness to discuss these issues with patients. In fact, already I have had opportunity to do so in my preceptor's office.

APPENDIX F

SEXUALITY IN CLINICAL PRACTICE

INFORMATION AND MODEL OUTLINE

COST ANALYSIS

"HUMAN SEXUALITY AND THE HEALTH CARE PROVIDER"

As this is a two-day seminar, most trips would require arrival on the preceding day, with departure either on the evening of the last day of the workshop or the next morning. As this is basically a "one-man workshop", costs will be kept down to the minimum. Known costs are as follows:

Equipment I already own (no cost to the military):

Movies: Love Toad
Sharing Orgasm
Slides: Miller Sex Education Series

Equipment needed:

Movies: The Sexological Examination by Laird Sutton #450 - Retail Cost $330; A Ripple of Time by Laird Sutton #415 - Retail Cost $330. (Both movies are sold by Multi-Media Resource Center, 1525 Franklin Street, San Francisco, CA 94109. Considering our proposed use, it may be possible to purchase the two films from them at a discount.)

Current round-trip flight cost at military reserved rate from Lansing, Michigan to each of the following bases:

Fort Bragg - $164
Fort Benning - $184
Fort Gordon - $182
Fort Ord - $292
TAMC - $459
MAMC - $272
Fort Belvoir - $104
Fort Sill - $230
Fort Polk - $254

Transportation expense for the entire project then totals $2,141 at current costs, allowing us to present the human sexuality workshop to all family practice residency training programs, plus the two bases with extensive family practice physician staffing. The only additional cost would be my personal food and lodging. The entire program can be presented to all of the bases above for less than the cost of presenting the similar AASECT course to only two bases. And, our program is more pointed and pertinent to army life.

COST ANALYSIS (cont'd)

The pilot program presented at Fort Belvoir 1½ years ago was accepted for CME credit, so I'm sure that this program also would be.

Ideally, these presentations could begin in May or June and be spaced out to the end of the year. This would allow continuing feedback and refinement of the presentation.

Ronald G. Aldridge, ACSW
Major, MSC
Social Work Officer

SEXUALITY IN CLINICAL PRACTICE

INSTRUCTOR: Major Ronald G. Aldridge, ACSW
Certified Sex Educator (AASECT)
Certified Sex Therapist (AASECT)

DAY 1

0900 Pre-course testing (mandatory for all course participants)

1000 Movie: "Love Toad"
Overview of sex education and therapy - history, implications and importance to the health care practitioner
Military role expectations as an etiology of sexual dysfunction

1300 Presentation of the Miller Sex Education slide series and discussion - sex education as an integral part of ongoing patient care

1400 Sexual myths and taboos exposed (group discussion)

1500 Adolescence - A Critical "Passage"
Movie: "About Sex" - discussion

Wrap-up

DAY 2

0900 The psychosexual history - its use and importance to the health care practitioner
Movie: "Pomeroy Takes a Sex History" - discussion

1000 The sexological exam - a technique for combining physical assessment and sex education for the couple presenting sexual problems
Movie: "The Sexological Exam" - discussion
Communication dysfunction in relationships - discussion and presentation of the University of Minnesota program, "Couple Communication"

1300 The treatment of sexual dysfunction: techniques for assessment and treatment
Movies: "The Squeeze Technique" - discussion
"Sharing Orgasm" - discussion

1430 Sex in the later years
Movie: "A Ripple of Time" - discussion

1530 Post-course testing (mandatory for all course participants)

Wrap-up

SEXUALITY IN CLINICAL PRACTICE (cont'd)

Audience: Although my research is specifically directed at the Family Practice Resident and Physician in the Army, Nurse Clinicians, Urologists, Gynecologists, Psychologists, Social Workers, Psychiatrists, General Medical Doctors, Army Health Nurses and other health care practitioners will find the course both pertinent and applicable to their practice.

Size: Up to 50 persons.

CME credit should be obtainable.

Equipment needed at each site: lecturn with throat mike, 16MM projector, 35MM Kodak Carousel slide projector, cassette tape recorder loud enough to be heard by all participants, blackboard and projectionist.

842 Tarleton Avenue
East Lansing, MI 48823
(517) 351-2025

TO: CHIEF, DEPARTMENTS OF FAMILY PRACTICE:

FORT BELVOIR
FORT BENNING
FORT BRAGG
FORT GORDON
FORT POLK
FORT SILL
MADIGAN AMC
TRIPLER AMC

Dear Sirs:

Thank you for allowing me to present my two-day workshop, "Sexuality in Clinical Practice," to you and your staff. Assistance in terms of transportation from and to the airport (I will travel in greens with nametag), officer club (preferred if available) or motel reservations and transportation to and from the course site would be appreciated if at all possible. Also, please inform me as to the duty uniform of your installation during the time I will be there, and any other information that you feel I should know.

As mentioned on the enclosed sheet, my focus for this course and my research is the family practice physician. However, other appropriate professionals are encouraged to attend as long as we can keep the attendance down to a maximum of 50 participants. For the purposes of my research, it is particularly imperative that all family practice participants take both the pre- and post-tests, and that I have a roster of all attendees, with complete home addresses, for purposes of follow-up. The course will run, in most cases, from 0900-1200 and 1300-1600 each day, allowing some time before and after for rounds, etc.

Your assistance and support is appreciated.

Sincerely yours,

Ronald G. Aldridge
Major, MSC

AIRPORT:

ARRIVAL DATE:
TIME:
FLIGHT:
AIRLINE:

DEPARTURE DATE:
TIME:
FLIGHT:
AIRLINE:

ACTUAL COURSE DATES:

SEXUALITY IN CLINICAL PRACTICE

FINAL MODEL

DAY 1

I. Opening Remarks

1. Overview
2. Pre-course testing

II. History

1. Havelock Ellis
2. Sigmund Freud
3. Kinsey
4. William Masters and Virginia Johnson

III. Current Treatment of Sexual Dysfunction

1. Premises
   1) Based on normal natural functioning
   2) Couple centered problem
   3) Sex exists from birth and ends with death
   4) All dysfunction has emotional as well as physiological components
   5) Most dysfunctions are treatable with a high rate of success
2. Basic approaches
   1) Number of therapists/patients
      i. Duo-sex therapist approach
      ii. Single sex therapist approach
      iii. Group therapy approach
   2) Time span
      i. Intensive (once a day)
      ii. Weekly (once a week)
3. Implications for the health care professional

IV. Film - Love Toad (Multi-Media Research Center)

1. Presentation of film
2. Discussion

FINAL MODEL (cont'd)

V. Sex Education

1. Presentation of the Miller Sex Education slide series (Williams and Wilkins)
2. Film - Free (Multi-Media Research Center)
3. Discussion
4. Lecture: Sex education as an integral part of ongoing patient care

VI. Sexual Myths and Taboos

1. Dissemination of the sexual myths and taboos list in McCary's text, Human Sexuality (3rd Edition)
2. Small group discussion; of segments of the list
3. Presentation by the small groups to the group of the whole
4. Large group discussion

VII. Adolescence as a Critical Passage

1. Film - About Sex (Texture Films, Inc.)
2. Discussion
3. Lecture/discussion on sexuality during adolescence

DAY 2

I. The Psychosexual History

1. Use and importance to the health care professional
2. Film - Pomeroy Takes a Sex History (Multi-Media Research Center)
3. Discussion of the film and other methods of obtaining an appropriate history

II. The Sexological Physical Exam - a technique for combining physical assessment and sex education for the couple presenting sexual problems

1. Presentation of the method
2. Discussion of advantages and disadvantages

III. Communication Dysfunction in Relationships

1. Presentation of a segment of the University of Minnesota's "Couple Communication" program
2. Lecture and discussion

FINAL MODEL (cont'd)

IV. Sexual Dysfunction

1. Etiologies
   1) Classic
   2) Those more specific to military life
2. Techniques for assessment and treatment
   1) Major male dysfunctions
      i. Film - The Squeeze Technique (Multi-Media Research Center)
      ii. Discussion
   2) Major female dysfunctions
      i. Film - Sharing Orgasm (Davidson Films)
      ii. Discussion
   3) Sensate focus exercises
   4) Specific treatment techniques

V. Sex in the Later Years

1. Film - A Ripple of Time (Multi-Media Research Center)
2. Geriatric sexuality
   1) Physical changes
   2) Emotional concerns
   3) Age and sexual repression
   4) Nursing homes and societal responses

VI. Discussion and Wrap-up

VII. Post-course Testing and Evaluation

APPENDIX G

COURSE EVALUATION FORM

SEXUALITY IN CLINICAL PRACTICE

COURSE EVALUATION SUMMARY

Instructor: Major Ronald G. Aldridge

Key

0 = Strongly Agree
1 = Agree
2 = Disagree
3 = Strongly Disagree

		Response (circle one)			
1.	The material presented in this workshop was useful to me as an individual.	0	1	2	3
2.	The material presented in this workshop was useful to me professionally.	0	1	2	3
3.	This workshop was an important part of my residency training program or my continuing medical education.	0	1	2	3
4.	Courses in this specialty area should be regularly offered as a part of the Army's CME program.	0	1	2	3
5.	This instructor's style of presentation was stimulating and interesting.	0	1	2	3
6.	This instructor provided us with incentive for further study and investigation.	0	1	2	3
7.	This instructor appeared to be concerned that workshop participants learn and gain from class presentations.	0	1	2	3
8.	This instructor seemed to be both competent and knowledgeable about the material covered.	0	1	2	3
9.	This instructor provided me with the opportunity to gain a broad knowledge base in this area on which to build.	0	1	2	3
10.	This instructor related well with the course participants.	0	1	2	3

Comments (written):

APPENDIX H

MILITARY ROLE EXPECTATIONS

AN ETIOLOGY OF SEXUAL DYSFUNCTIONS

MILITARY ROLE EXPECTATIONS:

AN ETIOLOGY OF SEXUAL DYSFUNCTION

By

Major Ronald G. Aldridge, ACSW

(A paper presented at the Eleventh National Sex Institute, Washington, D.C., March 31, 1978)

The purpose of this paper is to present to you a glimpse of military life and, in particular, role expectations which are important in the self-image and sexuality of the military person, male or female.

You might initially ask, what is different about the military in comparison to, say, big business or industry? There are many similarities, such as a chain of command (directional flow chart), leadership at different levels, dress codes (implied), orders being given and followed, etc., but there are also striking differences.

The major issue I'd like to address in this paper is role expectations, both overt and covert. To be considered a soldier or a sailor conjures up many fantasies and images for both military and non-military alike. Pause for a moment and reflect on what the word "soldier" means to you, what images you have, feelings and thoughts, what stereotypes begin to form in your consciousness as you allow your thoughts to come together. Even as a soldier, I see a man

in uniform, sharply dressed, a "macho" image of self-confidence and self-reliance. As I fantasize further, I might think in terms of words like "conqueror," "sexual stud," "strength," virility." Signs like "The Marines Need A Few Good Men" and "Be A Man, Join The Army," or sayings like "Sailors have a woman in every port," or "Sex with a soldier is a multiple orgasm," or "That flag we raised at Iwo Jima wasn't attached to a flagpole," also come to mind.

Let's take a brief look at some common sexual problems and see if we can relate any of them to the above. We have documented, both in our research and therapy, the strong tie that the occurrence of impotence and premature ejaculation can have to lowered self-image, depression, inability to reach role expectations, diminished feelings of self-worth and masculinity, and a myriad other etiologies. It seems that in the military we see more adherence to a "macho" masculine stereotype, by civilians and military alike, than in most other professions. Hence, we have more roles to strive to live up to and more difficulty in trying to live up to them. Add to this the numerous intra- and interpersonal problems that we all experience, and I think you can begin to feel the additional stress that some military people encounter in their everyday lives.

Let's take a brief look at how these roles and stereotypes are reinforced by both military and civilians. If any of you have ever visited a military base anywhere in the world, it is hard not to notice the military town atmosphere

which surrounds the base itself. Taking a look at the rule rather than the exception, there are pawn shops, massage (?) parlors, prostitutes, topless and bottomless bars, adult book stores and on, and on. The soldier is expected to utilize these facilities, and he must or they would go out of business. A basic recruit often can only walk to whatever entertainment he chooses and is often required to remain in uniform. If he takes a bus downtown he usually receives verbal and/or non-verbal abuse. I've had soldiers tell me that they were actually told by civilians to stay in the area delegated to them and to stay away from their young women. The man who related this particular story had gone downtown to worship in a church of his own faith.

Who are our soldiers? During World War II they were "OK" because they were fighting for freedom, but during peacetime it's a different story. The stereotypes remain, but the social stigma seems to increase. Is it any wonder that an 18-year-old soldier experiences impotence during his first sexual experience with a whore in the back room of a massage parlor? Is it surprising that the young Sergeant who drinks too much at the NCO club because he is lonely finally picks up a young woman later in the evening and then finds he can't even maintain his erection? And what of the woman's expectations? How about the officer who is having both relationship and sexual problems with his wife due to the stress produced by overwork, long hours at the Pentagon, periods of separation after which they never seem to have

the time to find themselves and each other again, and increasing depression? Many are so worried about their security clearance or their efficiency report, concerned that their supervisor might find out that they are not "perfect officers and men" that they put off seeking help until the problems are so severe that treatment is difficult and often long-term in nature.

This paper has so far addressed male problems, but females are increasing in percentage in all of the services and they are finding themselves dealing with many of the same kinds of issues. Once again I'd like you, for a brief moment, to get in touch with your fantasy of the military career woman. What do you see? The stereotypes I hear most often are "Women join the Army to find a husband," or All WACS are easy lays," or "WACS are more man than woman," or "Women join the Army to go to bed."

The military offers women more economic equality than most other professions. As an example, a Registered Nurse who joins the military right out of school will have a starting salary often three or four thousand dollars higher than her civilian classmate. Add to that free medical care, PX and commissary benefits, tax benefits, early retirement, and so on. The Army is now attracting the best female nurses, social workers, lawyers, medical technologists, etc., who are highly professional people. In the enlisted ranks, I can cite an example at Fort Belvoir, Virginia, where the top three graduates of one of the 1977 Power Generator School

graduating classes were all women soldiers. And yet, the female soldier continues to live with the old stereotypes and stigmas.

I'd like to briefly discuss the types of sexual dysfunctions I have seen in my military practice. For the male soldier, impotence is by far the most prevalent dysfunction. I would estimate that 70 percent of all male dysfunctions that I have seen in the last ten years presented secondary impotence, directly or indirectly related to self-image, role expectations, job satisfaction or relationship dysfunction. Of the women soldiers, a healthy 60 percent presented secondary orgastic dysfunction with similar etiologies. Here we have a patient population which seems to be inordinately influenced and affected by situational, environmental and systemic influences.

Enough about etiology, what can we do for our military person who has sexual dysfunction? There are currently two nationally certified sex therapists (AASECT) in the Army, of which I am one. I also know of one couple in the Air Force involved in sex therapy with selected patients. There are a few others in the process of applying for certification. Under current CHAMPUS insurance regulations, a couple cannot be referred to a civilian therapist for sex therapy per se, only for individual or joint psychotherapy.

Masters and Johnson feel that 50 percent of all marriages in the U.S. are struggling with a sexual dysfunction in that one or both partners are dissatisfied with their sexual

relationship. As this applies to the military too, it appears that we have a massive problem to deal with and only minimal resources available. What do we do? Obviously, we can't pull sex therapists out of the walls and install them in every social work service and mental health center within the military. But we can use the resources we have. One way might be to form an inter-service education and consultation center and offer training to health care practitioners and primary care professionals. A team of two or three certified sex therapists could travel from hospital to hospital offering workshops and inservice training programs to interested health care professionals, enabling them to increase their comfort level in dealing with the sexual problems of their patients. At the same time, this program would provide them with the expertise to do primary level sex education and treatment, while increasing their assessment skills. Additional areas where such training would be both appropriate, and in many ways essential, include the Armed Forces Medical School, the Academy of Health Sciences, our major teaching hospitals, and residency training programs, particularly in specialty areas such as internal medicine, urology, OB/GYN, family practice and psychiatry. The proposed center could coordinate this training on a national level.

Sex therapy is a comparatively new field with relatively little known and a limitless horizon. For me, the field is exciting, challenging and rewarding. And, as pointed out, the military is still "virgin territory" with

many needs and few resources.

FOOTNOTES

FOOTNOTES

[1]W. H. Masters and V. E. Johnson, Human Sexual Inadequacy (Boston: Little, Brown, 1970).

[2]K. E. Appel, E. H. Mudd, and P. Q. Roche, "Medical School Electives on Family Attitudes, Sexual Behavior and Marriage Counseling," American Journal of Psychiatry 112

[3]H. I. Lief, "What Medical Schools Teach About Sex," Bulletin of the Bull Tulane University Medical Faculty 22 (1963):161-68.

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