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IN BRIEF REPORT

# LGBT-Specific Education in General Psychiatry Residency Programs: a Survey of Program Directors

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## Abstract

**Objective** Lesbian, gay, bisexual, transgender (LGBT) and other sexual minority individuals are at higher risk than non-LGBT individuals for multiple psychiatric conditions and suicide. However, little is known regarding LGBT-specific training among psychiatric residents. The authors sought to characterize LGBT-specific training among adult psychiatry residency programs.

**Methods** An anonymous, cross-sectional survey was electronically distributed to U.S.-based adult psychiatry program directors between February and April 2018. Survey topics included program demographics, characteristics of LGBT-specific training, perceived barriers to implementation, and anticipated needs.

**Results** Seventy-two program directors (30.8%) provided complete survey responses. Over half (55.6%) of these programs had ≤ 5 h of LGBT-specific training ("lower-hour programs"). Lower- and higher-hour (> 5 h of LGBT-specific education) programs were similar on measured demographic variables, but lower-hour programs covered fewer LGBT-specific topics and program directors were more likely to report lack of interested or topic-expert faculty as a barrier to enhancing LGBT-specific training.

**Conclusions** Results of this survey suggest a need for the development and implementation of LGBT-specific educational curricula for use in U.S.-based adult psychiatry programs. In addition, future research may explore effective ways for programs to recruit, retain, and support teaching faculty with LGBT-specific expertise.

**Keywords** Residents: sexuality/sexual orientation · Minorities · Curriculum development · Faculty development

Rates of attempted suicide and depression, anxiety, and substance use disorders are significantly higher among lesbian, gay, bisexual, or transgender (LGBT) individuals [1–3] than heterosexual adults. Furthermore, the LGBT community is diverse and heterogeneous; specific subgroups (e.g., by ethnicity) may be more likely to encounter discrimination and certain mental health concerns [4]. Addressing the significant health disparities faced by the 10 million adults in the USA who identify as LGBT is a goal of Healthy People 2020 [5]. In this context, the Accreditation Council for Graduate Medical Education (ACGME) also recognizes the importance of working with diverse populations by including sexual orientation in the Psychiatry Milestone Project [6], which serves as a framework for assessing the development of psychiatry residents. However, LGBT-specific, ACGME training requirements are few and relatively nonspecific, and little is known regarding the characteristics of LGBT-specific training among adult psychiatry residency programs.

Understanding the extent of LGBT-specific psychiatric residency training is important to (1) characterize the content of LGBT-specific training among the future psychiatric workforce, (2) identify program characteristics that may differentiate programs with more LGBT-specific content compared to those with less, and (3) design empirically supported initiatives to enhance LGBT-specific training, especially among programs with relatively less LGBT-specific content in their curricula. In this context, the authors sought to examine LGBT-specific education among U.S. general psychiatry residency programs.

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## Methods

In February 2018, using data from the online American Medical Association Fellowship and Residency Electronic Interactive Database Access (FREIDA) [7], the authors emailed surveys to directors of ACGME-accredited general psychiatry residency programs that had graduated at least 1 cohort as of February 2018 ($n = 233$). Survey items included general program characteristics, specifically setting (urban, suburban, or rural), cohort size (2–5, 6–10, 11–15, or > 15 residents/year), hospital type (community, university, or military hospital), and geographic region. We delineated 5 regions based on the 4 regions denoted by the U.S. Census (i.e., Northeast, Midwest, South, and West) [8], and further divided West into Southwest (i.e., Arizona, New Mexico, Texas, Oklahoma) and West (i.e., the remainder of the U.S. Census West Region states) to examine differences among these geographic regions. Puerto Rico, which is not included in the 4 U.S. Census Regions, was added to the South Region. The remainder of the survey items addressed LGBT-specific training, which included topics covered, formats (e.g., lectures, case-based studies), presence of an LGBT-specific clinical rotation, and estimated number of hours dedicated to LGBT-specific training or education (0–5, 6–10, 11–15, 16–20, 21–30, 31–40, and > 40). In addition, the program directors were asked whether there were openly LGBT faculty and residents in the department, barriers to implementing LGBT-specific training into the curriculum, and a series of items regarding the institutional environment for LGBT patients and residents, and perceived needs to improve LGBT-specific training. The full survey is available from the authors upon request. Survey content was developed based on a previous survey of LGBT-specific content among New York City psychiatry training programs [9], a similar survey of emergency medicine residency program directors [10], and curricular topics listed in the online LGBT mental health syllabus of the Group for the Advancement of Psychiatry [11].

Program directors who did not submit responses following the initial request were sent up to 2 additional invitations to complete the survey approximately 1 and 2 months following the initial email. The survey closed in April 2018. The Institutional Review Board of the Cambridge Health Alliance granted a human-subjects review exemption because program director emails were not linked to individual survey responses.

The distribution of census regions and cohort sizes between programs with complete survey responses and programs with no or incomplete responses were compared using chi-squared tests. For analytic purposes, responses for 3 items were condensed due to low response rates for individual choices; specifically, program setting was dichotomized into "urban" and "suburban or rural," hospital type into "university hospital or university-affiliated community hospital" and "no university affiliation (i.e., Veterans Affairs, military, community, or other)," and cohort size into "2–5," "6–10," and ">10." Additionally, the total number of curricular hours dedicated to LGBT-specific training were dichotomized into ≤ 5 ("lower-hour") and > 5 ("higher-hour") because only 14.9% ($n = 11$) of the programs had > 10 h of training. Characteristics of lower-hour and higher-hour programs were compared using chi-squared or Fisher's exact tests and $t$ tests, for categorical and continuous variables, using STATA, version 13.1 (StataCorp). The alpha for significance was set at .05.

## Results

Among 233 program directors who were emailed surveys, 81 (34.6%) responded to the survey and 72 (30.8%) completed all items; programs with complete responses were not significantly different from all other programs (i.e., non-responders and incomplete responses) in geographic region ($p = .81$) and cohort size ($p = .80$). Lower-hour programs constituted 55.6% of the sample. Lower-hour and higher-hour programs were not significantly different in terms of setting (urban: 34% vs. 24% (lower- vs. higher-hour programs), suburban or rural: 6% vs. 8%; $P = .37$), census region (West: 4% vs. 5%, Southwest: 4% vs. 3%, Midwest: 14% vs. 5%, Northeast: 8% vs. 14%, South: 10% vs. 5%; $P = .13$), cohort size (2–5: 12% vs. 6%, 6–10: 16% vs. 15%, > 10: 12% vs. 11%; $P = .60$), and hospital affiliation (university hospital or university-affiliated community hospital: 16% vs. 19%, no university affiliation: 16% vs. 19%; $P = .88$). Among curricular topics covered, higher and lower-hour programs were similarly likely to include the history of psychiatry and homosexuality (40.6% vs. 30.0%), child and adolescent sexual development (78.1% vs. 62.5%), and geriatric LGBT people (12.5% vs. 2.5%). However, higher-hour programs were more likely to include sexual-history taking (93.8% vs. 67.5%), psychotherapy among LGBT people (62.5% vs. 12.5%), transgender mental health (87.5% vs. 40.0%), racial and ethnic diversity among LGBT people (37.5% vs. 7.5%), and substance use disorders in LGBT populations (56.3% vs. 15.0%); conversely, lower-hour programs were more likely to cover psychological development and life cycle among LGBT people (53.1% vs. 22.5%) and medical and mental health issues for LGB people (75.0% vs. 40.0%). Lower-hour programs were less likely to report having openly LGBT faculty (66.7% vs. 81.3%) who engaged in LGBT-specific resident education (46.2% vs. 84.6%). However, lower- and higher-hour programs were similarly likely to report having openly LGBT residents in their programs (66.7% vs. 71.9%) (Table 1).

Compared with program directors of higher-hour programs, program directors of lower-hour programs were more likely to identify a lack of interested or subject-expert faculty as a barrier to integrating LGBT content into their curricula

**Table 1** LGBT-specific educational content and associated institutional characteristics in U.S. general psychiatry residency programs

| | No. | | | |
|---|---|---|---|---|
| | Total sample ($n = 72$) | ≤5 h [a] ($n = 40$) | >5 h [a] ($n = 32$) | *P* Value |
| LGBT-specific content in curriculum | | | | |
| History of psychiatry and homosexuality | 25 | 12 | 13 | .35 |
| Taking a sexual history | 57 | 27 | 30 | .01 |
| Psychological development and life cycle among LGBT people | 26 | 17 | 9 | .01 |
| Psychotherapy with LGBT people | 25 | 5 | 20 | <.001 |
| Medical and mental health issues for LGB people | 40 | 24 | 16 | .003 |
| Transgender mental health | 44 | 16 | 28 | <.001 |
| Racial and ethnic diversity among LGBT people | 15 | 3 | 12 | .002 |
| Substance use disorders in LGBT populations | 24 | 6 | 18 | <.001 |
| Geriatric LGBT people | 5 | 1 | 4 | .16 |
| Child and adolescent sexual development (e.g., orientation, gender identity) | 50 | 25 | 25 | .15 |
| Formats used to teach LGBT-specific content | | | | |
| Lectures | 56 | 25 | 31 | <.001 |
| Case reports | 16 | 5 | 11 | .04 |
| Readings or independent study | 20 | 3 | 17 | <.001 |
| Journal clubs | 6 | 2 | 4 | .40 |
| Formal LGBT "track" | 2 | 1 | 1 | 1.00 |
| Other | 9 | 3 | 6 | .17 |
| Clinical LGBT rotation offered | 21 | 8 | 13 | .07 |
| Openly LGBT faculty | 52 | 26 | 26 | .04 |
| Openly LGBT faculty teach, supervise, or mentor residents around LGBT issues | 34 | 12 | 12 | .002 |
| Openly LGBT residents | 49 | 26 | 23 | .14 |
| Identified barriers to integration of LGBT topics into curricula | | | | |
| Lack of interested or subject-expert faculty | 33 | 25 | 8 | .002 |
| Lack of time in curriculum | 35 | 18 | 17 | .49 |
| Lack of training sites | 13 | 8 | 5 | .76 |
| Other [b] | 23 | 12 | 11 | .69 |
| | | M | | |
| How well program prepares residents to work with LGBT patients [c] | 52.4 | 45.0 | 61.6 | .002 |
| How receptive residents are to incorporating LGBT-specific into the required didactic curriculum [c] | 73.0 | 68.3 | 78.7 | .02 |
| How welcoming the institution is to: [c] | | | | |
| LGBT faculty | 76.5 | 71.7 | 82.3 | .01 |
| LGBT trainees | 79.9 | 74.4 | 86.7 | .003 |
| LGBT patients | 77.5 | 71.7 | 84.5 | .003 |
| Anticipated usefulness of specific resources to enhancing LGBT-specific education [c] | | | | |
| Online modules | 63.0 | 63.1 | 63.0 | .99 |
| A list of potential guest speakers | 63.7 | 66.8 | 59.5 | .15 |
| Clinical case vignettes | 67.3 | 65.8 | 69.3 | .52 |
| Presentations at national conferences (e.g., AADPRT, Association for Academic Psychiatry) | 53.2 | 53.6 | 52.6 | .85 |
| Written material (e.g., reference lists of relevant readings, seminal manuscripts) | 62.5 | 59.9 | 66.0 | .20 |
| Videos (e.g., documentaries, educational videos) | 64.7 | 63.7 | 65.9 | .70 |

*AADPRT*, American Association of Directors of Psychiatric Residency Training; *LGBT*, lesbian, gay, bisexual, or transgender

[a] Survey respondents were asked, "Approximately many hours would you estimate is dedicated to didactic teaching about LGBT issues in your program?" Response choices consisted of the following: "0 to 5," "6 to 10," "11 to 15," "16 to 20," "21 to 30," "31 to 40," and "more than 40"

[b] Included: lack of funding, lack of time due to call burden, perceived lack of need or relevance, perceived resistance from faculty, perceived resistance from trainees, and other

[c] Data represent responses to item-specific visual analog scales (range: 0 to 100)

(62.5% vs. 25.0%); rates of other identified barriers were similar between the groups, as was the total number of barriers (range: 0–4, mean(SD): 1.7(1.0) vs. 1.3(.8)). Program directors of lower-hour programs were less likely to believe that residents would be prepared to work with LGBT patients or would be receptive to additional LGBT-specific training and that their institution is welcoming to LGBT faculty, trainees, and patients. Lower- and higher-hour programs did not differ significantly in terms of the anticipated usefulness of specific educational resources.

## Discussion

In this sample of U.S. general psychiatry residency programs, over half reported ≤5 h of LGBT-specific training despite

national calls to address the unique health needs of LGBT individuals [12]. Lower- and higher-hour programs were not significantly different in terms of setting, census region, resident cohort size, and hospital affiliation. Taken together, these results suggest that lower- and higher-hour programs may be more similar than different in basic demographic characteristics; however, it is possible that the application of alternate demographic categories and interactions among these characteristics may have yielded significant differences. Unfortunately, the results of this survey preclude more fine-grained or alternative analyses. Nonetheless, lower-hour programs reported inclusion of fewer LGBT-specific topics and fewer pedagogic methods to convey this material in their curricula. Furthermore, lower-hour programs were less likely to report openly "out" LGBT faculty who were willing to lead LGBT educational initiatives, and lower-hour programs were more likely to cite lack of interested or subject-expert faculty as a barrier to enhancement of LGBT-specific residency training.

To our knowledge, this report represents the most comprehensive survey to assess the characteristics of LGBT-specific training among U.S.-based adult psychiatry residency programs. A previous survey of program directors and trainees within 19 programs in New York City, including both adult psychiatry residencies and child and adolescent fellowships, revealed a wide range of LGBT-specific education (1–25 h; mean = 6.4, SD = 7.8) [9]. In addition, 42.4% of trainees reported no formal LGBT-specific training in their program. In a different survey of emergency medicine program directors, only 33% reported incorporating LGBT-specific content into their curricula, with a mean of 45 min of material presented annually [10]. In contrast to the current report, the authors found that emergency medicine program directors cited "lack of need" as the most frequent barrier to inclusion of LGBT material (59%); however, they additionally cited "lack of interested faculty" as a prominent barrier (23%) [10]. Consistent with the current report, the authors found a positive correlation between the availability of LGBT faculty and any LGBT-specific education [10]. Particular attention has focused on training urology and plastic surgery residents to provide appropriate care for transgender patients, given the important role of these fields in gender-affirming surgery. Although the majority of urology and plastic surgery residents believe transgender-specific training is important [13, 14], residents and program directors report significantly more clinical exposure to transgender patients compared with didactic instruction [14, 15].

The results of this study should be interpreted in the context of several limitations. First, the relatively low response rate introduces the potential for response bias. However, the response rate is roughly consistent with previous surveys of adult psychiatry program directors [16, 17] and this sample was generally representative of all available programs in terms of census region and cohort size. In addition, it is possible that this report underestimates of the percentage of lower-hour programs because program directors with less LGBT-specific curricular content may have been less likely to respond to a survey about LGBT-specific education. Second, the anonymous nature of this survey restricted the ability to examine factors such as program directors' gender, state (e.g., whether LGBT-friendly legislation was related to LGBT-specific curricular content), and other identifying data. As mentioned above, a more granular examination of program demographic characteristics may have yielded significant differences between lower- and higher-hour programs. Third, program directors' perceptions may not be fully representative of their program attributes; future research in this field should examine objective measures of curricular content (e.g., using online didactic schedules for each program) and integrate trainee and other faculty input. Fourth, because of the survey design, it was not possible to distinguish lack of faculty interested in teaching LGBT-specific content from lack of faculty with expertise in this area as barriers to implementation. Last, it was not possible to assess the quality of instruction of LGBT-specific topics given the survey design.

Withstanding these important limitations, the current report yields practical implications and lays the groundwork for subsequent research. Specifically, certain topics were rarely addressed, such as racial and ethnic diversity among LGBT people and geriatric LGBT issues, which suggests the need for educational resources for these topics. In addition, whereas certain topics were covered more frequently by higher-hour programs, others, such as psychological development and life cycle among LGBT people and medical and mental health issues for LGB people, were more frequently included in the curricula of lower-hour programs. This result suggests that interventions to enhance LGBT-specific training should be tailored to the specific needs of each program, not simply based on the total number of time dedicated to LGBT-specific content.

Given that the current ACGME Psychiatry Milestones include limited guidance regarding LGBT-specific training and the Psychiatry Residency in Training Exam (PRITE) rarely addresses LGBT issues [18], the ACGME and the American College of Psychiatrists may consider placing greater emphasis on national LGBT-specific training requirements. Models for LGBT curricula include the online LGBT mental health curriculum developed by the Group for Advancement of Psychiatry [19], an "area of distinction" in LGBT studies during residency training [20], and LGBT-focused professionalism workshops [21].

Furthermore, program directors from lower-hour programs were more likely than those from higher-hour programs to cite a lack of interested or subject-expert faculty as a barrier to incorporating LGBT-specific training. This suggests that recruiting and retaining faculty (either internal or external to

the department or institution) who can lead LGBT-specific training initiatives may be a particularly high-yield intervention. This recommendation, however, is tempered by the fact that lower-hour programs may encounter less trainee support for LGBT-specific curricular changes and less welcoming institutional environments for LGBT individuals.

In conclusion, given the unique mental health characteristics and needs of LGBT individuals, it is essential that psychiatrists in training are equipped to work with patients from this diverse community. This study reveals that LGBT-specific training among many adult psychiatry programs is still limited; however, survey results identify potential specific areas for improvement, such as fostering teaching faculty with LGBT topical expertise and addressing specific LGBT topics.

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## Compliance with Ethical Standards

The survey on which this study was based was reviewed and declared exempt from human-subjects review by the Cambridge Health Alliance's Institutional Review Board.

**Disclosure** On behalf of all authors, the corresponding author states that there are no conflicts of interest.

**Disclaimer** The opinions expressed in this article are the authors' own and do not reflect the view of the National Institutes of Health, the Department of Health and Human Services, or the U.S. government.

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