Awareness of sexual medicine among a sample of mental health providers

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Background
Routine sexual history taking is an important component of psychiatric case formulation, and while sexual health problems are common, they are often left underdiagnosed in clinical practice. This study aimed to identify Egyptian mental health professionals' knowledge, skills, and attitudes toward sexual medicine and psychosexual history taking. In this cross-sectional online survey study, 242 mental health professionals (160 psychiatrists and 82 psychologists) currently practicing in Egypt completed the survey.
Results
About 98.3% of surveyed professionals were in agreement that collecting sexual history is vital to efficient clinical assessments. However, nearly half the participants believed that they lacked sufficient knowledge (51.7%) or clinical experience (50%) in psychosexual health matters, and one-third (34.7%) did not believe that they are confident in managing such problems. More than half (56.4%) do not routinely initiate taking sexual history, and about one-fifth (20.6%) were not comfortable initiating such questions. Common barriers included inadequate education and training (49.2%), irrelevance to patient's chief complaint (39.7%), limited time (38%) and privacy (34.7%), worry of offending the patient (28.5%), feeling of awkwardness (27.3%), lack of confidence (24%), and to a lesser extent, poor rapport (15.3%) and fear of being judged by the patients (10.3%).
Conclusion
Egyptian mental health professionals do not routinely discuss sexual health issues with their patients, despite understanding its importance, due to multiple social, educational, and personal barriers. Perceived lack of knowledge, limited clinical experience, personal difficulties, and social constraints are considered the main barriers.

Keywords:
attitude, Egyptian, mental health professionals, sexual health, sexual history

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Background

Sexual health is a fundamental component of general health, quality of life, and overall well-being. It is even embedded in the universal human rights of the Declaration for Sexual Rights by the World Association for Sexual Health (World Association for Sexual Health, 2014). Sexual health is a state of physical, emotional, mental, and social well-being. It is not merely the absence of disease, dysfunction, or infirmity. 'Sexual health requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having delightful and safe sexual experiences, free of coercion, discrimination, and violence' (World Association for Sexual Health, 2014).

In a large survey (Mitchell *et al.*, 2016), 22.8% of sexually active women and 38.2% men reported sexual problems, indicating the dire need for integrating sexual health issues by health care professionals in patient management and treatment (Nusbaum and Hamilton, 2002).

Every mental health care professional must consider the impact of sexual health issues to meet patients' needs. This can be achieved through managing and integrating the topic of sexual health in daily routine checkups and building a multidisciplinary and multiprofessional network of sexual health experts to afford patients the specialized care they require (Seitz *et al.*, 2020).

Many sexual-related health problems, such as sexually transmitted diseases, sexual dissatisfaction, anorgasmia, and other sexual-desire disorders that

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show no physical signs, emphasize the importance of patient–physician communication to identify problems and promote positive sexual health outcomes. It is recommended to incorporate routine sexual health discussions during medical visits for the benefit of quality patient care (Loeb *et al.*, 2011).

However, how mental health providers initiate history collection is a sensitive matter among certain populations. Asking direct questions about sexual health problems can provoke discomfort in the clinician–patient relationship, which then might inhibit proper history taking, diagnosis, and management. Avoidance in taking relevant history and subsequent incomplete case formulation is commonly attributed to inadequacy of training in the sexual health field (Ross *et al.*, 2021).

Few studies have investigated how physicians take sexual history or how they assess patients' sexual function and satisfaction. Other studies have investigated mental health professional's characteristics such as gender, age, race, sexual orientation, location of medical education, and type of practice with mixed results (Sobecki *et al.*, 2012).

To our knowledge, few studies have investigated the awareness and attitudes of Egyptian mental health professionals toward sexual medicine and obtaining a sexual history, and the obstacles interfering with providing efficient service to patients with sexual health problems.

Consequently, identifying the deficiencies in knowledge, skills, and attitudes of mental health professionals, and the obstacles they face during interviews with sexual-dysfunction cases, will subsequently help improve the services provided for those patients in the future.

This study aims to assess the knowledge, skills, and professional attitude of mental health professionals toward sexual history taking.

Patients and methods

Research design and setting

This is a descriptive cross-sectional online survey study.

Ethics approval and consent to participate: this study was approved by the Institutional Review Board of Zagazig University Hospitals with approval number [6286]. The participants provided a written consent to participate in the study by answering a question included at the beginning of the online survey.

Participants

The study included 242 mental health professionals (160 psychiatrists and 82 psychologists) actively working in Egypt, all of whom consented to taking the online survey designed for this experiment. The authors uploaded the survey using Google forms and the participants were recruited by sharing the survey online with them through social platforms and they were invited to share it with other mental health professionals using snowball-sampling technique from September 2020 to November 2020. Only completed forms were included in the study.

Study tool

The survey entailed a newly designed questionnaire divided into three sections. The first section contained sociodemographic data (age, gender, and professional details). The second section contained 15 multiple-choice questions assessing sexual medicine education and experience, attitudes of mental health professionals during taking sexual history, and the challenges they face during practice. The third section contained three questions assessing their knowledge of factors affecting sexual health in patients.

Results

Sample characteristics

A total of 242 mental health professionals completed the survey. About 75.6% (n=183) of the study sample were females, while 24.4% (n=59) were males. All participants were above 25 years old, with the largest age-group demographic being 30–35 years old representing 33.5% of participants. Among the participants, 66.1% (n=160) were psychiatrists and 33.9% (n=82) were psychologists. For additional sample characteristics, see Table 1.

Taking sexual history and knowledge about sexual health

For a list of the responses to the survey questions, see Table 2.

Discussion

It has been shown that sexual satisfaction correlates with a higher quality of life (Flynn *et al.*, 2016) and longevity (Yang and Gu, 2020). Psychosexual history taking is a crucial component of psychiatric case management, despite being often underestimated during routine assessment of mental health patients, patients in general practice (Mitchell *et al.*, 2016), or even in gynecological practice (Pauls *et al.*, 2005). Thus, the need for assessing the attitudes and barriers facing mental health professionals that

Table 1 Sample characteristics (*N*=242)

Characteristic	*n* (%)
Gender	
Male	59 (24.4)
Female	183 (75.6)
Age groups	
25–30	77 (31.8)
>30–35	81 (33.5)
>35–40	41 (16.9)
>40	43 (17.8)
Job title	
Psychiatry residents	51 (21)
Psychiatry specialist	74 (30.6)
Psychiatry consultant	35 (14.5)
Psychologist	82 (33.9)
Current practice of psychiatry	
Governmental hospital	150 (62)
Private clinic	57 (23.6)
Private hospital	120 (49.6)
Working area	
Urban	224 (92.6)
Rural	20 (8.3)
Years of experience in psychiatry	
Less than 5 years	88 (36.4)
5–10	93 (38.4)
More than 10 years	61 (25.2)

Not all percentages are 100 because of multiple answers.

prevent mental health professionals from integrating sexual history case formulation and providing adequate and efficient health service.

This study aimed to assess knowledge, skills, and professional attitude of mental health professionals toward sexual history taking with the intention to tackle the present barriers preventing mental health professionals from providing the necessary care required in addressing sexual health-related problems.

The results from this research showed that almost half the participants did not believe they have the adequate academic knowledge (51.7%) or clinical experience (50%) or confidence (34.7%) in managing such problems. Yet, nearly all of them (98.3%) recognize the importance of acquiring a sexual history and the role it plays in patients' quality of life. About one-third of the participants doubted their knowledge of the effects of illnesses (35.1%) or medication (33.1%) on sexual health, and about two-thirds (68.4%) had less than good knowledge about the role of medications in sexual-dysfunction field.

Table 2 Responses to survey questions (*N*=242).

Question	%
Section 2: 1. Where do you see most cases with sexual complaints?[a]	
Governmental hospital	31
Private clinic	11.7
Private hospital	57.3
2. What is the average number of cases with sexual health problems that you see weekly?	
Less than 5	84.3
5–10	12
More than 10	3.7
3. Do you consider yourself with professional experience in sexual problems management?	
Yes	21.5
No	50
Maybe	28.5
4. Does your educational program include formal curriculum on human sexuality?	
Yes	48.3[b]
No	27.7
Maybe	24
5. Where do you see most cases with sexual complaints?	
Governmental hospital	31
Private clinic	11.7
Private hospital	57.3
6. What is the average number of cases with sexual health problems that you see weekly?	
Less than 5	84.3
5–10	12
More than 10	3.7
7. In your opinion, how important is it to include sexual history in the case formulation?	
Very important	71.9
Moderately important	26.4
Moderately unimportant	1.7

(*Continued*)

Table 2 (*Continued*)

Question	%
Unimportant at all	0
8. In your opinion, how important is sexual health in relation to the patient's quality of life?	
Very important	75.6
Moderately important	19.9
Moderately unimportant	1.2
Unimportant at all	3.3
9. How often do you initiate asking your patients about their sexual health?	
Always	9.1
Often	35.5
Sometimes	40.9
Rarely	12.8
Never	1.7
10. How comfortable are you in initiating sexual health-related questions with your patients?	
Very comfortable	23.6
Moderately comfortable	55.8
Moderately uncomfortable	19.4
Very uncomfortable	1.2
11. How comfortable are you when your patient initiates complaints related to sexual health?	
Very comfortable	43.8
Moderately comfortable	44.2
Moderately uncomfortable	10.8
Very uncomfortable	1.2
12. How do you rate your own level of confidence in managing sexual problems in a clinical situation?	
Highly confident	9.1
Moderately confident	56.2
Moderately unconfident	28.9
Very unconfident	5.8
13. Do you ask about sexual-cycle phases?[a]	
Dysfunction	21.4
Desire	21.6
Excitement	14.5
Orgasm	15.5
Resolution	8.9
Postcoital pain	12.2
I do not ask	5.9
14. Do you ask about female sexual history? (for psychiatrists only, N=160)[a]	
Menarche	26.2
Duration of menses	23.8
Contraception	32.5
Involvement of husband in contraception choice	12.3
I do not ask	5.2
15. What are the reasons that might interfere with proper sexual history taking?[a]	
A feeling of awkwardness	27.3
Inability to form a rapport	15.3
Limitation on time in an overcrowded outpatient department	38
Lack of privacy in clinical settings	34.7
Asking for sexual complaints is irrelevant, as it is not connected to patient's chief complaint	39.7
Not confident as to what to do with answers and what the next question should be	24
Inadequate training and education in sexual health at undergraduate level	49.2
Worry that patient may feel offended	28.5
What would the patient think about them?	10.3
What if questions were considered as misconduct?	14.9
All of the above	7.4
Section 3: 16. Are you aware of the effects of illness (medical, psychiatric, . . . , etc.) on sexual health?	
Yes	64.9
No	1.2
Maybe	33.9

(*Continued*)

Table 2 (*Continued*)

Question	%
17. Are you aware of the effects of medication on sexual health?	
Yes	66.9
No	6.2
Maybe	26.9
18. What precautions do you take in sexual-dysfunction patients prescribed a medication that causes sexual side effect? (for psychiatrists only, *N*=160)	
Change to a drug with less side effects	76.3
Minimize the dose	6.9
Combine with sexual-directed treatment drug	15.6
Nothing	1.2

[a]Multiple answers were allowed in some questions. [b]From those who said they had a curriculum, when asked if it was satisfactory or not: 20% said 'yes,' 65% said 'no,' and 15% said 'maybe.'

In a previous study by Reda and Hussein (2006); 49 Egyptian hospital residents were surveyed about obtaining sexual history. They were asked about their knowledge about the impact of sexual dysfunction on patient medical condition and the effect of prescribed medication on sexual life of the patient. There was a very high statistically significant association between knowledge and specialty of residency as knowledge was the highest in endocrinology and dermatology residents followed by gynecology and obstetrics residents, then urologist.

An Egyptian study showed medical students to have insufficient knowledge (91.7%) of sexual health problems (Maraee *et al.*, 2016). Hautamäki *et al.* (2007) and Kotronoulas *et al.* (2009) identified that lack of knowledge and skills are the main barriers for discussing this sensitive and important issue. Studies from the United States, United Kingdom, and Australia have found a lack of opportunistic sexual history taking (Temple-Smith *et al.*, 1999) among doctors, a lack of opportunities available for medical students to observe doctors while they take sexual history (O'Keefe and Tesar, 1999), and a feeling that they were not adequately trained in such area (Merrill *et al.*, 1990). As consistent with our results, the physician's feeling of being inadequately trained is a reason often discussed in literature (Nusbaum and Hamilton, 2002; Tsimtsiou *et al.*, 2006; Parish and Clayton, 2007; Waineo *et al.*, 2010; Coverdale *et al.*, 2011; Bitzer *et al.*, 2013). Studies show that medical training in human sexuality medicine and routinely taking sexual history can promote comfort in doctor–patient relationship while addressing sexual-related problems (Schechtel *et al.*, 1997).

This study also showed that more than half (56.4%) of the mental health professionals in Egypt do not routinely initiate taking sexual history, and about one-fifth (20.6%) were not comfortable initiating such questions. However, this discomfort was less (12%) when they were required to respond to patients' sexual health-related questions. Even when the participants asked about details of sexual-cycle phases, it was more frequent to ask about less-embarrassing questions like dysfunction or desire rather than more intimate details like excitement, orgasm, resolution, and postcoital pain. This is not surprising, given that physician's embarrassment is an often-mentioned across a variety of literature discussing the reasons for not addressing sexual health (Nusbaum and Hamilton, 2002; Morand *et al.*, 2009; Seitz *et al.*, 2020). In contrast, it has been shown that revealing and containing sexual health problems are more likely to happen with physicians who are comfortable talking about sexual health (Burnap and Golden, 1967; Bachmann *et al.*, 1989) with patients preferring their doctors initiating the subject (Meystre-Agustoni *et al.*, 2011).

Reda and Hussein (2006) found that 63.5% of residents asked less than half of the questions of sexual history, indicating that they had a disinterested attitude toward sexual-history obtaining. They found that residents of endocrinology, dermatology, urology and gynecology, and obstetrics ask about sexual history more frequently than residents of cardiology, neuropsychiatry, general surgery, and general medicine. As consistent with our results, they found that residents focused on asking about sexual dysfunction and desire rather than other sexual-cycle phases.

In the opinion of Egyptian mental health professionals, the main barriers that may interfere with proper sexual history taking are inadequate education and training (49.2%), irrelevance to patient's chief complaint (39.7%), limited time (38%) and lack of privacy (34.7%), worry of offending the patient (28.5%),

feeling of awkwardness (27.3%), lack of confidence (24%), and to a lesser extent, poor rapport (15.3%) and fear of judgment from patients (10.3%).

Reda and Hussein (2006) found that the main barriers were that the questions of sexual history were not usually included in the master history-taking sheet, finding this topic unimportant or irrelevant, and lack of finding the proper wording to ask in Arabic, which indicates a lack of sexual health training.

Seitz *et al*. (2020) surveyed 100 psychiatrists about the reasons for not addressing sexual health issues in psychiatrists' daily routine and found the main reason (38.6%) to be the impression that other problems were more important for the patients. Other reasons were lack of time, abilities of recommendation for consultation, and treatment of sexual problems even if sexual issues are addressed, age, religion, and culture of the patient (Seitz *et al*., 2020). Time barrier is a well-reported barrier in sexual history taking (Rashidian *et al*., 2016).

As we found, literature showed that there is a lack of understanding about the importance of sexual health issues among physicians (Nusbaum and Hamilton, 2002; Morand *et al*., 2009) and a severe underestimation of the prevalence (Nusbaum and Hamilton, 2002; Papaharitou *et al*., 2008; Abdolrasulnia *et al*., 2010). In other studies, gender or culture differences between doctor and patient were reported as a source of difficulty in sexual history taking (Burd *et al*., 2006; Hautamäki *et al*., 2007; Löffler-Stastka *et al*., 2016; Seitz *et al*., 2020). Our results are consistent with other studies that shared similar barriers such as embarrassment with sexual language, recognized lack of training or skill related to the management of sexual health, fear of limited personal knowledge of sexual practices, fear of offending the patient, and the perception of nonrelevance to the chief complaint (Peck, 2001; Kingsberg *et al*., 2019). Clinical barriers such as lack of time, patient reluctance, discomfort discussing sexual activities, lack of staff support, and fear of insensitivity have also been reported by providers (Barbee *et al*., 2015).

Conclusions

In conclusion, Egyptian mental health professionals do not routinely discuss sexual health issues with their patients, despite understanding its importance due to multiple barriers. Perceived lack of knowledge, clinical experience and management skills, feeling of embarrassment, and worries of offending the patient are considered the main barriers.

Limitations

This study is limited by the small number of the sample size and the cross-sectional nature of the sampling technique. Holding the survey online lacks the advantages of face-to-face assessment, although this study design was the most convenient timely wise and to allow comfortable and nonbiased answers.

Recommendations

From the results of our study, we recommend holding further research on a nationwide scale to gain better insight into the status of sexual medicine knowledge and practice, and the challenges facing mental health professionals during their practice. Efforts should be directed toward improving sexual health education and training, and including sexual history taking in everyday clinical practice.

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Conflicts of interest

There are no conflicts of interest.

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