Research Article

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Sexual History Taking Competency: A Survey among the Clinicians in Bangladesh

Mohammad Shamsul Ahsan[1*], S.M. Yasir Arafat[2], Rubaiya Ali[3], S.M. Atikur Rahman[4], Srijony Ahmed[5] and Md. Mahbubur Rahman[6]

[1]*Assistant Professor, Department of Psychiatry, Bangabandhu Sheikh Mujib Medical University, Dhaka, Bangladesh.*

[2]*Resident, Department of Psychiatry, Bangabandhu Sheikh Mujib Medical University, Bangladesh.*

[3]*Consultant Dermatologist, Apollo Hospital, Dhaka, Bangladseh.*

[4]*Medical Officer, Department of Psychiatry, Bangabandhu Sheikh Mujib Medical University, Bangladesh.*

[5]*Resident in Psychiatry, Bangabandhu Sheikh Mujib Medical University, Bangladesh.*

[6]*Assistant Professor of Psychiatry at Manikganj Medical College, Manikganj, Dhaka.*

[*]Corresponding author
Mohammad Shamsul Ahsan, Assistant Professor, Department of Psychiatry, Bangabandhu Sheikh Mujib Medical University, Dhaka, Bangladesh, E-mail: mohammadshamsulahsan@yahoo.com

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Abstract

Introduction: *Sexuality is a hidden topic and not talked much in countries like Bangladesh with strong cultural & religious myths and having health seeking behavior of availing traditional healers and lack of specialized service center.*

Objective: *It was aimed to see how often the clinicians ask about sexual issues in their clinical practice; the level of comfortability in inquiring about sex related problems and the opinion regarding sexual health services.*

Methods: *A descriptive, observational, cross sectional analysis was carried out on willing clinicians who attended seminars on sexual dysfunction in Bangabandhu Sheikh Mujib Medical University. The data were collected by predesigned self-reporting questionnaire from clinicians attending in 3 different occasions at the same venue from 560 respondents as 125 in first round, 166 in second round and 269 in the third round. Nonprobability purposive consecutive sampling technique was chosen and data were analyzed by Statistical Package of Social Science (SPSS) 16.0 and Microsoft Excel 2007 version software.*

Results: *At first round 53.6% were comfortable and 35% were uncomfortable asking sexual history with 26% facing discomfort asking, 12% uncomfortable with extreme age, and 12% with fear of offending the patients. In second round 42% clinicians were uncomfortable asking sexual history. In 3rd round survey, 37% of the respondents were uncomfortable to ask sexual history. Majority of the respondents (95%) agreed specialized set up should be established for patients with sexual dysfunction.*

Conclusion: *Its first ever survey on clinicians of different discipline who are interested to deal with patients with sexual dysfunction with outcome recommendation of specialized set up for patients with sexual dysfunction.*

Keywords: Sexual History, Survey, Clinicians of Bangladesh.

Introduction

Sexual health is defined as physical, emotional, mental and social well-being related to sexual health and functioning. Apart from the absence of sexual related disease, dysfunction and disorders, management of sexual health also requires positive and respectful approachability in having safe sexual experience [1]. Disruption in individual sexual health may lead to disturbance of intimacy issues such as sexual relationship and body image [2]. Sexual health problems require sexual history taking by clinicians to address the problem specifically [3-5]. As a part of primary procedure in

diagnosis it is vital for clinicians to obtain accurate and detailed sexual history from patients so that appropriate measures such as screening, testing and psychological treatment can be carried out [3]. Significant stumbling blocks are identified to sexual history taking by clinicians [4] due to several psychological factors such as comfort ability and embarrassment [6], lack of time, fear of intrusion, age and sex of both clinician and patient, offending patient's behavior, difference in sexuality culture (ethnic, same-sex infatuation and youth), and presence of third party [7].

As a part of a routine most clinician should be feeling comfortable in taking sexual history if the patient's complaint revolves around sexual health which is a taboo topic in Muslim dominated Bangladesh [4]. In a predominant Muslim religion country such as Bangladesh, many still practice conservative traditional ideas that regard sex-related issues to be a sensitive subject [8]. This in turn relates to fewer competencies among clinicians in Bangladesh during routine sexual history takings which may be attributed to certain background and socio demographic variables along with sex knowledge and sexual attitudes [9]. In terms of job profession, many clinicians themselves are concerned about their ability to take an appropriate history from a patient. Most of the time the feeling of embarrassment and uncomfortable is from both side of the parties; patient and doctor [10]. A study done by Vollmer and Wells in California, at two different medical schools reported a finding that certain factors involved in sexual history taking such as same sex of both the medical student and patient, heterosexual nature of the patient's relationship, and non-AIDS patients seems to garner more comfort and competency of medical student in taking routine sexual history [11].

A study conducted by McKelvey et al. 1998, in Western Australia found profound relationship between negative expression and lower sexual knowledge among first-to-fifth year medical students and attending religious service frequently. The researcher also believed that education aiming at increasing sexual knowledge and improving negative attitudes may increase medical background students to be a more effective sexual history takers as well as sex counselors [9]. Recommendation by United States Preventive Task Force and the National Academy of Sciences' Institute of Medicine states that clinicians should obtain a sexual history at least annually to determine the need for further evaluation to determine the risk of sexual dysfunction [4]. Disturbance in sexual desire and psychophysiological changes associated with male and female adult sexual response are the main characterization of sexual dysfunctions [12].

One of the most prominent disorders concerning sexual dysfunction is Erectile Dysfunction (ED) which is a very common problem among middle-aged men and often overlooked due to more chronic disease and disorder such as diabetes, hypothyroidism, hyperthyroidism, hyperprolactinemia and hypogonadism which are normally associated with ED [13]. Classes of drugs that have been identified as a potential therapeutic treatment of male erectile disorders include Sildenafil, testosterone therapy, apomorphine, etc [14-16]. Observing the fact that ED is a prevalent medical disorder among men and frequent report of dissatisfaction with certain aspect of their sexual function among men of age 18 to 59, it is very crucial for clinicians to provide a better primary care to serve their patient [17]. Physician-patient bond construction is framed by treatment environment thus, it is very vital for clinician to create comfortable environment by introducing a friendly, professional and sensitive medical staff [18]. The primary care that clinicians could provide for patients seeking ED treatment includes sildenafil, counseling, lifestyle changes, medication changes, and vacuum-constriction devices [17]. As sexuality is talked much in Bangladesh because of strong cultural & religious myths and having health seeking behavior of availing traditional healers as well as lack of specialized service center it was aimed to see how often the clinicians ask about sexual issues in their clinical practice; the level of comfort ability in inquiring about sex related problems and the opinion regarding sexual health services.

Methods

Participants

A descriptive, observational, cross sectional survey was carried out on willing clinicians who attended seminars on sexual dysfunction in Bangabandhu Sheikh Mujib Medical University. The data were collected from the participants was by questionnaire form surveys. The surveys were given to clinicians attending the event in 3 different occasions at the same venue. The first round (n=125), the participants were asked to answer the questionnaire which was given to evaluate their socio-demographic variables and their comfort in inquiring about sexual history to their patients. The second occasion (n=166) had participant from the first occasion as well. The same process was repeated in the third occasion (n= 269), which brings the total respondent of the survey to 560 clinicians from specialties such as Psychiatry, Internal Medicine, Dermatology, Gynaecology, Endocrinology, Neurology, Urology, General Practitioner, and others.

Survey content

The study design was a questionnaire-based survey for clinicians from Bangladesh attending sexual dysfunction seminar. The main content of the survey revolves around determining the effect of socio-demographic variables in relation to comfort zone in taking of sexual history. With the promise of anonymity and confidentiality, a respondent were required to provide their particulars such as age, gender, profession, education, marital status, specialty, duration since graduating and their previous experience undergoing similar natured survey. The variable questions in the survey falls into categories such as 1) frequency of clinicians in inquiring about sexual history 2) Comfort zone of the clinicians when taking patient's sexual history 3) Their opinion on whether every patient should be asked about their sexual history 4) frequency in encountering patient with erectile dysfunction 5) Type of treatment the clinicians specializes in offering the patient 6) Their opinion on PDE51 as a sex stimulating drug 7) Their feeling on treating erectile dysfunction 7) Their opinion on specialized care for treatment of sexual dysfunction. The data were given input into SPSS version 16 and analyzed in SPSS version 16 and Microsoft Excel 2007.

Results

On top of descriptive analysis for clinicians and their related socio-demographics such as respondents age, gender, educational status, practicing specialty, practicing duration and etc.in percentage for categorical variables along with their means, medians and mode. By looking at the percentage frequency distribution we can examine the level of comfort among clinicians in Bangladesh when inquiring about sexual matters and determine their competency when it comes to taking sexual history of patients and treating sexual dysfunctions (Tables 1-5). Table 1 showing the distribution of demographic variables of the respondents.

Socio-demographic criteria		1st occasion	2nd occasion	3rd occasion
Age of	25-30	32.0	37.1	40.7
	31-35	27.2	26.9	24.6
	36-40	20.8	21.0	16.0
	41 & above	19.2	14.4	11.6
Gender	Male	64.0	82.6	79.9
	Female	35.2	16.8	13.4
Education status	Graduate	74.4	63.5	72.8
	Post graduate	24.8	35.9	20.5
Practicing duration	0-5 years	25.6	37.7	47.0
	6-10 years	34.4	32.3	28.0
	11-15 years	19.2	20.4	11.9
	> 15 years	20.0	9.0	6.0
Specialty of clinicians	Psychiatrist	20.0	12.0	8.6
	Urology	0.8	1.8	6.3
	Dermatology	14.4	10.8	6.3
	Internal Medicine	10.4	49.1	42.5
	Gynecology	5.6	0.6	7.5
	Neurology	0.8	6.6	3.0
	Psychologist	8.8	4.2	9.7
	Others	23.2	3.6	5.2
	GP	15.2	8.4	1.1
	Hepatology	0.8	0.6	9.7

Table 1: Distribution of Socio-demographic variables of the respondents (In percentage).

Frequency in sexual history taking		Comfort level			
	Percentage		1st Round	2nd Round	3rd Round
Every time	7.2	Comfortable	67	57	69
Very often	27.2	Uncomfort-able	43	42	37
Some times	54.4				
Never	4.8				
Others	6.4				

Table 2: Frequency in inquiring about sexual history (1st occasion) and clinician comfort zone during sexual history taking (In Percentage).

Response	Percent
Discomfort	26 %
<18 &>60 Y	12 %
Fear of Offending	12 %
Deficit Communication	7 %
Not Relevant	14 %
Not Trained	12 %
Time Constraints	8 %
Knowledge gap	9 %

Table 3: Reasons for discomfort in taking sexual history among clinicians in Bangladesh (1st occasion; n=125).

Patient's visitation frequency	Percent
Always	4.2 %
Most of the time	10.8 %
Frequently	26.9 %
Occasionally	49.7 %
Rarely	7.8 %

Table 4: Frequency of patient visitation regarding sexual problem (Occasion 2).

Response	Percent
Yes	95 %
No	4 %
Other	1 %

Table 5: Need for specialized service for sexual dysfunction (3rd Round).

Discussion

Read et al., 1997 reports that most patients report being 'satisfied' with their sexual relationship with their clinicians because they are holding back sexual problem discussions. Communication about sex has been touted very poor among patient and doctor to provide any form of benefit to both parties. Communication skills improvement may be the key to successful sexual history taking and therapy. Temple-smith et al., 1999 reiterated that clinicians are more tend to and confident in taking a sexual history towards a more obvious patient rather than a normal circumstance patient. Most of the clinicians felt that difficulty in sexual topic discussion with patients is due to the length of standard consultation which is lacking in time, more so seeing that sexual topics are raised at the end of each consultation session. The researchers also believed that it is quite difficult in improving sexual history taking by clinicians if they're borne to fill uncomfortable in discussing sexuality. Haist et al., 2004 reports that female clinicians are more prone and comfortable in taking sexual histories than male clinicians. This could be simply put that female clinicians are more likely to encounter high load of other female patients or they're more attuned to sexual health. In summary, the odds of clinicians

reporting to be comfortable in taking sexual history is still average in Bangladesh, several well attuned suggestions need to be carried out in order for the betterment for both treatment and well-being of sexual disorder stricken patients.

Conclusion

The comfort level needs to increase over the year to create a more competent management and treatment of sexual dysfunction in Bangladesh. Clinicians' opinions such as relevance of sexual history taking, specialization of sexual dysfunction treatment, conventional treatment mode needs to be taken into consideration in creating a framework for both sexual history taking. The importance of multi-disciplinary primary care system in an integrated medical health service would be crucial in the process of treating sexual dysfunctions in Bangladesh.

References

1. Edwards WM, Coleman E (2004) Defining sexual health: a descriptive overview. Arch Sex Behav 33: 189-195.
2. Kotronoulas G, Papadopoulou C, Patiraki E (2009) Nurses' knowledge, attitudes, and practices regarding provision of sexual health care in patients with cancer: critical review of the evidence. Supportive Care in Cancer 17: 479-501.
3. Temple-Smith MJ, Mulvey G, Keogh L (1999) Attitudes to taking a sexual history in general practice in Victoria, Australia. Sex Transm Infect 75: 41-44.
4. Wimberly YH, Hogben M, Moore-Ruffin J, Moore SE, Fry-Johnson Y (2006) Sexual history-taking among primary care physicians. J Natl Med Assoc 98: 1924-1929.
5. Mulvey G, Temple-Smith MJ, Keogh LA (1997) Sexually transmissible diseases knowledge and practices of general practitioners in Victoria, Australia. Genitourinary medicine 73: 533-537.
6. Skelton JR, Matthews PM (2001) Teaching sexual history taking to health care professionals in primary care. Med Educ 35: 603-608.
7. McKelvey RS, Webb JA, Baldassar LV, Robinson SM, Riley G (1999) Sex knowledge and sexual attitudes among medical and nursing students. Aust N Z J Psychiatry 33: 260-266.
8. Wong LP (2012) An exploration of knowledge, attitudes and behaviours of young multiethnic Muslim-majority society in Malaysia in relation to reproductive and premarital sexual practices. BMC public health 12: 865.
9. McKelvey RS, Webb JA, Baldassar LV, Robinson SM, Riley G (1999) Sex knowledge and sexual attitudes among medical and nursing students. Aust N Z J Psychiatry 33: 260-266.
10. Merrill JM, Laux LF, Thornby JI (1990) Why doctors have difficulty with sex histories. South Med J 83: 613-617.
11. Vollmer SA, Wells KB (1988) How comfortable do first-year medical students expect to be when taking sexual histories? Med Educ 22: 418-425.
12. Laumann EO, Paik A, Rosen RC (1999) Sexual dysfunction in the United States: prevalence and predictors. JAMA 281: 537-544.
13. Slag MF, Morley JE, Elson MK, Trence DL, Nelson CJ, et al. (1983) Impotence in medical clinic outpatients. JAMA 249: 1736-1740.
14. Boolell M, Gepi-Attee S, Gingell JC, Allen MJ (1996) Sildenafil, a novel effective oral therapy for male erectile dysfunction. Br J Urol 78: 257-261.
15. O'Carroll R, Bancroft J (1984) Testosterone therapy for low sexual interest and erectile dysfunction in men: a controlled study. Br J Psychiatry 145: 146-151.
16. Heaton JP, Morales A, Adams MA, Johnston B, el-Rashidy R (1995) Recovery of erectile function by the oral administration of apomorphine. Urology 45: 200-206.
17. Sadovsky R (2000) Integrating erectile dysfunction treatment into primary care practice. Am J Med 109 Suppl 9A: 22S-8S.
18. Chun J, Carson CC 3rd (2001) Physician-patient dialogue and clinical evaluation of erectile dysfunction. Urol Clin North Am 28: 249-258.
19. Scott E, Naismith S, Whitwell B, Hamilton B, Chudleigh C, et al. (2009) Delivering youth-specific mental health services: the advantages of a collaborative, multi-disciplinary system. Australasian Psychiatry 17: 189-194.