

## Challenges in Taking Sexual History: A Qualitative Study of Indian Postgraduate Psychiatry Trainees

Divya Hegde, Priya Sreedaran, Johnson Pradeep

### ABSTRACT

**Context:** In India, psychiatrist is an important point of helpseeking for sexual complaints. A detailed sexual history can go a long way in understanding sexual difficulties. In this background, there is inadequate information on the difficulties that psychiatry postgraduate trainees experience while taking a sexual history as part of a routine mental health evaluation. **Aims:** The aim was to study the difficulties experienced by postgraduate psychiatry trainees while taking sexual history as a part of routine mental health evaluation. **Setting:** This study was conducted in an Indian medical college general hospital psychiatry setting. **Materials and Methods:** This is a qualitative study using focus group discussions and in-depth interviews with postgraduate psychiatry trainees. **Statistical Analysis:** Content analysis was used to identify direct and latent themes. **Results:** Thematic saturation was achieved with 17 participants. Major themes of difficulties that emerged included trainee-related factors such as gender and sociocultural background of the trainee; patient-related factors such as age, gender, and sexual orientation; setting-related factors; and language-related difficulties. **Conclusions:** Specific and regular training in taking a sexual history is essential in addressing the difficulties faced by postgraduate psychiatry trainees in India.

**Key words:** Medical education, medical graduates, postgraduate, psychiatry, sexual history

### INTRODUCTION


Sexuality encompasses a variety of issues such as gender identity, sexual orientation, sexual abuse, and sexual disorders.<sup>[1]</sup> The World Health Organization defines sexual health as “the integration of the somatic, emotional, intellectual and social aspects of sexual beings in ways that are positively enriching and that enhances personality, communication and love.”<sup>[2]</sup> However, medical education about sexuality is universally inadequate.<sup>[3]</sup> This is of concern as problems

related to unsafe sex are among the leading causes of death and disability in adolescents.<sup>[4]</sup> Issues pertaining to sexual orientation and trauma are associated with an increased risk for suicidal behaviors and other psychiatric conditions.<sup>[5-8]</sup> In India, sexual practices are often labeled pathological or normal depending on the context, and sexual minorities have faced multiple hardships.<sup>[9-12]</sup> Despite contrary arguments from professional bodies, homosexuality is criminalized in

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India.<sup>[12,13]</sup> Hence, in India, mental health professionals have multiple roles to play in relation to sexuality and associated issues.

Psychiatrist in India is a primary point of helpseeking for sexual complaints.<sup>[14,15]</sup> Psychiatrists have to treat sexual problems such as erectile dysfunction, premature ejaculation, and vaginismus.<sup>[16,17]</sup> Psychiatrists have to help individuals with distress related to sexual issues and misconceptions.<sup>[18]</sup> Psychiatrists have to address sexual issues arising from mental illnesses and their treatments.<sup>[19,20]</sup> Psychiatrists are expected to assist in profiling sexual offenders, designing sexual education curriculums as part of medical education, and formulating policies and legislations related to sexuality.<sup>[1]</sup> In today's globalized world, where there is a large migration of general populations and health-care personnel, it is essential that all mental health professionals are culturally competent in matters pertaining to sexuality.<sup>[21]</sup>

The art of taking a sexual history is a necessary skill that can aid mental health professionals in understanding and relieving emotional distress in individuals.<sup>[22]</sup> Most health-care professionals, however, do not take detailed sexual histories from their patients unless there is a primary sexual complaint.<sup>[23,24]</sup> Psychiatrists manage complex emotional and mental health problems and hence can serve as resource persons for sexual history training.<sup>[25]</sup> This reiterates the need to focus on training requirements for psychiatry postgraduate trainees with respect to sexuality and sexual history taking.<sup>[26]</sup> In this background, we report on the difficulties experienced by psychiatry postgraduate trainees in India while eliciting a sexual history as part of the routine mental health evaluation.

## MATERIALS AND METHODS

The authors aimed to study the difficulties Indian postgraduate psychiatry trainees face in taking a sexual history while performing routine mental health evaluations. The authors employed a qualitative study design using the COREQ checklist and other standard recommendations.<sup>[27,28]</sup> Refer to Appendix 1.

### Settings

The study was conducted in a private medical college in South India. The study site has been running a nationally recognized postgraduate psychiatry training program of >10 years. The corresponding author performed interviews with all the participants at the study site except two interviews that were conducted through teleconferencing.

### Methodology

The authors performed this study on a purposive sample of postgraduate psychiatry students. Postgraduate

students from the study site as well as students from other institutions posted in the study site for training in consultation-liaison psychiatry were approached face to face. The authors selected participants who had completed at least a year of psychiatry residency, as this would have given students enough time to learn adequate interviewing skills and obtain experience in working with patients. The authors conducted the study through in-depth interviews or focus group discussions and recorded interviews on audio and transcribed them.

### Ethical considerations

The authors were aware that all potential participants in this study were being simultaneously taught and supervised by this study authors and thus could find it difficult to refuse consent. Hence, written informed consent was obtained at two time periods. First, participants were recruited after making them aware of the purpose of the study and obtaining informed consent. Second, transcripts were returned once again to the participants for their feedback as well as approval for inclusion in the study. The study was approved by the Institutional Ethics committee of the institution in July 2014 (IEC Approval no: 105/2014). In addition, the authors ensured confidentiality in the data analysis and use of illustrative quotes by removing all identifiers and assigning an alphanumeric coding to each participant.

### Interview guide

The authors used the following probes as the interview guide:

- What are the details they elicit as part of the sexual history?
- What are the difficulties they experience as part of eliciting sexual history?
- What are the ways in which they resolve these difficulties?

After conducting a pilot in-depth interview, study recruitment was initiated. After completing 2–3 interviews, the authors would code and analyze the transcripts. The authors recruited individuals and coded and analyzed transcripts till data saturation was achieved. As part of this process, the authors conducted one focus group discussion ( $n = 6$ ), one dyadic interview ( $n = 2$ ), one triadic interview ( $n = 3$ ), and eight single-participant interviews. The mean duration of all interviews pertaining to probes about sexual history was approximately 15 min. One participant was excluded as authors did not receive consent from that participant at the second level. Authors were not able to obtain text transcription from another audio recording. The authors achieved thematic saturation after completing analysis of transcripts of 17 participants and subsequently discontinued data collection.

**Statistical analysis**

The first author and the corresponding author jointly analyzed the data using framework of content analysis.<sup>[28,29]</sup> No assumptions were made prior to the study. The authors resolved disagreements by reaching consensus. The authors coded *in vivo* and used expressed words and phrases in the transcript to identify significant units of meaning. The authors also inferred from the underlying meaning of the text and generated an overall impression.

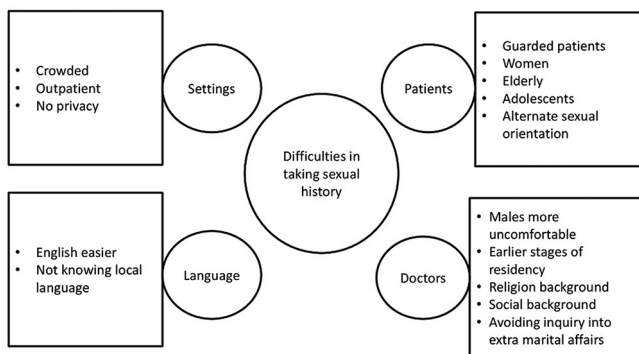
To reduce the number of themes into categories, data were further analyzed by comparison and refinement. A set of main categories was established by grouping together all the subcategories with similar meanings. Illustrative quotations for the subcategories were chosen from the transcripts for themes.<sup>[28,29]</sup>

**RESULTS**

The ages of all participants were within the range of 25–35 years. There were ten male and seven female postgraduate psychiatry trainees. Ten of the participants were from the study site itself, six were from an Indian tertiary mental health institution, and one was from an Indian government medical institute with general hospital psychiatry unit. Thus, participants hailed from diverse training settings [Table 1]. The study was conducted over 18 months since the time of ethical approval.

Figure 1 and Table 2 show all major and minor themes with some illustrative statements.

The authors further reflected on these themes and have represented the relationship between them using a model [Figure 2]. As illustrated in Figure 2, it is hypothesized that a combination of gender, trainee, and language-related factors in the presence of crowded settings makes it difficult for psychiatry trainees to take a detailed sexual history.



**Figure 1:** Coding scheme of major and minor themes in difficulties in taking a sexual history

**DISCUSSION**

These authors aimed to study the difficulties postgraduate psychiatry trainees experienced while taking a sexual history as part of a routine mental health evaluation. The findings are discussed below under the subheadings of the major themes [Figure 1].

**Characteristics of participants (doctors)**

In this study, postgraduate psychiatry trainees perceived differences between their own sociocultural backgrounds and that of their patients as barriers in taking a sexual history. Gender differences between the trainee and the patient were also experienced as prominent barriers. This finding gets support from other studies that indicate doctors report gender differences as a source of difficulty in taking sexual histories from patients.<sup>[30,31]</sup>

In this study, male psychiatry trainees especially experienced difficulties in interviewing women with respect to sexual matters. Previous research has indicated that female therapists have perceived themselves to be more competent in providing help to sexual abuse victims.<sup>[24]</sup> This gender-based finding should be kept in mind while training psychiatry postgraduate trainees.

**Characteristics of patients**

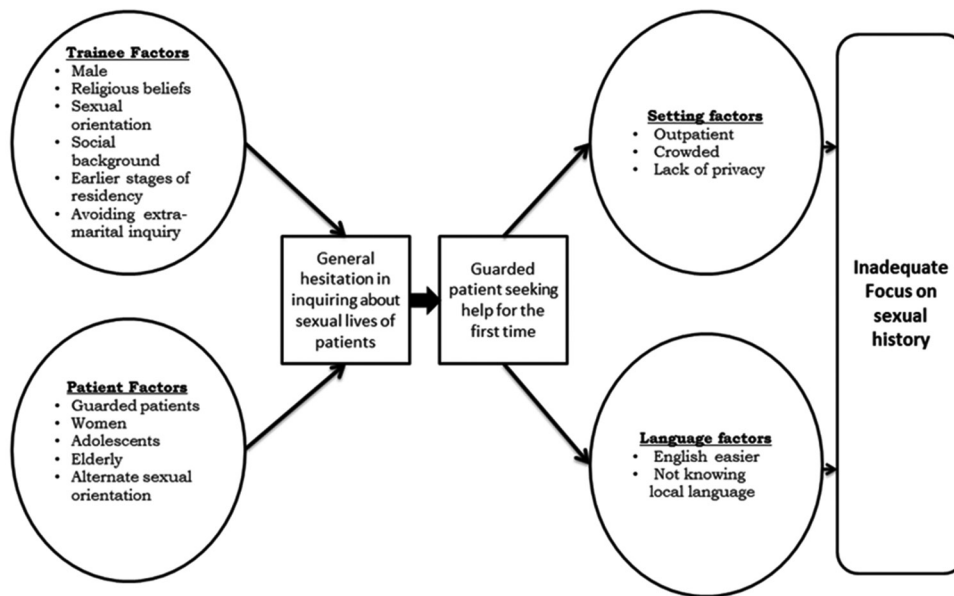
Certain characteristics that acted as barriers included patient’s age, gender, and sexual orientation. Participants of this study experienced a greater hesitation in taking a sexual history from the adolescents as well as the elderly. Several other studies have similarly reported that the age of the patients was a barrier while inquiring their sexual activities.<sup>[31-33]</sup> It is to be noted that adolescent and elderly age groups are vulnerable populations. The National Family Health Survey 2015–2016 (NFHS)

**Table 1: Distribution of participants’ sex and years of training**

Sex	Men	Women
Completed 1 year of specialized training	9	3
Completed 2 years of specialized training	0	2
Within a year of completing specialized postgraduate training	1	2

**Table 2: Illustrative quotations associated with themes**

Categories	Illustrative Quotations
Setting related difficulties	P3: “Sometimes the difficulty here...would be like in a crowded place like OPD where we have to talk about this but...we have no other room.”
Trainee related difficulties	P4: “I was highly uncomfortable when I knew the orientation of the person...if it is a male...is like different.”
Patient related difficulties	P2: “I feel females have this major difficulty about discussing sexual history, even when talking about extra-marital relationships or their masturbatory practice.”
Language related difficulties	P1: “When I am taking the sexual history in Kannada, I really don’t know what words to be used, if I am saying them correctly?”



**Figure 2:** Model showing the hypothesized interactions between various domains

showed that in the age group of 15–19 years, 5% of the girls had a live birth and 3% were pregnant.<sup>[34]</sup> Nearly 38% of women and 7% of men in the age groups of 25–49 years had their first sexual intercourse before the age of 18 years.<sup>[34]</sup> The NFHS demonstrates that a significant proportion of adolescents in India are sexually active and it is important for psychiatrists to take an adequate sexual history from adolescent patients.<sup>[34]</sup>

In a study on the health-care needs of the elderly, the topic of sexual health came up only once.<sup>[35]</sup> This indicates that discussion on sexual needs in elderly in India is a taboo subject.<sup>[35]</sup> It is essential that psychiatrists become comfortable in discussing sexual health topics in these vulnerable populations as these populations tend to face increased medical problems associated with sexual practices while simultaneously having inadequate resources to discuss related issues.

This study also showed that women were reluctant to discuss sexual matters with trainees. This reluctance has also been noted by other authors.<sup>[36]</sup> In a qualitative analysis of data gathered from a study on women survivors of breast cancer, it was noted that several participants refused to answer questions pertaining to sexual functioning.<sup>[36]</sup> Sexual and reproductive health is an essential aspect of women’s mental health, and an inability to elicit adequate sexual histories from women will impact their care.<sup>[37]</sup> Mental health professionals need to probe into this barrier systematically.

Postgraduate trainees in this study experienced difficulties in taking a sexual history from those individuals with alternate sexual orientations. This

difficulty has also been reported by other authors who noted that medical students and residents experienced increased discomfort while interviewing lesbian, gay, bisexual, transgender, and questioning populations for sexual history.<sup>[38]</sup>

**Characteristics of settings**

Another major theme in this study was the lack of privacy and crowded outpatient settings. Adequate sexual history is obtained only when doctor–patient confidentiality is ensured. Despite the suboptimal logistic organization in health-care services in India, it is still essential to keep patient-friendly infrastructure as a priority so that patients as well as doctors derive confidence to discuss sexual matters.<sup>[39]</sup>

**Language-related difficulties**

A final major theme that the authors encountered during the analysis was language-related difficulties. The lack of understanding of what the patient is trying to tell the doctor can pose several difficulties in obtaining an adequate sexual history. In addition to knowing the language, it is essential to know the terms or “slang” that is commonly used to describe various sexual terms such as masturbation and premature ejaculation. This is an impediment in India where postgraduate trainees might hail from different parts of the country and hence might not be fluent in the local languages. Several other authors have proposed guidelines for managing these difficulties.<sup>[16,40,41]</sup>

Finally, results from an anonymous web-based survey on psychiatry residents showed that psychiatry residents reported inadequate experience in multiple aspects of sexual health.<sup>[42]</sup> Psychiatry residents also reported that outpatient clinical work and didactic training

were the best forms of training.<sup>[42]</sup> This study similarly demonstrates that psychiatry postgraduate trainees experience multiple difficulties while taking sexual history as part of a routine mental health evaluation.

### Recommendations

The authors propose that psychiatry postgraduate trainees and other mental health and medical trainees should be imparted specific training in taking sexual history, taking into account barriers posed by their gender and sociocultural backgrounds.<sup>[43,44]</sup> Training should also take into account the possibility that vulnerable groups of patients will initially hesitate in opening up about sexual matters. Adapting Western models of interviewing to Indian settings is challenging. Hence, training should include culturally appropriate demonstrations of establishing rapport with this population of patients.<sup>[16]</sup> This recommendation is endorsed by research which shows that adequate training increases confidence of doctors in taking a sexual history.<sup>[44]</sup> This training could be mandated as part of their curriculum and could use interactive workshops, role-plays, and video-assisted standardized interview training sessions as proposed by other studies.<sup>[44]</sup>

While India continues to remain significantly underresourced in terms of health-care infrastructure as compared to other parts of the world, it is still recommended that priority should also be given to designing patient interview rooms to ensure patient confidentiality.<sup>[39]</sup>

The authors of this study also propose that in multilingual settings, there should be a focus on local language training as part of medical education. The local language training should include colloquial terms for various sexual practices without offending sensitivities. This is a feasible proposal, due to availability of a large number of bilingual individuals who can serve as trainers in a country like India.

Overall, the authors of this study recommend that there should be an active emphasis on training in sexuality and sexual issues as a part of medical and mental health education using various innovative as well as conventional strategies.<sup>[44]</sup>

### Strengths and limitations

This study has a robust qualitative design and obtained information on matters pertaining to sexual education as part of postgraduate psychiatry training in India. A limitation of this study is that, as the authors knew the participants prior to the interviews, it is possible that the participants did not reveal certain aspects with respect to their difficulties in taking a sexual history. Furthermore, this study focused only on certain limited

aspects of sexuality, and discussions on other topics such as gender identity and sexual practices did not arise during the participant interviews.

## CONCLUSIONS

The difficulties associated with taking a sexual history as part of routine mental health evaluation for postgraduate psychiatry trainees include trainee and patient factors in addition to setting- and language-related barriers. Specific and regular training at all levels of medical education could go a long way in improving the quality of conversations about sexual matters between psychiatrists in training and patients.

### Author information

All the authors are practicing psychiatrists, employed as faculty in the study site and have completed their postgraduation in psychiatry with a combined experience of >20 years in training psychiatry postgraduates. The first and corresponding authors jointly did all aspects of the analysis and reporting. All the authors contributed to the writing of the manuscript and its critique.

### Acknowledgments

The authors declare no conflict of interest with respect to this study. The authors acknowledge the participants of this study, Dr. Vidya Sathyanarayanan and Mrs. Angeline Grace, for their help in preparing this manuscript.

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Nil.

### Conflicts of interest

There are no conflicts of interest.

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**Appendix 1: Consolidated criteria for reporting qualitative studies (COREQ): 32-item checklist for the study titled 'Challenges in taking sexual history – A qualitative study of Indian postgraduate psychiatry trainees'**

No. item	Guide questions/description	Addressed in manuscript/response
<b>Domain 1: Research team and reflexivity</b>		
Personal Characteristics		
1. Inter viewer/facilitator	Which author/s conducted the interview or focus group?	Reported in author information- after conclusion'.
2. Credentials	What were the researcher's credentials? E.g. PhD, MD	Reported in 'author information'. Specific postgraduation degrees were submitted as part of title page to journal.'
3. Occupation	What was their occupation at the time of the study?	Reported in '- author information and submitted as part of title page to journal'.
4. Gender	Was the researcher male or female?	First two authors identify as female, while third author identifies himself as male
5. Experience and training	What experience or training did the researcher have?	Training mentioned in 'author information and as part of information submitted to journal'. The corresponding and third author also attended a three day qualitative research methodology workshop.
Relationship with participants		
6. Relationship established	Was a relationship established prior to study commencement?	Reported in 'Materials and methods - ethical considerations' and reiterated in 'Strengths and Limitations'
7. Participant knowledge of the interviewer	What did the participants know about the researcher? e.g., personal goals, reasons for doing the research	All participants were explained the study background, aims, and requirements for participation.
8. Interviewer characteristics	What characteristics were reported about the inter viewer/facilitator? e.g., Bias, assumptions, reasons and interests in the research topic	Reported in "Materials and methods"
<b>Domain 2: study design</b>		
Theoretical framework		
9. Methodological orientation and Theory	What methodological orientation was stated to underpin the study? e.g., grounded theory, discourse analysis, ethnography, phenomenology, content analysis	Reported in "Materials and methods"
Participant selection		
10. Sampling	How were participants selected? e.g., purposive, convenience, consecutive, snowball	Reported in "Materials and methods"
11. Method of approach	How were participants approached? e.g., face-to-face, telephone, mail, email	Reported in "Materials and methods"
12. Sample size	How many participants were in the study?	19
13. Non-participation	How many people refused to participate or dropped out? Reasons?	1 dropped out and did not cite any reason. 1 transcript was not completed.
Setting		
14. Setting of data collection	Where was the data collected? e.g., home, clinic, workplace	Reported in 'materials and methods'
15. Presence of nonparticipants	Was anyone else present besides the participants and researchers?	No
16. Description of sample	What are the important characteristics of the sample? e.g., demographic data, date	Reported in "Results"
Data collection		
17. Interview guide	Were questions, prompts, guides provided by the authors? Was it pilot tested?	Reported in "Materials and methods"
18. Repeat interviews	Were repeat inter views carried out? If yes, how many?	No
19. Audio/visual recording	Did the research use audio or visual recording to collect the data?	Reported in "Data collection"
20. Field notes	Were field notes made during and/or after the interview or focus group?	Yes
21. Duration	What was the duration of the inter views or focus group?	Reported in "Materials and methods"
22. Data saturation	Was data saturation discussed?	Discussed in "Materials and methods"
23. Transcripts returned	Were transcripts returned to participants for comment and/or correction?	Yes
<b>Domain 3: analysis and findings</b>		
Data analysis		
24. Number of data coders	How many data coders coded the data?	Reported in "Materials and methods"
25. Description of the coding tree	Did authors provide a description of the coding tree?	Yes, Figure 1.

*Contd...*

**Appendix 1: Contd...**

26. Derivation of themes	Were themes identified in advance or derived from the data?	Themes were derived inductively from the data. Reported in “Materials and methods”
27. Software	What software, if applicable, was used to manage the data?	No software used.
28. Participant checking	Did participants provide feedback on the findings?	No.
Reporting		
29. Quotations presented	Were participant quotations presented to illustrate the themes/findings? Was each quotation identified? e.g., participant number	Yes. Reported in Results
30. Data and findings consistent	Was there consistency between the data presented and the findings?	Yes
31. Clarity of major themes	Were major themes clearly presented in the findings?	Yes
32. Clarity of minor themes	Is there a description of diverse cases or discussion of minor themes?	Yes

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Source: Tong *et al.*<sup>[27]</sup>