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Sex education for patients with severe mental illness in Iran: A qualitative study

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ABSTRACT

Objective: Patients with severe mental illness may experience cognitive deficits, impaired judgment or loss of skills. Therefore, they are prone to sexual health complications. Sex education can promote sexual health, and in many countries, it is integrated into other domains of education. The educational contents taught in western countries are not necessarily appropriate for developing countries.
This study aims to address sex educational content for these patients in Iran.
Methods: We have conducted twenty-three face-to-face, deep and semi-structured interviews with patients, family members, psychiatrists, general practitioners, nurses and psychologists. We used the strategy of maximum diversity in selecting the participants.
Results: "Improving basic knowledge," "decreasing the risk of unsafe sex", "empowerment" and "persuading to ask for help" should be covered in the education.
Conclusions: Sexuality is not considered a priority for these patients. It is necessary to develop a training program with simple educational content for this high-risk group.
Innovation: Raising awareness and knowledge about the possible risks of social media on high-risk behaviours, developing social and behavioural skills, and encouraging patients to talk about their new challenges in sexual life is recommended. Cultural, spiritual and personal beliefs should be considered in designing the educational program.

1. Introduction

Seeking a healthy, happy and satisfactory sexual life is among the basic right of all humans [1] as well as patients with severe mental illness (SMI) including schizophrenia, schizoaffective and bipolar disorder. Patients with SMI may experience some cognitive deficits, impaired judgment or loss of skills according to the nature of the disease. They are prone to STD, AIDS, unwanted pregnancy, sexual dysfunction and some other complications [2-4]. Sex education as one of the elements of sexual health; can promote safe sex and decreased the rate of sexual abuse, unwanted pregnancy, unsafe abortion, sexually transmitted diseases (STD) and sexual dysfunction [5]. Sex education in patients with SMI must be taken seriously [6,4].

Although in many countries, sexual health is integrated into other domains of education in the general population, school-based comprehensive sexuality education (CSE) is still a challenge in some low and middle-income countries [7,8]. In a study, political and social leadership, context and resources, teacher preparation and meaningful involvement of young people are mentioned as critical factors in the implementation of sex education for the general population in developing countries [9].

Patients with SMI not only may experience marginalization, isolation and neglect, but they may also not receive proper sex education as a result of their condition [10,11]. A systematic review presents the necessity for considering some factors in the implementation of sex education for patients with SMI. These factors include who, when, where and how the training has to be provided. Moreover, patient acceptance of the training is another challenge [12]. In addition, there is a belief that sex education does not have any effect on these patients. Another challenge is the unclear content of training packages.

In a study in the UK, the authors proposed an educational package consisting of three sessions focusing on knowledge, motivation and behavioural intervention about safe sex [7]. In a different study, the role of booster sessions is mentioned [8].

The educational package and the contents taught in western countries are not necessarily appropriate for developing countries.

In Iran, as a developing country, there is no structured educational program for sexual health in the general population nor patients with SMI. Therefore, creating a sex education package with simple, short and straightforward content is another challenge.

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In this study, we try to address the main educational content for patients with SMI regarding the cultural and spiritual issues in our country by applying qualitative research and making in-depth interviews with these patients, their families and health care providers in Iran.

2. Methods

2.1. Design

This qualitative study is the main part of a research project on designing an educational package about sexual health for patients with SMI in Roozbeh Hospital, a referral hospital in Iran.

We used the conventional content analysis approach. We allow the categories and their names to gather from the data.

We have conducted twenty-three face-to-face, deep, semi-structured interviews with four patients, five family members, nine psychiatrists, one general practitioner, two nurses and two psychologists. Two psychiatrists and a clinician with a PhD degree in reproductive health care were the interviewers.

The interviews started with open questions and continued with close-ended. The patients were asked about their sexual needs, and special concerns and clinicians and families were asked for explaining their experience regarding sexuality in their patients. Narratives initiated with these questions: “What is your experience with sexuality in patients with severe mental illness?” “Which challenges these patients usually faced?” “What do you do when a patient needs sexual education?” Furthermore, the interviewers used open-ended questions and asked patients and families about what they needed to know about sexuality. The interviewers used probing, reflective statements and encouragement. The duration of each interview was around 90 min.

2.2. Participants

We used the strategy of maximum diversity in selecting the stakeholders, age of the participants, duration of illness and experience to ensure all themes have been identified.

The authors drafted a list of experts, patients, and families referred to the rehabilitation centre of Roozbeh hospital in a meeting. Then, the process of research was explained to the participants in a telephone call. If the participant accepted, they planned for an interview. In the interview, written informed consent was obtained after more explanation of the research project. The interviews with patients and families were made in the rehabilitation centre of Roozbeh hospital. The interviews with clinicians were made in the hospital or their office.

The eligible criteria for the patient and their families were a history of SMI in the remission phase, the age over eighteen years old and the ability to communicate with the interviewer. The patients with a history of substance use, comorbidity with personality disorders, being in the acute phase of illness, were excluded. The inclusion criteria for psychiatrists, psychologists, general physicians and nurses were having at least 5-year experience in providing health care services to these patients.

2.3. Data collection

Data collection was performed from September 2017 to September 2020. In the beginning, the authors established an interview guide. After using it in two pilot interviews, some changes were made based on the results. All of the interviews were audio-recorded, and then transcribed verbatim and analyzed using qualitative conventional content analysis.

We tried to achieve an overall sense of the content after each interview. When no new code was gained in the last two interviews; the data was considered saturated. The accuracy of transcriptions was frequently checked to ensure consistency. The distracted codes, categories and themes were finalized by discussion in several sessions.

2.4. Analysis

After elementary responses, reflective and probes expressions were used to confirm experiential specificity [9]. The number of interview sessions was between 1 and 2. Interviews were audiotaped. Following each interview, the collected data were directly transcribed verbatim and analyzed using qualitative conventional content analysis.

Data analysis launched within data collection, with active listening of the interviews and reading of the interview transcripts. The researchers tried to obtain an overall sense of the implication of each interview, after careful reading, it was coded. Repeated reading of the extracted codes supported to identify the diversities and homogeneities of data, and in organizing them. The categories are gathered by inductive reasoning [10]. We used MAXQDA 10 software for managing extracted codes.

To ensure the trustworthiness of research, the Lincoln and Guba framework was used [11]. Credibility was addressed by the second author, three academic colleagues, and the first author as expert and research supervisor, independently interpreting the data and then discussing the consistency of the identified categories. To confirm the reliability of the data, extracted codes with two of the participants was member checked [12]. The research team performed a team-thinking regarding the codes and categories during different steps of the study. To guarantee the capability of the study, the documents were kept in each step. Researchers' interest in this concept, long-term exposure to data and codes, as well as categorization were the other factors to guarantee the verification.

2.5. Ethical consideration

The reasons for doing the research were explained, and written informed consent were obtained from all participants.

The Ethics Committee of Tehran University of Medical Sciences has approved this study (Ethic's Code: IR.TUMS.MEDICINE.REC.1395.914).

3. Results

The characteristics of the participants are presented in Table 1.

Based on the results of the interviews, these domains should be able to cover in the educational package: “Improving basic knowledge”, “decreasing the risk of unsafe sex”, “empowerment” and “persuading patients to ask for help” (Table 2).

Table. 1
The participants characteristics.

Code	Gender	Participants Role	Diagnosis	Age
1	male	psychiatrist		70
2	female	Psychiatrist		63
3	male	psychiatrist		47
4	female	psychiatrist		40
5	male	psychiatrist		45
6	female	psychiatrist		57
7	male	psychiatrist		57
8	male	psychiatrist		66
9	male	psychiatrist		35
10	male	GP		49
11	female	nurse		40
12	female	nurse		45
13	female	psychologist		60
14	male	psychologist		45
15	female	patient	bipolar	31
16	male	patient	bipolar	55
17	female	patient	schizophrenia	27
18	male	patient	schizoaffective	42
19	female	family	schizophrenia	55
20	male	family	bipolar	60
21	female	family	schizoaffective	60
22	female	family	bipolar	59
23	male	family	schizophrenia	29

Table. 2
The main expectations of a patient sex education package.

	Category	Sub-category
The main expectations of a patient sex education package	Improving basic knowledge	a. Sexual needs as a human right b. Relationship and intimacy c. Responsibility d. Transmission of STDs and unwanted pregnancy e. Violence and sexual abuse
	Decreasing the risk of unsafe sex	a. Abstinence b. Being faithful c. Condom use d. Being alert about cues e. Decreasing the use of substances and alcohol f. Proper use of social media
	Empowerment	a. Assertiveness b. Communication c. self-esteem d. Problem-solving
	Persuading patients to ask for help	a. Experiencing any change in sexual desire b. Experiencing any kind of sexual abuse c. Experiencing any sexual problem

3.1. Improving basic knowledge

In the view of participants, basic knowledge should be improved in five domains including: "Sexual needs as a human right", "relationship and intimacy", "responsibility", "transmission of STDs and unwanted pregnancy", "violence and sexual abuse".

3.1.1. Sexual needs as a human right

This subcategory represents that sexual needs are not supposed as a human right for these patients in Iran. So no one cares about sex and sex education in these patients.

A participant statement is:

"Some patients want to get married. The common reaction of the family in most cases is opposition. One common statement is why do you want to get married. You will make someone miserable. However, what is reality? This is a human right and planning for special circumstances. They can get married and control their life" (A 49-year-old clinician).

3.1.2. Relationship and intimacy

This subcategory represents the role of emotional relationships in these patients.

"Some patients consider themselves incompetent to make an emotional relationship. They only need to equip with some skills to build a relationship (A 57-year-old psychiatrist).

3.1.3. Responsibility

This subcategory represents the role of considering the consequences.

"Although it is a human right, they should be responsible for their sexual behaviour consequences (A 57-year-old psychiatrist).

3.1.4. Transmission of STDs & unwanted pregnancy

We should consider the risk of STDs belonging side to unwanted pregnancies in these patients.

Some statements are mentioned below:

"Some patients are not aware of the risk of STDs in a sexual relationship. The risk of infection persists even in incomplete penetration" (A 57-year-old psychiatrist).

"A married woman in a manic episode had a sexual relationship and became pregnant. Abortion was not allowed" (A 45-year-old psychologist).

3.1.5. Violence and sexual abuse

This subcategory represents the necessity of being alert about the risk of sexual violence and sexual abuse in these patients.

"In some circumstances, sexual violence is a presentation of relapse. These patients should be aware and report any changes in their sexual desire" (A 57-year-old psychiatrist).

"These patients are at risk of being sexually abused. They should be aware of this risk and should be empowered by some skills to protect themselves" (A 57-year-old psychiatrist).

"Some patients have risky behaviours in relapse. This is a sign of the illness. They are prone to consequences" (A 57-year-old psychiatrist).

3.2. Decreasing the risk of unsafe sex

The contents of education must decrease the risk of unsafe sex in patients with SMI. Subcategories are: "abstinence", "being faithful", "condom use", "being alert about cues", "decreasing the use of substance and alcohol" and "proper use of social media". Some participants` statements are mentioned below:

3.2.1. Abstinence

This subcategory represents that in Iran, the patients' sexual needs, could be ignored. Many patients, family members and clinicians do not feel any need for sex education due to religious beliefs.

In this regard, a 45-year-old psychologist said: "The first step in safe sex is abstinence".

"When we experience a desire, we should control it" (A 27-year-old patient).

"My son is a religious person and always goes to the mosque. She does not need sex education" (A 60-year-old family member).

3.2.2. Being faithful

This subcategory is also shown the role of religious beliefs in Iran.

"Some people act on any sexual desires. They should be committed to their partners and postpone some of these desires" (A 31-year-old patient).

3.2.3. Condom use

"One must be taught to use a condom in any sexual relationship" (A 45-year-old psychiatrist).

3.2.4. Being alert about cues

"Some clues can propose that an intimate relationship may eventually lead to sexual harassment. These clues need to be identified" (A 45-year-old psychiatrist).

"Some situations may expose patients to the risky relationship. The patients should recognize these risky situations" (A 49-year-old clinician).

3.2.5. Decreasing the use of substance and alcohol

"A patient with a severe mental illness may become more vulnerable to substance and alcohol use" (A 49-year-old clinician).

3.2.6. Proper use of social media

"Some patients may have friends on social media. Moreover, they can search for everything. Some information is not accurate" (A 49-year-old clinician).

"My brother did not sleep. He spent most of the time in using social media" (A 55-year-old family member).

3.3. Empowerment

An appropriate sex education package should be able to empower the patient in four domains including: "Assertiveness", "communication", "self-esteem", and "problem-solving".

3.3.1. Assertiveness

This subcategory represents the necessity of being assertive.
Some participants` statement is mentioned below:

"These patients should be assertive in their relationships" (A 63-year-old psychiatrist).

"We have to define specific limits in our relationships" (A 27-year-old patient).

3.3.2. Communication

This sub subcategory represents the role of communication skills in the emotional and sexual relationship in these patients. This skill may be affected by chronic illness.

"Some skills are needed to build an emotional relationship as a proper context for creating a meaningful sexual relation" (A 57-year-old psychiatrist).

"He has sexual needs, but he can't make an emotional relationship" (A 59-year-old family member).

3.3.3. Self-esteem

"An intimate relationship is developed in a context of self-esteem. They should accept that they are loveable" (A 57-year-old psychiatrist).

3.3.4. Problem-solving

This subcategory represents some impairment in a higher level of cognition in these patients.

"This is a basic skill in all human beings. As people face any problem, they should use problem-solving skills to find the best solution. When the patients face a problem, they should use this skill" (A 57-year-old psychiatrist).

"Some patients may experience cognitive impairment and lose some of their skills due to the nature of illness and chronicity. Decision making is one of these competencies" (A 57-year-old psychiatrist).

3.4. Persuading patients to ask for help

Proper educational content must encourage patients to ask for help. The subcategories include: "Experiencing any change in sexual desire", "experiencing any kind of sexual abuse" and "experiencing any sexual problem".

3.4.1. Experiencing any change in sexual desire

Any change in sexual desire may represent an early warning sign. Some participants` statements are mentioned below:

"Patients are often ashamed and embarrassed to talk about sexual issues in the remission phase. We should encourage them (A 63-year-old psychiatrist).

"Sexual problems may represent an early warning sign in the acute phase of illness (A 63-year-old psychiatrist).

3.4.2. Experiencing any kind of sexual abuse

"These patients are prone to be abused by others. They should be aware and report it if happened" (A 57-year-old psychiatrist).

3.4.3. Experiencing any sexual problem

"Family members may ignore any sexual problem in this group. Therefore, patients should ask when they have a question or a problem" (A 57-year-old psychiatrist).

4. Discussion & conclusion

4.1. Discussion

Sexual health needs in patients with severe mental illness have been discussed in some studies [7,13,14]. Although sexual health is a part of overall health, it is sometimes neglected by family members and health care providers [15]. Moreover, there is limited evidence about the effective interventions to promote sexual health in these patients [7].

In this study, analysis of the twenty-three interviews identified codes which were categorized in 18 subcategories and 3 categories including "Improving basic knowledge", "Decreasing the risk of unsafe sex", "Empowerment" and "Persuading patients to ask for help".

According to our findings, sexuality was not considered a priority for patients with severe mental illness. Moreover, similar to some other studies, there is no proper information about their sexual needs [16,17]. Sexual rights must be respected and fulfilled [18]. Patients with severe mental illness are interested in sexual health. They have a range of sexual needs that should be explored and responded to [11]. These patients have some concerns about relationships and intimacy which may affect their sexual life. Some other studies also emphasized the challenges of the relationship and intimacy in these patients [17,19,20]. Lack of experience, feelings insecure in establishing a relationship, living for long periods without proper social relationships, lack of assertiveness in developing relationships [18], experiences of discrimination; and the internalization of stigma [21] may justify some part of their problems in the concept of relationship. Therefore, focusing on factors influencing establishing and maintaining intimate relationships, providing information about good and less good relationships and assertive communication can be helpful for these patients [14,18].

These patients are prone to HIV, STDs and risky behaviours. Unfortunately, in a recovery-oriented approach, sexual issues are neglected [22].

Consistent with our results, most literature emphasized the risk of HIV and STDs and proposed to include this topic in the training programs for patients with SMI [3,23,42]. Moreover, patients with SMI are more vulnerable to sexual coercion, exploitation, violence and abuse compared to the general population [26]. The need for implementing risk reduction interventions is highlighted. In a study, participants discussed and explained how sexual abuse negatively affected their self-worth and made it difficult to trust others or enjoy physical intimacy [21].

The necessity of designing appropriate tools and interventions to equip these patients by creating specific skills is mentioned in some studies. These skills should be developed in a sensitive and supportive manner [28]. Moreover, patients in outpatient settings commonly experience mental illness stigma which can affect their sexual life [22].

According to our findings, promoting abstinence, condoms use, being faithful or monogamy, sensitivity about sexual signs and its monitoring are the necessary contents that should be addressed in the education of patients with SMI. Similarly, limited studies also have shown some of these factors for sexual health education [29,30]. The use of

psychoactive medications is higher in psychiatric patients compared to the general population (25.1 and 8.9%, respectively). Unprotected sexual behaviours and having multiple partners are associated with coexisting drug and alcohol use in this population [31,32]. Therefore, developing sex education programs on these issues should be regarded. In a controlled trial study on HIV prevention, patients who received a substance use reduction program were more likely to reduce the number of sexual partners and risky sexual behaviours and had a stronger intention to use condoms compared to controls [31].

Proper use of social media was the other issue mentioned by our participants. Increasing evidence is showing high rates of social media use among individuals with mental disorders [33]. They usually use app platforms to share their illness experiences or seek advice from others [34]. Although social media facilitate social interactions among this group by overcoming obstacles such as stigma and mental health symptoms, access to information and services, but also poses some risks. Misleading information can be one of the most important risks [33]. Therefore, it is so important to raise awareness and knowledge about the possible risks of social media.

Regarding our results, developing special social and behavioural skills including assertiveness, communication, problem solving and improvement of self-esteem should be planned as essential contents in the educational material. Similar emphasizes have been mentioned in some studies [30,35,36]. In a study that applied assertiveness training for women living with a severe mental illness, it worked as a comprehensive HIV-risk-reduction program for this vulnerable population [36]. Problem-solving skills, condom use, and safer sex assertiveness skills that were used in a mental health service decreased the number of sexual acts [37].

Encouraging and educating patients to talk about their new challenges and problems, especially sexual issues, has been found as an important point in our interviews. Because of the limited sex education in Iran and difficulty in talking directly about sex, patients' sex life as an important issue might be neglected even by themselves [15]. Quinn stated that patients address sexual issues if only to be faced with a serious problem [38]. The other issue which should not be missed in this regard is that health care providers often experience confusion, embarrassment, and avoidance when are confronted with sexual issues in the care settings [39]. Therefore, providing the ways for increasing this awareness for both, patients and health care providers, should be considered.

In Iran, there is no structured sex educational program for the general population [40]. Patients with SMI who are more prone to high-risk behaviours have not received any pieces of training too. So, it is necessary to develop a training program at least for this at-risk group.

Moreover, Islam is recommended safe behaviours. Religious beliefs have a profound influence on Iranian society and emphasize abstinence, sexual relations only through marriage and fidelity. Therefore, religious beliefs should be a protective factor that can reinforce abstinence as a solution.

At the same time, religious beliefs may be an obstacle to sex education, so education should be in line with the religious beliefs of individuals. Another article discusses ways to increase the effectiveness of the sex education package [41].

4.2. Limitation

Although we emphasized that all recorded voices are kept confidential, some people may feel ashamed to share their experiences with us.

4.3. Innovation

Raising awareness and knowledge about the possible risks of social media, developing social and behavioural skills, encouraging patients to talk about their new challenges is recommended. Cultural, spiritual and personal beliefs should be considered in designing the program.

4.4. Conclusion

Sexuality is not considered a priority for patients with SMI in Iran. It is necessary to develop a training program with simple educational content for this high-risk group.

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Disclosure statement

The authors report no conflicts of interest. The authors alone are responsible for the content and writing of the paper.

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