'No sex please, we're British'

Taking a sexual history from in-patients

Swaran P. Singh and Andrew J. Beck

The case notes of 100 consecutive admissions to a general adult psychiatry service revealed that no sexual history was recorded in 73 cases. Only one patient had a detailed sexual history taken. In 22 cases the sex history was limited to a single mention of 'reduced libido' and in another four cases a brief explanation was done. Sexual side-effects of medication were not explored in any case. Sex history was more likely to be recorded when the doctor and patient were of the same sex; in cases with a history of sexual abuse or relationship problems; and where psychopathology had a sexual content.

The effects of psychiatric disorders on sexual functioning, the psychological impact of sexual dysfunction on mental health, and the effect of psychotropic medication on sexuality all suggest possible high rates of sexual problems among psychiatric patients. In an out-patient population study, 36% of depressed patients and 49% of schizophrenic patients reported sexual dysfunction (Kockott & Pfieffer, 1996). Sexual problems have also been associated with all classes of psychotropic drugs (Gitlin, 1994), especially antidepressants (Balon *et al*, 1993). Such side-effects may be particularly important in determining compliance with treatment. We conducted this study to establish whether psychiatrists in Nottingham are taking a sexual history from patients admitted to acute wards.

The study and findings

The case notes of 100 consecutive admissions to general adult psychiatric services in Nottingham, excluding admissions to the alcohol and drug treatment unit, were studied (51 men, 49 women, mean age 36.9 years). Wherever more than one history was available for the same admission, the more detailed history was considered for the study. We also scrutinised the notes for the presence of specific problems that might be associated with sexual dysfunction (history of sexual abuse, relationship problems, and sexual content of psychopathology).

The main diagnostic categories were schizophrenia and paranoid psychosis, affective disorders, neurotic disorders, personality disorders and substance abuse. Histories were taken by trainees in most cases with only five histories taken by consultants. An equal number of male and female doctors took the histories. A history of past sexual abuse and relationship problems was recorded in 10 cases and psychopathology had a sexual content in 12 cases.

No sexual history was recorded in 73 case notes. In 22 cases, a single mention of "reduced libido" was made without any elaboration. Of the five remaining case notes; there was mention of homosexual orientation in two; a brief mention of sexual dissatisfaction in married life in two; and a detailed recording of the patient's sexual functioning and satisfaction in one case. These five cases were added to the 22 with a single mention and data dichotomised into "sexual history not recorded" and "sexual history recorded".

Table 1 summarises the results. Diagnosis, age of patient, the grade of doctor taking the history and the hour of admission had no significant influence on the recording of sexual history. A gender match between the patient and doctor was statistically significant, with sexual history taken more often when doctor and patient were the same sex. However, the only case with a detailed sexual history was that of a young man with schizophrenia where a female doctor had specifically explored the patient's sexuality after the patient had complained of lack of sexual satisfaction. Sexual history was more likely to be recorded in cases of sexual abuse, relationship problems, or with a sexual content of psychopathology. The effect of psychotropic medication on patient's sexual functioning was not recorded in any case.

Comment

The absence of sexual history in the in-patient notes of almost three-quarters of patients could be due to several reasons. The history may be taken but not recorded, which this study design can neither confirm nor refute. Time of admission, severity of psychopathology and more

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Table 1. Analysis of casenotes

Variable (n=100)	Sex history not recorded	Sex history recorded	χ^2 (d.f.)	P
Age			5.75 (4)	0.22
18–25	15	3		
26–35	23	11		
36–45	20	5		
46–55	6	6		
>55	9	2		
Diagnosis			1.63 (4)	0.80
Affective disorder	23	9		
Schizophrenia/paranoid psychosis	42	15		
Neurotic disorder	3	2		
Personality disorder	3	0		
Substance abuse	2	1		
Grade of doctor			1.37 (3)	0.71
Senior House Officer	34	14		
Registrar	15	6		
Senior registrar	21	5		
Consultant	3	2		
Gender match			8.51 (1)	0.00
Same sex	18	15		
Opposite sex	55	12		
Specific problems			55.69 (3)	0.00
None mentioned	65	3		
Sexual psychopathology	4	8		
Relationship problem	2	8		
Sexual abuse	2	8		
Admission time			0.00 (1)	0.99
Out of hours	17	7		
Working hours	49	20		

immediate concerns such as risk assessment could preclude a detailed exploration of sexuality at admission. This presumes that the sexual history is taken at a later stage following admission. Even in patients with long-standing contact with the services, a detailed sexual history was often missing.

The mounting evidence of the significance of childhood sexual abuse in adult psychopathology (Whitwell, 1990) highlights the importance of sexual history in psychiatric assessments. Jacobson *et al* (1987) found that psychiatric assessments very often did not include history of sexual abuse. Patients may be reluctant to spontaneously report sexual difficulties and specific enquiries in this area may facilitate disclosure (Kockott & Pfieffer, 1996). In our series, even in cases of past sexual abuse, relationship problems, and where psychopathology revealed sexual concerns, the sexual history recorded was very brief, restricted mostly to a comment about libido. Our finding of the effect of gender match suggests that it might be beneficial to offer the patients the choice of determining when and with whom they might like to discuss this aspect of the history.

Our study would benefit from a comparison with an out-patient population where the focus of history taking may be different. Although patients are not admitted to acute wards primarily for sexual dysfunction, a failure to adequately explore issues concerning sexuality could influence the quality of their clinical care. If our findings were confirmed in other settings what might be the explanation? Is sexuality now solely in the domain of specialist clinics for sexual dysfunction? Or is it our conscious, or perhaps unconscious, attempt to repudiate psychiatry's Freudian heritage by diminishing the importance of sexuality in mental health?

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