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Sexual dysfunction and schizophrenia: psychiatrists' attitudes and training needs

AIMS AND METHOD

We conducted a survey of the knowledge, attitudes and practices of sexual dysfunction and schizophrenia of general adult psychiatrists in Leicestershire and Lincolnshire mental health trusts.

RESULTS

Two-thirds of psychiatrists that we interviewed do not routinely enquire about sexual dysfunction in their patients and only 17% felt competent in assessing sexual dysfunction, despite 88% agreeing that good sexual function is important to patients. Most practitioners (81.6%)

have had no training in this area and wanted some.

CLINICAL IMPLICATIONS

Sexual dysfunction is under-recognised and possibly under-treated; suggestions on how to address this are made in this paper.

Sexual dysfunction is a common and distressing symptom in schizophrenia, with rates of up to 86–96% reported in more recent studies (Macdonald *et al*, 2003), and persisting throughout the course of the illness. Fortier *et al* (2003) reported a higher incidence of sexual dysfunction among young adults and long-stay patients with schizophrenia. The high rates could be caused by illness variables and treatment. Bitter *et al* (2005), in a large study of antipsychotic-naïve patients with schizophrenia, found high rates of sexual dysfunction at initiation, and at 3 months and 6 months of treatment with antipsychotic medication. Putative mechanisms for sexual dysfunction in schizophrenia include medication-related effects, such as elevation of plasma prolactin levels, sedation owing to antihistaminergic effects, adrenergic effects and serotonergic blockade. Illness variables include negative symptoms mediated by low libido, direct effects of psychosis and abnormalities in the limbic system (Baldwin & Mayers, 2003; Malik, 2007). Sexual dysfunction is implicated as a major factor causing non-compliance (Fakhoury *et al*, 2001; Perkins, 2002). Patients often find it hard to complain and physicians may find it difficult to enquire about the problem (Clayton, 2001).

However, sexual dysfunction in schizophrenia can be addressed in a number of ways. These may include thorough assessment to exclude physical pathology, medication changes including the use of new atypicals, dose reduction, switching medications and referrals to specialists.

The extent to which staff enquire about sexuality in people with schizophrenia has depended on their general attitude to the importance of sexual issues in schizophrenia which has varied over the years (Kelly & Conley,

2004). In the past, people with schizophrenia were stopped from procreation, and excessive masturbation was once considered as a possible cause of schizophrenia (Eerlinmayer-Kimmling *et al*, 1969; Akhtar *et al*, 1977). Another study (Pinderhughes *et al*, 1972) showed that professionals believed people with schizophrenia were unable to manage their sexuality and that staff were reluctant to discuss sexual issues with them.

Psychiatrists have an important role in effectively addressing these problems. As patients are often reluctant to talk about difficulties in their sexual life, it has been observed that they are more likely to open up when physicians raise this issue (Montejo-Gonzalez *et al*, 1997). Smith *et al* (2002) argued that clinicians should routinely enquire about sexual dysfunction in their patients, but it is unclear what the training experiences and attitudes of psychiatrists are. Identifying these will help improve the care patients receive.

Method

Questionnaire

We drafted a 14-item self-report questionnaire assessing psychiatrists' views on sexual dysfunction and schizophrenia, which was generated after a literature review and focus group discussion (see online data supplement). An initial pilot study was completed among colleagues at Pilgrim Hospital Boston and the community mental health team in Lincolnshire.

The areas covered by the questionnaire included demographic characteristics, knowledge, attitudes,



practice and desirability for training in the management of sexual dysfunction in schizophrenia. Responses were assessed using a five-point Likert scale.

Participants

The population sampled included trainees and consultants working in general adult psychiatry in Leicestershire Partnership National Health Service (NHS) Trust and Lincolnshire Partnership NHS Foundation Trust. Questionnaires were distributed at local psychiatry academic meetings and by post. All 142 doctors working in general adult psychiatry were eligible for the study, which was anonymous. The Leicestershire ethics committee approved the study. Data were collected and analysed using SPSS version 12 for Windows.

Results

Sample characteristics

We obtained 76 responses (53.5%) out of the 142 distributed questionnaires; 54 from male and 22 female psychiatrists. Twenty-two respondents (28.9%) had practised psychiatry for less than 3 years and 42 (55.2%) for more than 9 years.

Attitudes

The majority of respondents ($n=54$; 68%) felt comfortable assessing sexual dysfunction, 19 (25.3%) felt unsure about it and 5 (6.7%) reported not feeling comfortable making assessments, with no significant differences between psychiatrists with less than or greater than 3 years' experience. As many as 52 respondents (69.7%) preferred patients to volunteer information about their sexual dysfunction, rather than asking them themselves.

Psychiatrists were also asked to rate how important they thought good sexual functioning was to their patients. A great majority ($n=67$, 88.2%) recognised it was important, 31 (40.8%) strongly agreed, 36 (47.4%) agreed and 8 (10.5%) were unsure. Only one person did not respond (1.3%) to this question. Clinicians' attitudes to enquiring about sexual dysfunction are illustrated in Table 1.

Practice

Participants reported having seen on average 48 patients with schizophrenia in the last year (range 0–300 patients). We assume that consultant adult psychiatrists would see larger numbers of patients while newer trainees would see fewer.

For all psychiatrists the average number of patients seen with erectile dysfunction was about four in the previous year. It was not possible to determine the gender distribution of people with schizophrenia seen by psychiatrists in the study over this period.

More than half of the psychiatrists in the study ($n=50$, 65.8%) reported that they do not routinely enquire about sexual dysfunction of their patients

Table 1. Clinicians' attitudes to enquiring about sexual dysfunction

Attitude	<i>n</i> (%)
Sympathetic	53 (67)
Concerned	50 (65.8)
Adequate	65 (85.5)
Motivated	19 (25.5)
Competent	13 (17.1)
Helpless	10 (13.2)
Unskilled	18 (23.7)
Angry	0
Frustrated	5 (6)

with schizophrenia. Their reasons are presented in Table 2.

Knowledge

Respondents were asked to estimate the percentage of people with schizophrenia they routinely see that suffer with sexual dysfunction: the mean score was 38.4% ($s.d=25$).

Training

As regards training in the management of sexual dysfunction in schizophrenia, 62 psychiatrists (81.6%) had not had any; 60 respondents (78.9%) agreed they would want training, with 19 (26.3%) agreeing strongly that this was required.

Discussion

To our knowledge, this is the first study on the management of sexual dysfunction in schizophrenia that uses a questionnaire to assess the domains of knowledge, attitudes, practice and training needs of psychiatrists. The items on the questionnaire may not comprehensively capture everything that is needed to assess these categories comprehensively. It cannot be assumed that responses reflect participants' actual practices and attitudes in real life, as they were based on completed self-report questionnaires and are not free from social desirability biases. Also, the questionnaire had not been previously validated. We recognise the difficulties in sampling this population, which may affect the study's

Table 2. Common reasons for non-enquiry

Reason	<i>n</i> (%)
Lack of confidence	13 (26)
Ineffective treatments	5 (10)
Afraid of upsetting vulnerable people	10 (20)
Lack of time	4 (8)

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generalisability, but we believe the number of responses and the relative high response rate allows us to comment on current psychiatric practice. The response rate (53.5%) is reasonable given the topic under investigation and the survey methodology; lower response rates are not unusual in postal questionnaires (Kazantzis *et al*, 2005).

The study makes some important observations. First, psychiatrists do not routinely enquire about sexual dysfunction (two-thirds in our study). Invariably the rate of identification of erectile dysfunction is low – in this study it is about 20% assuming a gender ratio of 1:1, while the expected rate would be at least 30–50% (Macdonald *et al*, 2003).

Second, the study identifies some of the reasons for not asking about sexual dysfunction routinely. These include lack of confidence of healthcare professionals in asking these questions, lack of confidence in available treatment, risk of upsetting vulnerable people and time constraints. The findings are consistent with the findings of Stevenson (2004) and Gott *et al* (2004).

This paper additionally demonstrates a marked change in attitudes from previous surveys (Eerlinmayer-Kimmling *et al*, 1969; Akhtar *et al*, 1997). Psychiatrists in our study generally recognised the importance of sexual functioning to their patients, had good knowledge and helpful attitudes in this area.

Finally, the study demonstrates the need for training in order to deliver effective treatments to people with sexual dysfunction in schizophrenia. Effective treatments exist, but most of the psychiatrists have not had training in this area, although they are willing to. One way of ensuring adequate training is the development of a training package with a pilot programme that should involve all staff. Another way of addressing this problem would be to establish a specialised clinic, but effectiveness of a sexual dysfunction clinic would need to be evaluated. There is also a need to increase recognition and awareness on part of the psychiatrists, patients and carers. This could be done through regular dissemination of information on the impact of the problem and available treatments, the routine use of brief questionnaires for people with schizophrenia addressing this issue, and the determination of pathway to care for these problems.

Pharmaceutical companies have had their role in promoting the awareness of obesity in schizophrenia. They could have a similar role in the promotion of training, research and treatment for sexual dysfunction associated with schizophrenia.

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The study was approved by the Leicestershire research ethics committee.

Declaration of interest

None.

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