

## Insufficient Assessment of Sexual Dysfunction: A Problem in Gynecological Practice

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**Key Words:** female sexual dysfunction; gynecology; sexual health; sexuality; psychoemotional barriers.

**Summary.** *Background and Objective.* Sexual health is an important part of a woman's life and well-being. Female sexual dysfunction is a complicated problem, it is often underestimated in the healthcare process, and its management is complex. Giving women the opportunity to talk about sexual problems is a fundamental part of healthcare and may improve their quality of life. The aim of this study was to find out patients' experience and attitudes toward the involvement of gynecologists addressing sexual issues, to disclose the main barriers to initiate a conversation, and to assess the prevalence of sexual disorders among patients in a gynecological clinic.

*Material and Methods.* A questionnaire-based approach was used to survey 18- to 50-year-old voluntary patients in the gynecological clinic. The study population comprised 300 different gynecological (except oncologic) patients independently of reasons for being in the clinic. The duration of the study was 6 months.

*Results.* Only one-third of the patients had ever been asked about their sexual life by a gynecologist, whilst the majority (80%) of the respondents reported they would like to be asked and discuss sexual issues. The patients mostly did not complain because of psychoemotional barriers, and shame was the main barrier for patients to talk about their problems. Sexual dysfunction was a frequent disorder among gynecological patients, reaching especially high levels in the arousal (46.41%) and lubrication (40.67%) domains.

*Conclusions.* The assessment of sexual health is insufficient in gynecological care, and sexual history-taking and evaluation of sexual functions should be included in routine gynecological health assessments.

### Introduction

Sexuality is a fundamental and important part of the human life cycle (1). Female sexual dysfunction is defined as disorders of sexual desire, arousal, orgasm, and pain, which lead to personal distress (2). It is well known that the satisfaction with one's sex life is a major indicator of the quality of life (3). While sexual health has been recognized as an integral part of overall health (4), it is often ignored in routine visits (5). Sexual dysfunction in women is a health issue often overlooked by medical personnel, but it is a topic of great importance to both the patient and her sexual partner (3). Female sexual dysfunction is highly prevalent, occurring in 25%–63% of women (6), and the prevalence tends to increase with age (7). Factors that can contribute to female sexual dysfunction may be psychogenic, physical, mixed or unknown. Psychogenic factors include a lack of knowledge regarding one's body and the sexual response cycle, religious beliefs, social pres-

sure, sexual abuse, negative sexual experiences, unrealistic expectations, relationship conflict, or resentment toward a partner. Physical factors include medications and acute or chronic health conditions (1). Sexual problems are often the first symptoms of a disease, and many diseases and drug therapies can increase the prevalence of sexual problems (8, 9). Short-duration problems of sexual functions may create frustration and anguish, and if the problems are chronic, they may lead to anxiety and depression and may damage relationships or create problems in other areas of the patient's life (10). The diagnosis and treatment of female sexual dysfunction are currently based on subjective reporting by the woman and physical examination (11). Measuring sexual function is a challenging task, not only because of the sensitive and personal nature of the subject matter but also because measures are subjective. The indicators of sexual function are all self-reported (12). Woman's expression of her sexuality is unique to her and is likely to change over time (13). Most available validated questionnaires for the

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evaluation of female sexual function and satisfaction ask women to summarize or recall how they felt concerning their sexual experiences over a certain period (12). Specific instruments, such as vaginal probes to measure vaginal blood flow or genitosensory analysis, are used as research tools (14).

Approximately 40%–45% of women are thought to have had at least one sexual dysfunction at some point in time (5). The complexity of sexual dysfunction in women leads to a multidisciplinary approach by the specialists of physical and mental health (15). Healthcare professionals noted embarrassment as a major obstacle to initiate a discussion about sexual health, and the time limit and a lack of training were important barriers to their addressing sexual problems (16).

Sexual functions in women decline with age. The relationship among sexuality, interest, satisfaction, and other factors among older people is complex (17), although numerous studies have demonstrated that many older women retain an interest in their sex life (18). Physicians need a biopsychosocial model rather than the traditional medical illness model in the management of sexual dysfunction (19). Since gynecologists are physicians who have knowledge about the impact of different reproductive endocrine changes on women's well-being, mood, and physiology of the sexual response throughout their life, they are one of the most eligible specialists to find the first signs and symptoms of female sexual dysfunction.

There are no previous studies about the prevalence of sexual dysfunction among gynecological patients in Latvia, as well as there are no data about the level of underreporting of sexual complaints and its reasons. Barriers to talking about these issues can be population and culture specific. The objective of this study was to investigate whether the assessment of sexual dysfunction in the gynecological clinic was sufficient, to disclose women's experience and attitudes toward sexual issues in the gynecological healthcare process, and to find out the prevalence of sexual disorders in the gynecology clinic. The tasks of the study were to survey the patients attending the gynecological clinic by using a questionnaire-based approach, to perform statistical analysis of the obtained data, and to draw conclusions.

### Material and Methods

A 2-part questionnaire was used to survey patients in the gynecological clinic. The first part was an 8-item questionnaire developed by the authors in order to find out patients' experience regarding sexual disorders, level of reporting symptoms to a gynecologist, barriers for talking to a physician, information sources about sexuality, involvement of a gynecologist by questioning, attitudes to the role of a gynecologist in addressing sexual issues, and relationship status. All patients completed the first

part of the questionnaire. The second part was the standardized and validated Female Sexual Function Questionnaire 28 (6, 20) with 28 questions to assess the function of female sexuality in the main domains (desire, arousal sensations, lubrication, cognitive excitement, orgasm, pain, satisfaction, and partner) and to evaluate the level of the sexual function of sexually active patients. The second part was applied only to those women who had had sexual activities during the last 4 weeks. The validity of the Female Sexual Function Questionnaire 28 at both the item and domain levels supports the use of individual domains as primary endpoints. The Female Sexual Function Questionnaire 28 can identify both the presence of sexual dysfunction and the specific components of the sexual function affected. Both the physical and cognitive aspects of sexual response are evaluated within the items, and cutoff scores for the function of each domain are generated. In compliance with the Female Sexual Function Questionnaire 28, the patient's sexual function was classified into 3 categories for all domains (desire, arousal sensations, lubrication, cognitive excitement, orgasm, pain, satisfaction, and partner): normal sexual function, borderline function, and sexual dysfunction. The borderline function is defined as the tendency to and probability of sexual dysfunction, but additional information is required before making a diagnosis. According to the questionnaire interpretation, there is no section of sexual dysfunction in the partner domain. There is only a normal versus borderline function, which indicates a possible sexual problem because of a partner/relationship. The study population was directed to analyze different patients independently of reasons for being in the gynecological clinic in order to see problems and attitudes of an average gynecological patient and to apply conclusions to ordinary gynecological care visits. A central, wide-spectrum gynecological clinic, representing patients from all over the country, was chosen for this study. The study population comprised 18- to 50-year-old patients from the Department of Gynecology, Riga East Clinical University Hospital, who voluntarily agreed to participate in the study. The age restriction of 18 years was related to the study interest in adult sexuality, but the age restriction of 50 years was related to a highly possible impact of menopause on sexuality. The duration of the study was 6 months; the response rate was 89.82%. In total, 300 correctly completed questionnaires were collected and used for data analysis. The researcher who had a direct contact with the patients for the study purposes was not directly involved in patients' clinical care to minimize any influence on answers. Comfortable conditions and privacy were provided as well as time being enough to complete the questionnaire accurately. Each questionnaire got a code, and no private data were used.

Prior to participation, the patients were not screened to rule out any particular medical conditions or medications or any reasons for being hospitalized. Questions about the role of the gynecologist were pointed to all past life experience. The study was approved by the Ethics Committee of Riga Stradins University. Female Sexual Function Questionnaire 28 scores were calculated, and results were interpreted complying with the standardized scoring system. In statistical analysis, the chi-square or Fisher exact tests were used to evaluate the associations among dichotomous and categorical variables. Categorical data are presented as frequency (percentage) by category. All the tests were two-sided, and  $P < 0.05$  was considered statistically significant. The SPSS software (version 20, IBM) was used for analysis.

**Results**

The mean age of the patients was 32.36 years. More than half (69.67%) of the respondents had had sexual activity during the last 4 weeks. Of the sexually active patients, 40.67% had unregistered cohabitation and 39.23% were married. Less than one-fifth (17.22%) had regular relationships without cohabitation, 2.39% had inconstant irregular relationships, and 0.48% had incidental relationships; 2.87% had more than one parallel sex partner. Of those who had parallel sex partners, 50% reported having sexual problems only with the regular partner, but not with the parallel partner.

Only 36% of all the women admitted that their gynecologist had ever asked them about sex life and complaints. Less than two-thirds (64%) of the respondents reported that their gynecologist had never asked about their sex life. The majority (80.33%) of the respondents declared they would like to be asked about their sex life by a gynecologist, and 19.67% would not want their gynecologist to ask about sexual issues. More than half (54%) of the patients had ever faced sexual problems in their lives, but less than two-thirds (62.35%) of those who had ever had sexual problems never asked a physician for help. Those who sought for help consulted with a gynecologist (83.82%), a psychotherapist (7.36%), a general practitioner (4.41%), and a sexologist (4.41%). The reasons for not talking about sexual complaints among the patients who had sexual problems, but not consulted with a physician (62.35%,  $n=101$ ), are described in Fig. 1, showing that psychoemotional barriers predominated, and this emphasizes the importance of the initiation of conversation by a physician. These patients were divided in 2 age groups to analyze the differences in reasons for not talking between the age groups: aged 18–35 years (57.43%,  $n=58$ ) and 36–50 years (42.57%,  $n=43$ ). The patients of the younger age group (68%,  $n=34$ ) felt shy to talk more often in comparison with their older counterparts (32%,  $n=16$ ), with a difference being significant ( $\chi^2=4.53$ ;  $df=1$ ;  $P=0.033$ ). There were no significant differ-

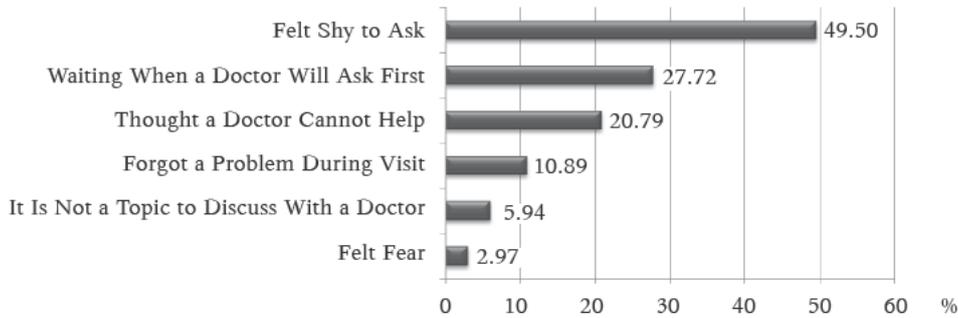


Fig. 1. Reasons for not asking for help from a doctor in case of sexual concerns

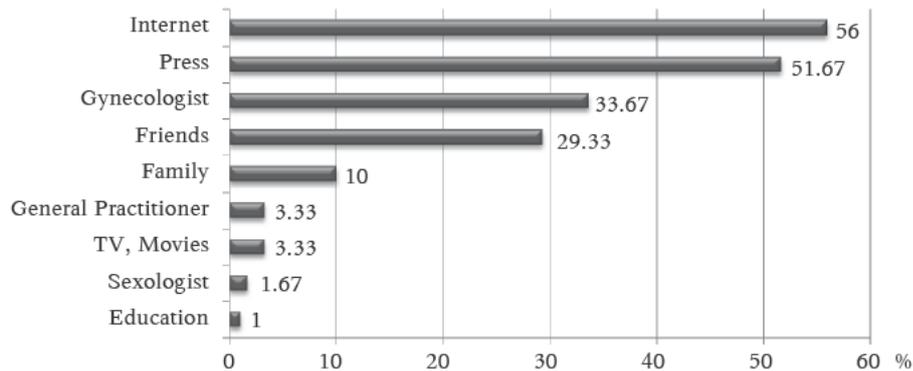


Fig. 2. Sources of information about sexuality

ences in other barriers for talking between the age groups. Fig. 2 summarizes the sources of information that were used by all patients ( $n=300$ ) to seek information about sexuality and sexual health. These results clearly confirm a serious lack of education on sexuality and sexual health in the general education system. All the patients were divided in 2 age groups to analyze the differences in the sources of information between these groups: aged 18–35 years (63%,  $n=189$ ) and 36–50 years (37%,  $n=111$ ). The analysis of using the Internet as a source of information (56%,  $n=168$ ) showed that the patients of the first age group (80.36%,  $n=135$ ) used the Internet more often in comparison with the second age group (19.64%,  $n=33$ ) with a difference being significant ( $\chi^2=49.35$ ;  $df=1$ ;  $P<0.001$ ). There were no significant differences in using other sources of information between the age groups.

Based on the Female Sexual Function Questionnaire 28, the sexual function of those patients who had had sexual activities during the last 4 weeks ( $n=209$ ) was classified into 3 categories in all 8 evaluated domains (desire, arousal sensations, lubrication, cognitive excitement, orgasm, pain, satisfaction, and partner): normal sexual function, borderline sexual function, and sexual dysfunction. A significant association among these parameters was shown ( $\chi^2=538.8$ ;  $df=14$ ;  $P<0.001$ ). The prevalence of female sexual dysfunction among sexually active gynecological patients is shown in Fig. 3. The results showed a high prevalence of dysfunction across all 3 domains of female sexual arousal: arousal-sensations (46.41%), arousal-lubrication (40.67%), and arousal-cognitive (38.76%). More than one-third of the patients had orgasm dysfunction (29.67%) and desire dysfunction (26.79%); 15.31% and 6.22% of the respondents had satisfaction dysfunction and pain dysfunction, respectively. The prevalence of borderline sexual function is described in Fig. 4, showing the highest level of borderline sexual function in the desire domain (51.20%). Fig. 5 depicts the prevalence of normal sexual function, showing the highest levels of normal sexual function in the partner (88.04%) and pain (80.86%) domains.

### Discussion

There is obvious evidence in the literature and research (3, 5, 7) that sexual health is an integral part of overall health; consequently, it cannot be ignored either in the education system or the healthcare system. Although gynecologists perform regular examinations of women's health and have an opportunity to ask them about their sex life together with other usual questions of an intimate nature, our study showed that only 36% of the patients had ever been asked about sexual issues by their gynecologist. The level of sexual dysfunction among gynecological

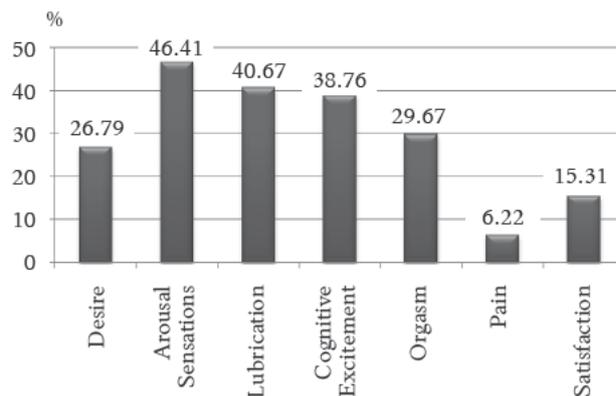


Fig. 3. Prevalence of sexual dysfunction according to the main domains of sexual function

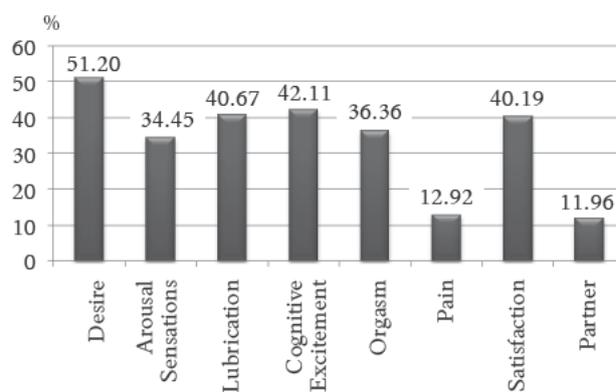


Fig. 4. Prevalence of borderline sexual function according to the main domains of sexual function

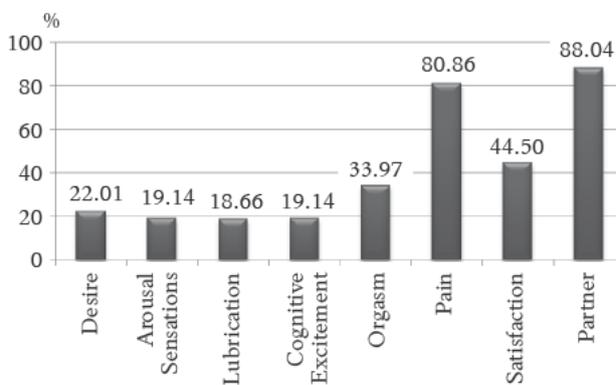


Fig. 5. Prevalence of normal sexual function according to the main domains of sexual function

patients found in our study along with the low level of questioning by a physician allows us to draw a conclusion that the underdiagnosis of sexual dysfunction is really a problem in the gynecological clinic. The literature data show the similar problems of insufficient attention to sexual health in other medical specialties as well (1, 3, 5, 21, 22). Although theoretically gynecological disorders could possibly increase the occurrence of sexual disorders, the prevalence of sexual dysfunction among

gynecological patients in this study in general corresponds to the prevalence in the general population (3, 15, 23), nonetheless showing a higher prevalence of arousal dysfunction in all 3 domains describing arousal (arousal sensation, lubrication, and cognitive excitement).

Only a small part of the patients with sexual complaints asked for help, and this is in line with the data reported in the literature (3, 24–26). The most common causes for not asking were also similar, but showing the more frequent tendency of being shy and waiting when the doctor will ask first, despite the fact that the categories for the barriers mentioned may also overlap. The explanation for this could be the mentality and character features of the study population. Disbelief that a physician will be able to help or will not pay attention to the problem predominates in other studies (3). If nearly two-thirds of patients with sexual complaints do not talk to a physician and it is mostly because of the shame, it is a serious reason to revise the current approach to the structure of taking a case history during gynecological healthcare visits, because most of patients admit they would like to discuss sexual issues with their gynecologist. Even though education systems vary across countries, a lack of sexual education as part of medical education is observed in many countries (1, 27). If professionals are not accordingly educated, they are not able to deal with such problems appropriately. The results of our study also show a considerable lack of information about sexuality in the general education system – only few patients had got knowledge about sexuality from education. If society is not educated properly, the use of unreliable sources of information leads to growing myths, illusions, false perceptions, and more frequent sexual difficulties.

Wide interpretation of the study results and generalization to the whole population of gynecological

patients are restricted by a relatively small sample size, but it gives an opportunity to see and analyze tendencies and demonstrate the problem.

An intrinsic disadvantage of a questionnaire-based approach is a subjective conception of questions, recall failures, and impossible verification of answers. However, considering the objective of the study and an emotional and intimate nature of this topic, the questionnaire-based approach was chosen as most suitable for this study.

In general, a proof of the existing problem of the insufficient assessment of sexual health in gynecological practice and the insight into associated problems were achieved by this study. Gynecologists in daily practice cannot manage all forms of sexual dysfunctions and it would not be possible also because of lack of knowledge, skills, time, and different therapeutic approaches required in sexology; however, our practical recommendation from this study is that the gynecologist should screen all patients for sexual disorders, provide basic information and recommendations, and refer to a specialist if it is necessary.

### Conclusions

The assessment of sexual dysfunction in the gynecological clinic is insufficient as gynecologists do not ask women about sexual complaints routinely and most of the patients do not complain of their sexual problems, which is mostly because of psychoemotional barriers. The main source of information about sexuality is the Internet, but the vast majority of patients would want to talk to their gynecologists about sexuality. Female sexual dysfunction is a frequent disorder among gynecological patients, and arousal dysfunction is the most common form.

### Statement of Conflict of Interest

The authors state no conflict of interest.

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