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Barriers to talking about sexual health issues with physicians

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Abstract

Objective: Although patient barriers to discussing sexual problems within medical consultations remain relatively unexplored patients may have a hard time talking about sex at one time or another. Whether asking a medical sex question to the physician, sex talk can feel anywhere from awkward to impossible. Keeping silent about sex keeps patients ignorant and potentially leads to negative health outcomes and allows perpetuating sex myths. Research shows both patients and physicians face barriers to communication about sexuality. The aim of this study was to explore patients' barriers to talk about sexual health issues with physicians.

Method: A face to face questionnaire was conducted among patients attending to gynecologic polyclinics, where participants were asked explicitly about their sexual life, problems and talking about sexual health issues with physicians and experience of seeking treatment for sexual problems.

Results: This study reports findings from a questionnaire with 43 women aged 25–59 years (mean 38.81± 8.28), 62.8% housewife of 79.1% gave a sexual satisfaction point of ≥ 6 points over 10 (mean 6.74±2.59) with her partners. The age of first sexual intercourse was 22.58±6.28 years old. 60.5% had a dyspareunia of a pain score of 3.21±2.11(over 10 points scale) and 34.9% avoid having a sexual intercourse because of the pain in the past six months. 53.5% did not talk sexual health issues with physicians but 83.7% of them thought it should be talked with physicians. The patients' barriers to talking about sexual health issues with physicians were embarrassment and lack of a trusting and comfortable professional relationship 18.6%, waiting the physicians to ask the sexual issues 7 %, don't think that physicians help to sexual problems 2.3%, and forget asking the sexual problem during consultation 4.7%. Patient may speak sexual issues if the patient is in confidence in speaking about sexual practices and had a reason to talk about sexual health 51.2%, if physician asks about sexual issues 32.6%, if the physician is women 2.3%.

Conclusion: Although sexuality is a key aspect of women's physical and psychological health, it is often not discussed during the course of general practice consultation. The most obvious reason is that physicians usually focus on the problem of the day and there is a lack of the time to discuss general health issues. However there may be many other reasons for not talking to patients about sex, including embarrassment, fear of alienating the patient, lack of a trusting and comfortable professional relationship with the patient (although a close relationship can also act as a barrier), lack of confidence in speaking about sexual practices and lack of a reason to talk about sexual health.

Keywords: *Talking sexual issues, barriers, physician aspects*

1. Introduction

A WHO expert group described sexual health as “the integration of the somatic, emotional, intellectual and social aspects of sexual being in ways that are positively enriching and that enhance personality, communication and love” (1,2). Despite the high prevalence of female sexual dysfunction, most healthcare providers do not address the condition in their practices (3). There are several patient and provider barriers that compromise optimal communication about female sexual health. Female patients have several concerns and questions about their sexual health and may benefit from discussing their concerns with a sex-positive healthcare provider (4,5).

Several useful tips have been provided to help healthcare providers successfully communicate with their female patients about sexual health. Female sexual dysfunction (FSD) is defined as the various ways in which a woman is unable to participate in a sexual relationship as she would wish (6). It is an umbrella term that includes 4 major categories: persistent or recurrent disorders of sexual interest/desire, disorders of subjective and genital arousal, orgasm disorder, and pain and difficulty with attempted or completed intercourse (7).

Sexual history taking is a chronological classification of human life cycle consisting sexual

behaviour, emotions, expectations, experiences, and social changes (8,9). It gives information about the characteristics (aetiology, onset, severity and duration of symptoms, psychosocial impacts) of the current sexual dysfunction, the changes causing trouble, available personal resources, aims and motivations of marriage, expectations from the therapy, and interpersonal relationship of partners (8-11).

Fears of the physician about irritating the patient, seeming curious, anxieties about inability to solve sexual problems or fear of going beyond the limits of doctor-patient relationship are some of the obstacles in sexual history taking (12). Others are (13);

a) Prejudgements of the health professionals

b) Limitations in medical knowledge

c) False expectations and beliefs of health professionals

d) Cultural, religious, ethnic factors related to patient's attitudes and beliefs

e) Language and terminology problems

2. Materials and methods

A face to face questionnaire was conducted among patients attending to gynecologic polyclinics, where participants were asked explicitly about their sexual life, problems and talking about sexual health issues with physicians and experience of seeking treatment for sexual problems.

3. Results

This study reports findings from a questionnaire with 43 women aged 25–59 years (mean 38.81± 8.28), 62.8% housewife of 79.1% gave a sexual satisfaction point of ≥ 6 points over 10 (mean 6.74±2.59) with her partners. The age of first sexual intercourse was 22.58±6.28 years old. 60.5% had a dyspareunia of a pain score of 3.21±2.11 (over 10 points scale) and 34.9% avoid having a sexual intercourse because of the pain in the past six months. 53.5% did not talk sexual health issues with physicians but 83.7% of them thought it should be talked with physicians. The patients' barriers to talking about sexual health issues with physicians were embarrassment and lack of a trusting and comfortable professional relationship 18.6%, waiting the physicians to ask the sexual issues 7 %, don't think that physicians help to sexual problems 2.3%, and forget asking the sexual problem during consultation 4.7%. Patient may speak sexual issues if the patient is in confidence in speaking about sexual practices and had a reason to talk about sexual health 51.2%, if physician asks about sexual issues 32.6%, if the physician is women 2.3%. Although 18.6% of women with any distressing sexual problems sought formal care from a physician, 51.2% of the time the women, rather than the physician, initiated the conversation. Most patients preferred to receive sexual health information from their provider who initiated the conversation (32.6.1%).

4. Discussion

Although sexuality is a key aspect of women's physical and psychological health, it is often not discussed during the course of general practice consultation. The most obvious reason is that physicians usually focus on the problem of the day and there is a lack of the time to discuss general health issues (14). However there may be many other reasons for not talking to patients about sex, including embarrassment, fear of alienating the patient, lack of a trusting and comfortable professional relationship with the patient (although a close relationship can also act as a barrier), lack of confidence in speaking about sexual practices and lack of a reason to talk about sexual health. The US National Health and Social Life survey, which was undertaken in people aged 18–59 years, reported that sexual dysfunction is more prevalent for women (43%) than men (31%) (15). Another US study of 1550 women and 1455 men aged 57–85 years found that the prevalence of sexual activity declined with age (73% among respondents who were 57–64 years of age, 53% among respondents who were 65–74 years of age, and 26%

among respondents who were 75–85 years of age); women were significantly less likely than men at all ages to report sexual activity (16). In our study, 79.1% of the patients gave a sexual satisfaction point of ≥ 6 points over 10 (mean 6.74±2.59) with her partners. Of the women, 60.5% had a dyspareunia of a pain score of 3.21±2.11(over 10 points scale) and 34.9% avoid having a sexual intercourse because of the pain in the past six months.

The majority of participants agreed that PCPs should give information to all patients (74%), ask all patients (69%), and have questions on medical history forms (55%) about SDs. Fifty-eight (58%) participants preferred to start the conversations about SDs with PCPs themselves, but all of these participants did not object to PCPs asking them about SDs.). Indicate that a substantial proportion of patients prefer PCPs initiate, and even patients who preferred to start the discussion did not object to information or questions about SDs from PCPs (17-19).

5. Conclusion

In order to address sexual health in existing service delivery points – whether family planning clinics, STI clinics, antenatal care clinics or primary health care posts – staff need to have knowledge about sexuality, skills to deliver appropriately the information, treatment and care people need, and the willingness and ability to deal with ease with sexuality-related issues (17).

This may seem self-evident, but in most contexts and settings, one or more of these dimensions are lacking. Sexual and reproductive health and well-being are essential if people are to have responsible, safe, and satisfying sexual lives (20,21). Sexual health requires a positive approach to human sexuality and an understanding of the complex factors that shape human sexual behaviour. These factors affect whether the expression of sexuality leads to sexual health and well-being or to sexual behaviours that put people at risk or make them vulnerable to sexual and reproductive ill-health (22). Health programme managers, policy-makers and care providers need to understand and promote the potentially positive role sexuality can play in people's lives and to build health services that can promote sexually healthy societies.

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