Sexual Problems Among Family Medicine Patients

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A self-administered questionnaire assessing sexual satisfaction and presence of a number of common sexual problems was developed. Following assessment of reliability and validity, the questionnaire was administered to 142 patients seen in a family medicine center. While 56 percent of patients reported one or more sexual problems, such problems were noted in the medical record in 22 percent of the cases. The nature of many of the problems (ie, techniques of foreplay, fear of pregnancy, and differences in attitudes and expectations between partners) suggests an effective role in treatment for the primary care physician.

While much attention has been focused on treatment of sexual problems, there is little information available about the extent of sexual problems seen in primary care settings. Most descriptions of sexual problems and treatment programs have focused on sexual dysfunctions such as impotence, premature ejaculation, dyspareunia, and anorgasmia.[1-3] There is evidence, however, that such dysfunctions are far less common than "sexual difficulties." In a survey of 100 couples, Frank et al found that 50 percent of men and 77 percent of women surveyed reported difficulties that were not dysfunctional in nature (eg, lack of interest or inability to relax).[4] An important finding of this study was that the number of such "difficulties" was more strongly and consistently related to overall sexual dissatisfaction than was the number of "dysfunctions."

A number of treatment programs have been described, many of which report good results in treating sexual disorders.[1-3] However, most persons with sexual problems will probably continue to be seen by primary care physicians rather than specialty treatment clinics. In addition, several workers have documented and discussed deficiencies in medical education and treatment of sexual problems.[5-9] It will be difficult to correct these deficiencies until more is known about what kind of problems a primary care physician sees.

The purpose of this study was to:

1. develop an instrument which can help in the identification and assessment of sexual problems among medical patients,
2. determine the frequency of sexual problems and concerns among patients seen in a family practice,
3. determine how frequently resident physicians identify sexual problems of their patients.

Methods

The literature was reviewed to determine which sexual problems and medical concerns were most frequently identified in general settings. Articles concerning the assessment of sexual behaviors and existing questionnaires were reviewed to de-

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termine their suitability for the purposes of this study.[10-15] Burnap and Golden, in a survey of 60 physicians, ranked the frequency of the 20 most common sexual problems, ranging from 1,917 cases per year of anorgasmia to five cases per year of satyriasis (excessive impulses for sexual intercourse in the male).[16] Using the ranking as a basis, some areas were excluded, such as "extramarital intercourse" which appeared to relate more to a relationship disturbance than a sexual problem. There were many areas of overlap between "relationship" and "sexual" problems, such as lack of desire or painful intercourse. These areas were retained in the questionnaire. Questions regarding relationship problems were excluded because a pilot study showed that they made the questionnaire too long for use in a primary care setting.

Several existing questionnaires included problems listed as being the most frequent concerns by Burnap and Golden but also asked detailed questions concerning either the conjugal relationship and/or sexual behavior not necessarily indicative of sexual problems (eg, frequency of heterosexual anal intercourse). Because the purpose of this questionnaire was to serve as a screening device in a physician's office, and not to research the sexual behavior of the population in general, it was decided to develop a more concise and problem oriented questionnaire.

A three-page questionnaire dealing with 11 major question areas was developed.* The first set of questions asks for demographic data, reason for the appointment, and the sex of the patient's regular physician. The next set of questions asks whether an individual's sexual life might be improved in any of seven specific ways. Subjects are also asked to list other ways in which their sexual life might be improved. The next question area lists 18 potential sexual problems and asks patients to indicate whether any of the items are problems for them. If the answer is affirmative, subjects are then asked whether this is of no concern to them, of some concern, or of great concern. Again, space is provided for the patient to list additional problems. The final question on the questionnaire asks about the ease with which the partners communicate about their sexual needs.

Any questionnaire must have acceptable validity if it is to be useful. The most convincing test of validity—a high positive correlation between observed and reported sexual problems—is not practical, because there is no way to observe the patients' sexual behavior. A practical measure of validity is to compare the questionnaire with the standard method of assessing sexual function (ie, the clinical interview). Eleven patients completed the questionnaire and then were interviewed by a psychiatrist using a semi-structured interview. The psychiatrist was not aware of the results of the questionnaire at the time of the interview. In all but one case, the information provided by the questionnaire and the interview was identical, in this one case the subject reported more sexual problems on the questionnaire than during the interview. Because the instrument was constructed on the basis of the frequencies reported by Burnap and Golden, the content validity or the degree to which the questionnaire covers a representative sample of the area to be measured is assumed to be high.

Reliability of the questionnaire was assessed in two settings. Fifteen medical patients in a family medicine center completed the questionnaire twice, once before their visit with the physician and once after the same visit. The coefficient of stability (the correlation between the first and the second tests) was .98. When 18 psychology patients completed the test twice, with a 14 to 18-day interval between testing, the coefficient of stability was .94.

Another important issue in developing a questionnaire on this subject is acceptability. In this study, 152 medical patients in a family practice center waiting room were asked by a psychologist, psychiatrist, or a medical student, with whom the patient had no prior contact, to complete the questionnaire. Seven persons refused for physical reasons (eg, poor eyesight); three declined because of the content of the questionnaire. When a psychologist asked 19 patients with whom he had an ongoing relationship to complete the questionnaire twice, none refused. (One terminated treatment during the two-week interval and never completed it a second time.)

On the basis of interviewer availability, half-days were selected over three weeks during which all patients over age 16 years who were seen at a family medicine center were asked to complete the questionnaire. The questionnaire was completed

*Available from the authors upon request

either in the waiting room or in the examining room. Of the 152 patients asked, 142 completed the questionnaire.

Medical records of the subjects were reviewed by one of the experimenters who was not aware of the results of the questionnaire. Medical records were audited to determine whether the physician noted either a sexual or a marital problem for any visit during the preceding six months.

Results

The average age of patients surveyed was 32.5 years (range 17-78 years) and 79 percent of the patients were female. (Approximately two thirds of all patients seen in the family medicine center are female.) Sixty percent of the patients were either married or living with a member of the opposite sex. Seventeen percent were divorced or separated. Forty-five percent of the patients had more than a high school education.

More than 90 percent of the patients were return patients to the family medicine center. Forty-five percent of the subjects came to the office for health maintenance. Fifty-one percent were seeking treatment for a specific problem.

One hundred eighteen (84 percent) of the subjects were involved in a sexual relationship at the time they filled out the questionnaire, 21 (16 percent) did not have a current sexual relationship. Patients not having a sexual relationship at the time of the visit were included in the data analysis because at least some of the individuals might not have had sexual partners at the time of the study due to personal sexual problems, and to exclude those patients would bias the sample.

Twenty-nine percent of subjects described the quality of their sexual life as excellent, 38 percent described it as good, 13 percent said it was fair, and 9 percent said it was poor. Fifty-seven percent of subjects indicated they were able to discuss their sex life freely and openly with their partner(s), 24 percent could talk about some areas but were inhibited concerning others, four percent were generally inhibited and uncomfortable when talking about sex, and four percent said they never talked about sex with their partner(s). Eleven percent did not respond to this question.

Table 1 lists specific sexual problems reported by subjects. It also indicates the percentage of persons feeling this problem was of "some concern" or of "great concern" to them. Attitudinal differences between partners was the most commonly identified problem (30 percent of subjects).

Table 2 lists the percentage of subjects who believe their sexual lives could be improved in a particular way. Different or longer foreplay and more frequent sex were the most frequently identified ways in which individuals felt their sexual life could be improved. Fifty-six percent of patients identified at least one sexual problem on the questionnaire and 22 percent of patients were noted to have either a marital or sexual problem in the medical record.

Discussion

There are several possible explanations for the difference in number of problems identified by patients and recognized by the physician. Physicians may not routinely inquire about sexual problems, patients may not spontaneously report them, and physicians may be aware of them but elect not to record them in the record.

Thirty-seven independent variables were examined to determine whether they were associated with physician notation of a sexual or marital problem in the medical record. Chi-square tests indicated that lack of overall sexual satisfaction, desiring decreased frequency of sexual intercourse, the partner's climaxing too quickly, and the subject being female were associated with an increased likelihood of the physician noting a sexual or marital problem. Because of the large number of variables examined, the overall alpha level is above accepted levels; however, variables with significant alpha levels done in a review of multiple tests are worthy of further investigation. For the entire sample, overall dissatisfaction was most closely associated with recognition by the physician. For women who reported overall dissatisfaction, the most commonly reported problems were desiring less frequent sex (73 percent) and partner's achieving orgasm too quickly (64 percent). Eighty percent of women who wanted less frequent sex said their partners climaxed too quickly.

If the most common specific sexual complaint

Table 1. Sexual Problems Reported by 142 Family Medicine Patients

Problem	% Indicating it is a problem	% Indicating it is of some concern	% Indicating it is of great concern
Attitudinal differences between partners	30	22	3
Fatigue	24	14	3
Lack of time	22	17	0
Subject's partner wishes to have sex more frequently than subject	21	11	2
Subject wishes to have sex more frequently than partner	21	11	2
Techniques of petting and foreplay	18	16	1
Lack of privacy	18	13	1
Fear of pregnancy	15	11	4
Subject does not achieve orgasm	13	6	6
Partner achieves orgasm too quickly	13	6	4
Subject has pain on intercourse	13	8	4
Position of sexual intercourse	10	8	1
Subject's inactivity	6	6	0
Partner does not achieve orgasm	5	4	1
Partner's inactivity	4	4	1
Subject achieves orgasm too quickly	4	1	2
Partner has difficulty in erection	4	2	1
Subject has difficulty in erection	1	0	1
Other (eg, pregnancy interfering; partner's request for a particular form of sex, such as oral sex, which is distasteful to the patient; wanting a deeper involvement with the partner)	4	0	1

of women was to indicate dissatisfaction with their partners, this was not the case for males in the sample. Where males reported overall sexual dissatisfaction, the most common problem reported was achieving an orgasm too quickly (60 percent of males who reported overall dissatisfaction). Thirty percent of men who reported dissatisfaction with their overall sex life reported difficulty achieving an erection.

Many of the concerns identified in this survey might be significantly improved by brief intervention of a primary care physician. Techniques of treatment for many of the problems identified in this survey have been described.[1-3] Many of the techniques are appropriate in a primary care setting. Problems concerning techniques of foreplay and problems with positions while having intercourse might respond to educational and permission giving interventions. Likewise, problems such as premature ejaculation frequently respond to education about specific techniques, such as the "squeeze technique." Other problems such as painful intercourse require evaluation by a physician. Problems such as attitudinal differences, lack of privacy, and lack of time may respond to counseling interventions by the primary physician.

This study has demonstrated that a questionnaire about sexual problems can be used in a pri-

Table 2. Ways Family Medicine Patients Believe Their Sex Lives Could Be Improved

	% Indicating this would improve the quality of their sex lives
Different or longer foreplay	27
More frequent sex	26
Less worry about pregnancy	14
Sex with different partner(s)	8
Different method of birth control	6
Less frequent sex	5
Partner could enjoy sex more	5
Other specific problem, eg, curing partner's alcoholism, male not being willing to delay his climax, history of rape, bladder infections associated with frequent sex, being unable to slow down at work or at home, feeling dominated by possessive partner, feelings of being in a rut, symptoms of depression	14

mary care physician's office to increase the identification of sexual problems. Furthermore, the questionnaire used in this survey appeared to be well-accepted by patients. More data are needed on the effect of intervention in those patients who do not come to the office complaining of sexual problems. The nature of the most common problems (ie, questions about foreplay, males climaxing too quickly) suggest that education and brief counseling might improve sexual satisfaction in many of these individuals.

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