Management of Female Sexual Problems: Perceived Barriers, Practice Patterns, and Confidence among Primary Care Physicians and Gynecologists

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ABSTRACT

Introduction. Although approximately 40% of women report female sexual problems—and particularly sexual desire disorders, there are numerous practical, professional, and personal barriers to their diagnosis and management by treating clinicians.

Aim. To identify practice patterns, perceptions, and barriers to the diagnosis and management of female sexual problems among U.S. practicing primary care physicians (PCPs) and obstetrician/gynecologists (OB/GYNs).

Methods. A random sample of practicing U.S. PCPs and OB/GYNs were sent a case-vignette survey by e-mail and fax. Response to the survey was considered consent. A regression model was analyzed to assess predictors of confidence.

Main Outcome Measure. Frequency and variability in diagnostic tests ordered and treatment recommendations provided for a patient with diminished sexual desire. Percent of physicians who reported they were confident in treating hypoactive sexual desire disorder (HSDD) and percent who reported significant barriers to initiating a dialogue about sexual health with female patients.

Results. A total of 505 responses were analyzed (8.8% response rate). Of respondents, 21% of OB/GYNs and 38% of PCPs stated they were not at all confident in treating HSDD. The majority of physicians would order a thyroid panel (PCP = 63%, OB/GYN = 53%) to assess a patient’s diminished desire and recommended counseling and stress management to treat a patient with sexual complaints (PCP = 48%, OB/GYN = 54%). Regression results identified time constraints, the perceived lack of effective therapies, perceptions regarding patient-physician gender discordance, years in practice, number of patients seen per week, and perceptions regarding continuing medical education and practice experience as significant and independent predictors of confidence in treating HSDD patients.


Key Words. Physician Practice Patterns; Sexual History Taking; Sexual Dysfunction; Sexual Desire Disorder

Introduction

Female sexual dysfunction (FSD) encompasses a range of sexual disorders involving desire, arousal, orgasm, and pain during sexual activity [1]. It is estimated that approximately 40% of U.S. women have a sexual complaint [2,3]. While the exact prevalence of specific sexual dysfunctions varies by the population studied and the instruments used, decreased desire is frequently the
most common concern [2,4]. Many women with this concern may in fact have hypoactive sexual desire disorder (HSDD). HSDD is defined in the DSM-IV as a “deficiency or absence of sexual fantasies and desire for sexual activity, causing marked distress or interpersonal difficulty and not better accounted for by another Axis I disorder and not due exclusively to the direct physiological effects of a substance (drug abuse or medication) or a general medical condition” [5]. Since decreased sexual desire can be secondary to psychosocial influences as well as the direct physiological effects of a substance or underlying medical condition, clinicians evaluating this complaint must assess multiple factors that can affect sexual functioning before making a diagnosis of HSDD. Currently, there are no medications with an FDA-approved indication for HSDD treatment. As a result, the condition is predominantly managed through psychosexual therapy and off-label medication use.

Identifying the patient with low sexual desire is a critical, but challenging first step in HSDD management. Discussion of FSD is often highly dependent on patient initiative [6]. Most patients who are bothered by sexual dysfunction would like to be able to discuss these issues with their primary care or obstetrician/gynecologist (OB/GYN) physician, but only a minority actually broach the subject with their physician [6–10]. Patients are often deterred from seeking help because of embarrassment and many delay care until distress levels are substantial [6]. Discussion may be further hindered by the terminology associated with FSD and its assessment, which appears to be awkward for both patients and physicians [11].

Given patients’ reluctance to talk about FSD, physician leadership in asking about sexual health and creating a comfortable discussion climate is essential. Yet, physicians report that they infrequently initiate conversations with patients about sexual health [12,13]. Physicians also underestimate the prevalence of sexual difficulties in their patient population and are often uneasy asking about these issues, even at routine gynecologic exams [12–14]. Inadequate physician training is a major contributor to this reticence. Physicians providing gynecologic care typically receive education on sexuality and sexual health during medical school and residency, but this education is usually didactically delivered and of inconsistent quality [15,16]. This training typically enables physicians to proficiently communicate about safe sex practices and contraception, but less consistently prepares physicians to discuss particularly sensitive aspects of sexuality [14,17]. It is therefore not surprising that many physicians cite their own embarrassment as a significant deterrent to discussing sexual health [14]. Physicians are even more uncomfortable discussing sexuality with patients when their cultural backgrounds are discordant [18–20]. Gender differences are a well-recognized impediment to physician-initiated discussion about sexual health, but communication is further hindered when patients significantly differ in age, marital status, education, race and ethnicity [18–20].

Even when FSD is brought into the open, determining a meaningful intervention appears difficult. In fact, a study of women with sexual complaints found that the majority who sought help from their physician received no treatment at all [6]. Few studies have specifically explored how physicians assess and treat female patients with sexual dysfunction, but it is fairly clear that physicians are unsure how to best approach this problem. Many physicians consider current treatment options to be lacking or of limited efficacy [11,14]. This may partly reflect a perceived lack of skill and time to provide counseling on such a complex issue, as well as limited referral options, particularly for primary care physicians [19]. Physician uncertainty is likely compounded by the absence of medications approved for treating sexual dysfunction.

This study sought to further explore perceptions and practice patterns of primary care physicians (PCPs) and OB/GYNs regarding FSD and its initial evaluation and treatment. These physicians were targeted since women turn to these specialties most often for help with sexual concerns [6]. The study was specifically designed to examine perceived barriers to initiating discussion of sexual health with patients, confidence in treating the most common sexual dysfunction— HSDD, and clinical decision-making in managing female sexual problems. The study also explored characteristics associated with PCP and OB/GYN confidence in treating HSDD. Findings from this study are expected to inform future educational interventions on FSD.

Methods
Survey Instrument
A survey was developed by the authors to explore practice patterns and confidence in managing FSD as well as training and barriers associated with sexual history-taking (Appendix A). Practice patterns were specifically assessed with a set of ques-
tions centered on a case vignette. This methodology has been shown to be an effective and cost-efficient method for measuring physicians' clinical decision making [21,22]. The case vignette described a married woman who is found to have low sexual desire during an annual visit. The case was followed by an open-ended question asking physicians what diagnostic tests they would order to evaluate the patient's diminished libido. A second open-ended question asked physicians how they would treat the patient if assessment reveals no evidence of depression or laboratory abnormalities.

Prior training in taking a sexual history was assessed by having physicians rate the adequacy of their training received from medical school, residency, and CME courses using a 10-point scale (1 = not at all adequate; 10 = extremely adequate). The survey explored the impact of four physician barriers on the initiation of dialogue about sexual health with their patients using a 10-point scale (1 = not a barrier; 10 = major barrier). Physicians were also asked to rate their confidence in treating women with HSDD (1 = not at all confident; 10 = extremely confident). A fourth rating question assessed the perceived influence of continuing medical education (CME) and practice experience on management of female patients with HSDD. Additional items were added to the survey that assessed physicians' personal and practice characteristics including respondent gender, years in practice, and the number of patients under age 50 seen per week reporting a sexual problem that interfered with their relationship.

Data Collection Procedures
Based on a simple random sampling strategy a list of U.S.-practicing OB/GYNs and PCPs specializing in family medicine and internal medicine were selected from the American Medical Association 2007 Masterfile database. Participants were invited to complete the 15-minute survey by e-mail and fax between February 1 and March 4, 2008. A $50 gift card was offered as an incentive. Physicians who received an email were able to complete a web-based version of the survey, while those contacted by fax were able to complete the web-based survey or fax back a paper-based version. Using a waved recruitment method, a total of 5,786 physicians were issued invitations. Individuals who did not respond after three contacts were replaced by others drawn randomly from the same database until a sample size of approximately 250 for each physician group had been achieved. All data were directly exported from the data entry and online surveying system into a Statistical Package for Social Sciences (SPSS Inc., Chicago, IL, USA) v. 15.0 database. All personal information was removed for data analysis.

Data Analyses
Descriptive analyses were performed to calculate means and percentages and examine the distribution characteristics of the data. For questions using a 10-point rating scale, responses were collapsed and reported, as appropriate, into low (rating of 1–3), intermediate (rating of 4–7), and high (rating of 8–10) groupings.

A multiple linear regression analysis was conducted to examine the relationship between confidence in treating HSDD as a function of physician characteristics (years in practice, gender, number of female patients reporting a sexual problem seen per week), perceived physician barriers to initiating dialogue about sexual problems as well as the perceived influence of CME and practice experience on HSDD management. Separate models were derived for PCPs and OB/GYNs and were analyzed using the Enter method. These tests were conducted using a level of statistical significance of 0.05. All analyses were conducted using SPSS v.15.0.

Results
Participant Characteristics
A total of 512 responses were obtained (8.8% response rate). After excluding seven responses due to incomplete data, the final dataset contained 257 PCPs (82% family physicians, 18% internists) and 248 OB/GYNs. Table 1 shows the characteristics of the respondents by specialty. For both groups, the average number of years in practice was 17 years. The majority of respondents were men (PCP = 70.6%, OB/GYN = 56.9%). In both groups, respondents and non-respondents were similar with respect to gender distribution, but OB/GYN respondents had fewer years in practice than non-respondents (P = 0.003). On average, PCPs reported seeing an average of 4.5 female patients per week who reported a sexual problem that interfered with their relationship, while OB/GYNs reported seeing an average of 8.4 such patients. A substantial number of respondents reported inadequate training in taking a sexual history from female patients during medical school.
(PCP = 42%, OB/GYN = 47%, P = 0.122) as well as residency (PCP = 29%, OB/GYN = 32%, P = 0.248). Many PCPs and smaller numbers of OB/GYNs also reported inadequate training in sexual history taking from CME (PCP = 30.1%, OB/GYN = 12.5%, P < 0.001).

**Barriers to Initiating Dialogue about Sexual Health**

Both PCPs and OB/GYNs rated the perceived lack of effective therapies as a significant challenge to initiating dialogue with patients about sexual problems. Mean ratings for both groups are shown in Table 2. Time constraints were also considered a moderate barrier by both groups, but were of less concern for OB/GYNs (P < 0.001). PCPs also perceived personal beliefs and attitudes as well as gender differences as lesser, but still significant barriers to initiating dialogue, while OB/GYNs did not consider these issues to be a major impediment (P < 0.001 for both items). No differences in mean barrier ratings by gender were observed among PCPs, however male compared to female OB/GYNs perceived lack of therapies as less problematic (P = 0.037), but reported gender differences as a more significant barrier to initiating dialogue (P < 0.001).

**Practice Patterns in Managing Sexual Complaints**

Respondents were given a case vignette describing a 39-year-old married woman presenting for an annual exam. On history-taking, she is found to have had “no interest in sex for months.” The patient had recently lost her job and takes a biphasic oral contraceptive pill. (See Appendix A for full case description) Table 3 shows the leading responses to an open-ended question asking what tests, if any, would be ordered to evaluate the patient’s decreased sexual desire. The most frequently ordered tests were thyroid panel (PCP = 63.0%, OB/GYN = 53.2%, P = 0.016), testosterone (PCP = 35.0%, OB/GYN = 40.3%, P = 0.128) and complete blood count (CBC) (PCP = 34.2%, OB/GYN = 17.3%, P < 0.001) and follicle stimulating hormone (PCP = 32.7%, OB/GYN = 14.1%, P < 0.001). Notably, a small but significant portion of respondents indicated that they would not order any diagnostic tests (PCP = 5.7%, OB/GYN = 18.1%, P < 0.001).

For the same patient, respondents were also asked how they would treat this patient, assuming that lab results came back normal and there was no evidence of depression on a symptom rating scale. The leading recommendation among both PCPs and OB/GYNs was some form of counseling and stress management (PCP = 48.6%, OB/GYN = 54.4%, P = 0.112). Smaller, but still significant numbers of respondents also recommended an antidepressant or anxiolytic (PCP = 21.6%, OB/GYN = 14.6%, P = 0.021), changing or discontinuing hormonal contraception (PCP = 10.8%, OB/GYN = 25.4%, P = 0.015).
12.3%, OB/GYN = 28.3%, P ≤ 0.001) or a trial of androgen therapy (PCP = 18.4%, OB/GYN = 26.3%, P = 0.033).

Factors Related to Confidence in Treating HSDD

Figure 1 illustrates the distribution of the dependent variable—confidence levels of PCPs and OB/GYNs in treating HSDD. Results indicate that 20.7% of OB/GYNs had low confidence (rating of 1, 2, or 3 on a 10-point Likert scale), and a significantly higher percentage (38.2%) of PCPs indicated low confidence in treating HSDD (P < 0.001). Based on ratings using a 10-point scale, physicians in both groups perceived a moderate influence of CME (mean: PCP = 5.2, OB/GYN = 6.1, P < 0.001) and practice experience (mean: PCP = 6.5, OB/GYN = 7.6, P < 0.001) on their management of female patients with HSDD.

Multiple linear regression analysis evaluated the individual contributions of potential predictors to confidence in treating HSDD. Analyses were conducted separately for the two specialty groups and are summarized in Table 4. In general, the predictors for confidence in treating HSDD were similar between PCPs and OB/GYNs. For PCPs, time constraints to elicit information (β = −0.107, P < 0.05) and perceived lack of effective therapies to treat a sexual problem (β = −0.191, P < 0.001) were negatively related to their confidence in treating HSDD. In addition, the volume of patients seen per week, gender, and perceived influence of CME and practice experience were significant predictors. PCPs who saw more patients per week who report sexual problems that cause personal distress were more confident in treating HSDD (β = 0.088, P < 0.001). Female PCPs were significantly less confident in treating HSDD than male PCPs (β = −0.761, P < 0.001). Perceptions about CME courses (β = 0.127, P < 0.05) and practice experience (β = 0.366, P < 0.001) also positively influenced confidence in treating HSDD. These predictors explained 50% of the variability in PCP's confidence to treat HSDD (r-square = 0.50, F = 25.7, d.f. = 9,236, P < 0.001). Similar trends were observed among OB/GYNs. Perceptions regarding time con-
Barriers to elicit information (β = -0.117, P < 0.05) and lack of effective therapies to treat a sexual problem (β = -0.213, P < 0.001) were negatively related to confidence in treating HSDD. OB/GYNs who saw more female patients reporting sexual problems per week were more confident in treating HSDD (β = 0.039, P < 0.05). However, gender was not a predictor of confidence in treating HSDD for OB/GYNs. In contrast, OB/GYNs who have been in practice longer were more confident in treating HSDD (β = 0.372, P < 0.001). These predictors explained 39% of the variability in OB/GYNs’ confidence to treat HSDD (r-square = 0.39, F = 15.2, d.f. = 9, 217, P < 0.001).

**Discussion**

Our study found an overall inconsistent approach by both OB/GYNs and PCPs in the assessment and management of women complaining of low sexual desire. The results of our study support prior research from a pilot study, which found a majority of PCPs in an academic primary care facility do not routinely screen for, diagnose, or manage sexual problems [12]. Similarly, a recent study found that physician specialty influences

![Figure 1](image-url) Distribution of confidence in treating HSDD among primary care physicians and obstetrician/gynecologists. Confidence measured on a 10-point Likert scale (1 = not at all confident, 10 = extremely confident). How confident are you in your ability to treat women with hypoactive sexual desire disorder (HSDD)?

<table>
<thead>
<tr>
<th>Table 4 Predictors of confidence in treating HSDD by specialty</th>
<th>Confidence in treating HSDD</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Predictors</strong></td>
<td><strong>PCPs (β)</strong></td>
</tr>
<tr>
<td>Barriers affecting the physician in initiating a dialogue with patients</td>
<td>0.078</td>
</tr>
<tr>
<td>Your personal attitudes and beliefs</td>
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<tr>
<td>Time constraints to elicit information</td>
<td>-0.110*</td>
</tr>
<tr>
<td>Lack of effective therapies to treat a sexual problem unrelated to physiological or urogynecological issues</td>
<td>-0.198**</td>
</tr>
<tr>
<td>Gender differences (physician barrier)</td>
<td>-0.004</td>
</tr>
<tr>
<td>Practice and Personal Characteristics</td>
<td></td>
</tr>
<tr>
<td>Years in practice</td>
<td>-0.044</td>
</tr>
<tr>
<td>Female patients seen per week who report a sexual problem that interferes with their relationship</td>
<td>0.239</td>
</tr>
<tr>
<td>Gender</td>
<td>-0.164*</td>
</tr>
<tr>
<td>Influence on management of female patients with HSDD</td>
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</tr>
<tr>
<td>Continuing medical education courses</td>
<td></td>
</tr>
<tr>
<td>Practice experience</td>
<td>0.393**</td>
</tr>
</tbody>
</table>

PCP = primary-care physician; OB/GYN = obstetrician/gynecologist; R² for PCP Model = 0.50; R² for OB/GYN model = 0.39.

*P < 0.05; **P < 0.001.

Note: Columns showing “b (s.e.)” were removed and table reformatted.
physician confidence and willingness to perform or precept women’s health skills, with academic general internists far less confident or willing than family practitioners [23]. Clinicians showed considerable variation in their choice of tests for a woman concerned about decreased sexual desire. A high proportion of respondents did not select potentially appropriate laboratory tests such as prolactin levels and thyroid function which can assist in the differential diagnosis of conditions such as pituitary prolactinoma and biological hypothyroidism, respectively [24,25]. Interestingly, the second most common response for both groups was testing for testosterone level, despite the fact that there is no established link between testosterone levels and female sexual dysfunction [26,27]. Notably, a segment of physicians would not obtain any laboratory tests. Physicians also demonstrated diversity in their approach to managing decreased sexual desire. In the absence of an available, approved pharmacologic treatment for FSD, about one-half of physicians stated that they would recommend couples therapy, and the remaining recommending a range of other approaches. These findings suggest that many PCPs and OB/GYNs are confused how to optimally evaluate and manage women with decreased sexual desire, which has been associated with a less active sex life and decreased sexual and relationship satisfaction [28].

The most favored pharmacologic intervention by OB/GYNs (recommended by 28%) was discontinuation or switching of the patient’s oral contraceptive. This may reflect their clinical experience or published findings in some, but not all studies suggesting that oral contraceptives may adversely affect mood and sexual desire [29–31].

Topical or systemic testosterone was the most commonly recommended pharmacologic intervention by PCPs (26%) and was the second most commonly recommended pharmacologic intervention by OB/GYNs (18.4%). No such therapy is approved for women in the United States. Only one trial on premenopausal women has been published, a 1 x 1-month crossover trial of a testosterone topical gel vs. placebo in only 10 premenopausal women, which showed superiority for the active gel only for subjective arousal, not for sexual desire [32]. In Europe, a testosterone transdermal system is approved for surgically post-menopausal women only. Thus, the finding that a majority of U.S. PCPs recommend testosterone to premenopausal women must reflect uncontrolled clinical experience rather than familiarity with the literature.

While a somewhat greater percentage of OB/GYNs than PCPs expressed confidence in treating HSDD, overall confidence in managing HSDD was low, with particularly low rates among women PCPs. This finding is consistent with the observed variability in assessing and treating women with low sexual desire. As we anticipated, our study found that perceptions related to time constraints and the lack of effective therapies were important barriers to clinician confidence in treating HSDD among both PCPs and OB/GYNs. A significant portion in both groups acknowledged that medical and residency education provided inadequate training in sexual history-taking; however, both groups perceived CME courses and practice experience as influential sources of learning about HSDD management, highlighting the importance of these vehicles in improving sexual health skills. Approximately one in three physicians indicated that their personal attitudes and beliefs would be at least somewhat of an obstacle in initiating a dialogue about sexual health, identifying an important gap that additional research should address.

As such, there is a need for the development and implementation of training and medical education activities that provide clinicians with both an extensive knowledge base as well as the opportunity to develop clinical management skills, which are essential to build the personal confidence necessary for practice [33]. These educational efforts should focus on helping clinicians identify physiologic and pharmacologic causes that may underlie an FSD diagnosis, as well as reviewing appropriate diagnosis, laboratory assessments, and treatment approaches for FSD. Making screening tools available in physician offices may also be helpful. Such tools identify sexual health concerns as an appropriate discussion topic in the physician office and may offer reassurance that their physician is receptive to addressing sexual difficulties such as HSDD. Standardized assessment tools may also facilitate timely assessment of HSDD and other forms of sexual dysfunction by cueing physicians to key diagnostic criteria [4,34].

There is also a need to educate clinicians about available resources and referrals for the management of FSD and to enhance communication skills to improve patient–clinician dialog. Ideally, such training will enable physicians of both genders and all ages to confidently raise and address female sexuality concerns as part of their daily practice. Clinician confidence has been strongly associated with training and experience in performing
routine procedures [35]. For example, increasing clinical experience has been associated with decreasing patient care errors [36], and physician confidence in treating alcoholism has been associated with a higher frequency in referring alcoholic patients for treatment [37]. Studies have demonstrated that a didactic course coupled with experiential learning improves knowledge and attitudes/confidence more than a didactic approach alone [38,39]. Consequently, medical school/residency programs have begun to integrate communication labs or training to facilitate enhanced clinician confidence in physician-patient interviews—especially in dealing with stressful or difficult encounters, such as sexuality issues, family violence, or delivering bad news [40–42].

Finally, future areas of research should investigate the priority placed on sexual dysfunction by clinicians during patient visits, further understanding of perceptions and attitudes around sexual health and dialogue, possible geographic disparities and differences, as well as approaches taken by practicing clinicians with patients of different ethnic and cultural backgrounds.

There are several limitations to this study. First, this study used self-reported survey responses as a surrogate measure of PCPs’ and OB/GYNs’ knowledge, attitudes and clinical decision-making. However, the use of case vignettes has been shown to provide good insight into physicians’ actual practice patterns [21,22]. Second, our listing of perceived barriers was not exhaustive. We specifically selected this listing based on responses to a series of focus groups where we asked clinicians to describe their challenges in initiating a dialogue with their patients about sexual health. This type of methodology has been shown to be an efficient way to elicit and prioritize responses from practicing clinicians [43,44]. However, future studies are needed to examine more specific attitudes and perceptions that may be strong determinants of confidence and clinical behaviors. Third, the randomly selected population of OB/GYNs may be skewed to include more females than the overall OB/GYN population. This could potentially affect findings of the study. Fourth, we note the low response rate to the survey and that respondents were given a small honorarium to complete the study, which may also affect study findings. We did not find significant differences between responders and non-responders with respect to age and gender, but were unable to determine whether other relevant differences existed. Finally, the cross-sectional design of the study does not allow for causal inferences to be drawn and future study designs such as cohort and longitudinal designs are needed.

Conclusion

In conclusion, this study highlights significant gaps and needs among practicing PCPs and OB/GYNs in understanding sexual dysfunction and in their confidence to manage women concerned about their decreased sexual desire. Discussion of sexual problems in the clinical setting is difficult. However, there are independent predictors of confidence in treating patients with decreased sexual desire. Interventions from educational programs in these key areas are needed to improve communication and confidence gaps in the management of these patients.

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Statement of Authorship

Category 1

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(b) Acquisition of Data
U. Shanette Granstaff; Nancy Roepke

(c) Analysis and Interpretation of Data
Maziar Abdolrasulnia; Linda Casebeer; Richard M. Shewchuk; John Dean; Andrew T. Goldstein

Category 2

(a) Drafting the Article
Maziar Abdolrasulnia; Richard M. Shewchuk; Linda Casebeer; U. Shanette Granstaff; Nancy Roepke
References


4 Hayes RD, Dennerstein L, Bennett CM, Fairley CK. What is the “true” prevalence of female sexual dysfunctions and does the way we assess these conditions have an impact? J Sex Med 2008;5:777–87.


34 Aslan E, Fynes M. Female sexual dysfunction. Int Urogynecol J Pelvic Floor Dysfunct 2008;19:293–305.

35 Wickstrom GC, Kelley DK, Keyserling TC, Kolar MM, Dixon JG, Xie SX, Lewis CL, Bogner BA, DuPre CT, Coxe DR, Hayden J, Williams MV. Confidence of academic general...


Appendix A

Case Vignette: Your new patient, a 39-year-old loan office clerk, presents for an annual exam. Her firm has recently downsized and she has lost her job. Her husband owns a small business. Her only child recently married and moved away. She is currently taking terbinafine HCl for a nail infection, a multivitamin, and a biphasic oral contraceptive pill. She leaves the sexual history portion of the patient history blank. When you comment on the lack of information the patient shrugs and mumbles “I just don’t care anymore.” Upon further probing, the patient says “I’ve had no interest in sex for months. I think it’s just stress.”

What tests, if any, would you order in order to evaluate her diminished libido? (please describe)

Case continuation: The patient’s lab results came back normal and the Hamilton Rating Scale for Depression (HAM-D) did not indicate possible depression. Based on what you know about this patient, how would you treat her? (please describe)

How would you rate your training in taking a sexual history with female patients? (select one number for each item)

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<th>Adequate</th>
<th>Extremely adequate</th>
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How would you rate the extent to which the following potential barriers affect your initiation of a dialogue with your patients about sexual health? (select one number for each item)

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<thead>
<tr>
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<th>Major barrier</th>
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<td>Time constraints to elicit information</td>
<td>1 2 3 4 5 6 7 8 9 10</td>
<td></td>
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<tr>
<td>Time constraints in dealing with sexual health issues</td>
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<tr>
<td>Lack of effective therapies to treat a sexual problem unrelated to physiological or urogynecological issues</td>
<td>1 2 3 4 5 6 7 8 9 10</td>
<td></td>
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<tr>
<td>Gender differences</td>
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How confident are you in your ability to treat women with hypoactive sexual desire disorder (HSDD)? (select only one number)

<table>
<thead>
<tr>
<th></th>
<th>not at all confident</th>
<th>somewhat confident</th>
<th>extremely confident</th>
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<tr>
<td>1 2 3 4 5 6 7 8 9 10</td>
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How would you rate these influences on your management of female patients with hypoactive sexual desire disorder (HSDD)? (select one number for each item)

<table>
<thead>
<tr>
<th></th>
<th>No influence</th>
<th>Somewhat of an influence</th>
<th>Major influence</th>
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<tr>
<td>Continuing medical education courses</td>
<td>1 2 3 4 5 6 7 8 9 10</td>
<td></td>
<td></td>
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<tr>
<td>Practice experience</td>
<td>1 2 3 4 5 6 7 8 9 10</td>
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