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Women's perceptions of sexological interview during gynaecological consultations: A cross-sectional study

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Abstract

Sexological interviews in gynecological consultations remain a practice that is not routinely undertaken despite the importance of sexual health. The objectives of this study were to investigate patients' expectations from a sexological interview, and the elicitation of sexual dysfunctions. A cross-sectional study was performed at the Maternity and Neonatology Center of Tunis. We included patients aged >18 years who consulted for gynecological reasons outside of any emergency or pregnancy. Our study included 200 patients with a mean age of 41 (±10) years. We found that72.5% of the patients appreciated the approach to sexuality during gynecological consultations. A total of 77.5% of the women indicated that their current gynecological pathology affected their sexuality. The mean of female sexual function index score was 25.05 (±5.03). The most affected domain was desire, with a mean of 3.54 (±1.05). The main predictive factors for sexual dysfunction were: age > 40 years, endometriosis, gynecological cancer, and abnormal uterine bleeding. Thus, it's important to introduce sexological interviews in gynecology consultations, especially for patients at risk of sexual dysfunction. *(Afr J Reprod Health 2025; 29 [11]: 116-124).*

Keywords: gynecological consultation, sexual dysfunction, sexual desire disorder, quality of life, gynecologic disease

Résumé

Les entretiens sexologiques en consultation gynécologique restent une pratique peu pratiquée malgré l'importance de la santé sexuelle. Les objectifs de cette étude étaient d'étudier les attentes des patientes vis-à-vis d'un entretien sexologique et les principales dysfonctions sexuelles. Une étude transversale a été réalisée au Centre de Maternité et de Néonatologie de Tunis. Nous avons inclus des patientes âgées de plus de 18 ans consultant pour un motif gynécologique en dehors de toute urgence ou grossesse. Notre étude a inclus 200 patientes avec une moyenne d'âge de 41 (±10) ans. Nous avons constaté que 72,5 % des patientes appréciaient l'abord de la sexualité en consultation et 77,5 % des patientes ont indiqué que leur pathologie gynécologique actuelle affectait leur sexualité. Le score moyen de female sexual function index était de 25,05 (±5,03). Le domaine le plus affecté était le désir, avec une moyenne de 3,54 (±1,05). Les principaux facteurs prédictifs de la dysfonction sexuelle étaient : l'âge > 40 ans, l'endométriose, le cancer gynécologique et les saignements utérins anormaux. Il est donc important d'introduire l'entretien sexologique en consultation de gynécologie surtout pour les patientes à risque de dysfonction sexuelle. *(Afr J Reprod Health 2025; 29 [11]: 116-124).*

Mots-clés: consultation gynécologique, dysfonction sexuelle, trouble de désir sexuel, qualité de vie, pathologies gynécologiques

Introduction

New research on sexual function has focused on other aspects of sexuality, which for a long time focused on the psychological dimension. Indeed, it was only in the 1950s and due to the work of Masters and Johnson that the concept of the human sexual response cycle (HSRC) emerged.[1] Since then, the term "sexuality" itself has been replaced by "sexual function" and "sexual response."[1] This new terminology allows for a scientific approach to the somatic functioning of genital organs from a psychological perspective, not just a physiological one.

The somatic aspect is critical for sexual response, but the incorporation of other dimensions of sexuality, particularly social, cultural, and relational, is essential for a better understanding of sexual dysfunction. Indeed, the World Health Organization defines sexual health as 'a state of

physical, emotional, mental, and social well-being in relation to all aspects of sexuality and reproduction, not merely the absence of disease, dysfunction, or infirmity'.[2]

Several studies addressing female sexual function are limited to the study of the impact of certain pathologies on sexual life; the generalization of the evaluation of sexual function during gynecological consultation has not been addressed.[3-5]A review of the literature reveals that less than one in two doctors would include questions about sexuality in their history-taking.[6] Physicians' reluctance to discuss sexuality can be attributed to a lack of knowledge and communication skills to conduct sexological interviews.[7-9] These gaps in medical training inevitably combine with other cultural difficulties that hinder approaches to sexuality.

However, different academic societies recommend that gynecologists should address sexuality during consultation.[9]

Indeed, addressing sexuality in gynecological consultations remains a taboo subject and is not commonly undertaken. This disparity between the need to address sexuality and the lack of integration of this sexological inquiry into daily practices in gynecological consultations led us to conduct a cross-sectional study that sought to describe women's expectations for addressing sexuality during gynecological consultations, the main sexual dysfunctions, and the predictive factors.

Methods

Study design

Our study was a cross-sectional study performed at Maternity and Neonatology Center of Tunis over a period of one year from May 2022 to May 2023.

Participants

We included consenting patients aged over 18 years who consulted for gynecological reason outside of an emergency and whose diagnosis had been established. Pregnant patients, illiterate women, and patients who had consulted for early post-operative follow-up (a 6-month post-operative follow-up period was chosen to avoid early and late post-operative complications) were not included, as were consultations due to cancer-related pathologies.

Sample size calculation

The formula for calculating the sample size was $\boldsymbol{n} = \boldsymbol{z}^2 \times \boldsymbol{p}\ (1–\boldsymbol{p})/\boldsymbol{m}^2$.

$\boldsymbol{z}$ = 1, 96 (confidence level at 95%)

m = 5% (Margin of error)

p = 85% (prevalence from French study.[10])

n= $1{,}96^2 \times 0{,}85\ (1–\boldsymbol{0{,}85})/0{,}05^2$.

In our study, the calculated sample size n was 195,9. Thus, a total sample size of 200 participants was established for this study.

Data collection and study tools

To determine women's expectations for addressing sexuality during gynecological consultations and the main sexual dysfunctions, we conducted semi-structured interviews to gather patients' reactions to addressing sexuality, the influence of current gynecological pathology on their sexuality, and sexual dysfunction reported (subjective evaluation).

We distributed the validated Arabic version of the Female Sexual Function Index (FSFI)[11] to have an objective assessment of sexual function.

FSFI has 19 questions that evaluate sexual function over the previous four weeks and look at its different phases [11] . Sexual dysfunction was defined as a score ≤ 26.55.

To determine the predictive factors of sexual dysfunction in gynecology consultation, we collected sociodemographic parameters, medical history, duration of sexual activity, source of information on sexuality, and data from the current consultation. We also distributed two self-administered standardized questionnaires the French version of the Locke and Wallace Marital Adjustment (marital satisfaction) and the Arabic version of the Short Form- 36 (SF-36)(quality of life).

The French version of the Locke and Wallace Marital Adjustment included 15 questions scored in points; a score of less than 80 suggested major problems in the partnership.[12]

Participants completed the Arabic version of the Short Form- 36 (SF-36), derived from the questionnaire of the Medical Outcomes Study (MOS), and designed to obtain a generic measure of

perceptual health status.[13] A cutoff value of 66.7indicates an impaired quality of life.[13]

Statistical analysis

SPSS 21 statistical software was used for the statistical analyses. The quantitative parameters of the participants are presented as means ± standard deviations, and binary classification data are presented as percentages. The correlation between different parameters was established using Pearson's method for quantitative variables and Spearman's method for qualitative variables.

Multiple regression analysis was employed to identify determinants of sexual dysfunction in gynecology consultation.

The adjusted odds ratios (ORs) were estimated for the β coefficient obtained with their 95% confidence intervals (CIs). For all statistical tests, the significance level p was set at 0.05

Ethical considerations

- Our work was submitted to the ethics committee of the Maternity and Neonatology Center of Tunis and approved with reference number ref: 03/22. Informed and voluntary written consent was obtained from all patients for publication.

Results

In our study, 200 participants were recruited. The mean age of the patients was 41(±10) years. Approximately 54% of our population was in perimenopause, with ages ranging from 40 to 50 years.

Regarding medical history, 25% of the patients had diabetes, 21.5% had thyroid disorders, and 14% had high blood pressure. Regarding gynecologic history, 27% of the participants had at least one uterine fibroid and 9.5% had endometriosis. The average gravidity and parity of our patients were both 2, and 29% of the patients had more than 3 children.

According to the current gynecological pathology, we distinguished 4 main categories:

confirmed gynecological neoplasia in 5% of cases (breast cancer (n=2), endometrial cancer (n=5) and cervical cancer (n=3)), chronic pelvic pain in 27.5% of the cases (fibroid pathology, endometriosis, ovarian cysts, or other), abnormal uterine bleeding in 24% of cases, with the diagnosis being benign (fibroids, adenomyosis and functional endometrial pathology), and primary or secondary infertility in 24% of cases.

The assessment of previous sexuality showed an average debut of sexual activity at 14 years. Regarding the history of a previous sexual approach in a medical setting, 31% of patients reported having had a sexology interview during a previous consultation. Among patients who had previously undergone a sexological interview, 72.5% expressed appreciation for this approach to interviewing. When asked about their desire for more frequent discussion of sexuality during gynecological consultations, 79.5% of the patients responded “yes”. We also asked the participants about their sources of information about sexuality. Thirty-three percentsaid the Internet was their primary source of information on sexuality, 22% solicited friends, 15% considered their doctors to be their source of information about sexuality, and 23% indicated that they had no source of information about sexuality. Sexual dysfunction was reported in 55% of women (subjective evaluation). Desire disorders were reported in 59.5% of the patients. Orgasm disorders were reported in 29% of the population, arousal disorders in 27%, and sexual pain disorders in 21%.Desire disorders were reported by 55% of patients aged between 40 and 50 years and by 88.5% of patients aged over 50 years (Figure 1).

The objective evaluation of sexuality found that the average FSFI score was 25.05 (±5.03). We also calculated the average scores for all FSFI domains, as summarized in Table 1.We found that 50.5% of patients had sexual dysfunction (objective evaluation).

The mean FSFI score for patients followed for malignant pathology was 19.7, and 23.5 for patients followed for chronic pelvic pain, 26.8 for patients followed for abnormal uterine bleeding, and 23.3 for patients followed for infertility.

The mean marital adjustment score was 91.5 (±12). We found that 42.5% of our patients had scores<80, indicating serious problems within the couple. By comparing the mean marital adjustment score according to the type of gynecological pathology, we noted that the lowest score was in patients followed for abnormal uterine bleeding (Figure 2).

The mean SF36 score was 72.5 (±6.5). According to the cutoff value of 66.7, 63% of the population had impaired quality of life.

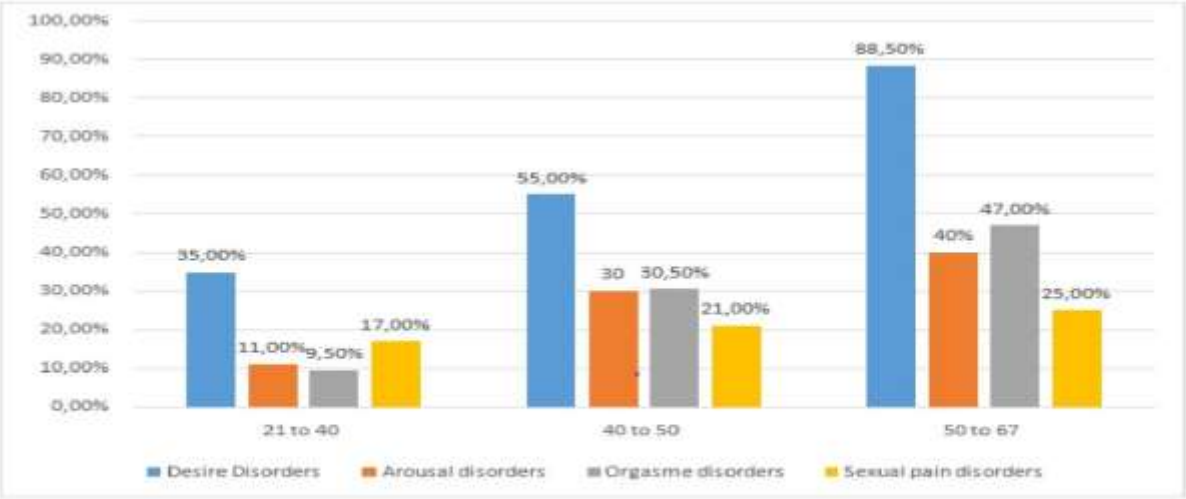

Figure 1: Distribution of reported sexual dysfunctions by groups of age

Table 1: Summary table of FSFI score and sub-score averages of patients in gynecological consultation

FSFI domains	Average	Standard Deviation
Desire	**3,54**	1,05
Arousal	4,09	1,17
Lubrication	4,35	1,37
Orgasm	4,21	1,03
Satisfaction	4,45	1,02
Pain	4,28	1,07
Total score	25,01	5,03

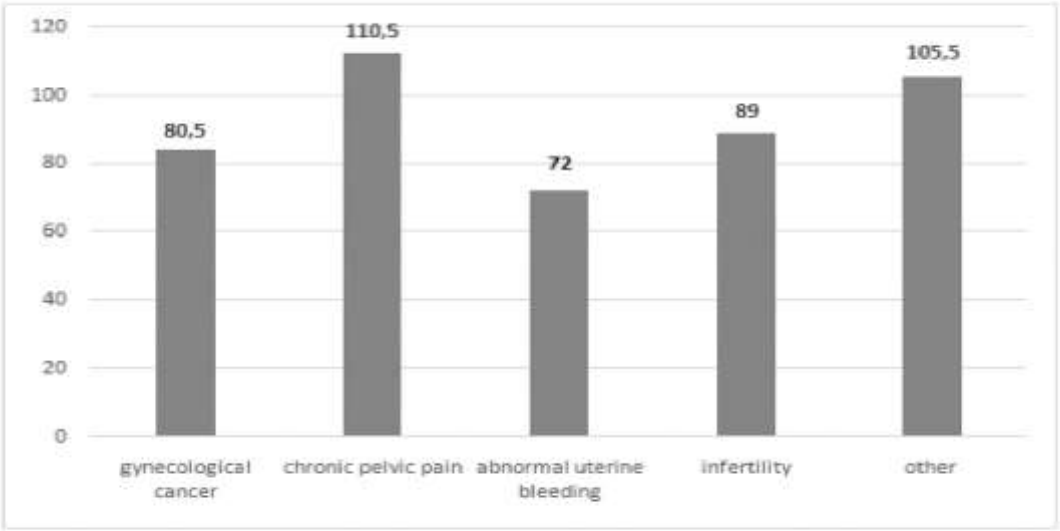

Figure 2: mean marital adjustment score according the type of gynecological pathology

Table 2: Main Risk factors of female sexual dysfunction of patients in gynecological consultation

Parameters	P	Adjusted odds ratio (OR)	CI
Age < 40	0,122	0,9	0,789- 2,9
Age > 40	**0,03**	**2,1**	0,978- 2,37
History of diabetes	0,053	3,5	0,967-11,4
History of HBP	0,432	0,358	0,028-4,64
Endometriosis	**0,009**	**3,12**	0,085-12,11
History of gynecologic cancer	**0,005**	**3,11**	0,962-10,6
Duration of sexual activity >10 years	0,129	1,4	0,897-4,3
Parity > 3	**0,03**	**1,45**	0,666-3,16
No Source of Information about Sexuality	**0,009**	2,7	0,877-5,45
current pathology:			
Malignant pathology	**0,009**	**2,5**	0,314-20,06
Chronic pelvic pain	**0,043**	**2,09**	0,354-12,4
Abnormal uterine bleeding	**0,044**	**1,4**	0,065-3,27
infertility	0,087	1,18	0,149-9,41
Degree of marital satisfaction:			
Locke and Wallace Score <80	**10,0001**	**2,08**	1,039-2,33
Locke and Wallace Score >80	0,055	1,07	1,017-1,120
Altered quality of life according to SF36	**0,009**	**2,37**	0,190-2,9

The domain most affected was mental function (vitality, mental health limitations, and social well-being).

To establish predictive factors for sexual dysfunction, we conducted multivariate analysis using binary logistic regression, through which ten significant factors were identified (Table 2). Among these factors, age ≥ 40 years (odds ratio [OR] =2.1), history of endometriosis (OR=3.12), and history of gynecological cancer (OR=3.11) were noted.

Discussion

Only 31% of our patients indicated their sexuality had been addressed by their gynecologists. Among patients who had previously undergone a sexological interview, 72.5% expressed appreciation for this approach, and when asked about their desire for more frequent discussion of sexuality during gynecological consultations, 79.5% of our patients responded "yes." These results were comparable to those of other studies on sexuality during gynecological consultations. Briedite *et al* found that only 36% of patients indicated that their gynecologist had addressed sexuality in the past, and 80.6% expressed a desire for their gynecologist to discuss sexuality more frequently.[14]

Another study conducted by Berman *et al*, estimated that 40% of diagnosed patients with sexual dysfunction admitted to never having consulted a doctor, and 54% of them expressed a wish for the topic to be addressed by their doctors during consultations.[15]

Indeed, several studies have demonstrated that women expect their gynecologist to initiate a conversation about sexuality.[6,14-16]This passive expectation, despite the presence of real complaints that impact the quality of life of women, indicates that sexuality is still considered taboo in our socio-cultural environment. Indeed, Islam prohibits discussing sexual practices with other people. Furthermore, sex education has not been introduced into Tunisian society. Therefore speaking with friends or a doctor is a more embarrassing way to learn about sexual health than the internet.

However, when initiated by a doctor, patients may be willing to discuss it because of the professional nature of their interlocutor.[17]Thus, although they often provide only brief responses to questions about sexuality, they believe that the context of gynecological consultation is the most appropriate for addressing this topic. As suggested in studies by Wendt *et al*[17]and Metz *et al*[18], women seek this trusting relationship with their doctors, which is further supported by confidentiality, to help them disclose their sexual complaints more easily.

Desire disorders accounted for 59.5% of the study population. Second, orgasm disorders were present in 29% of the population, followed by arousal disorders in 27%, and sexual pain disorder in 21%. These results are comparable to those found in the literature, especially in studies evaluating female sexual function during gynecological consultations.[14,16,19] Regarding distribution by age, we found that desire disorder came first in all groups, which was confirmed by similar findings in the literature.[20-23]

In young women, sexual disorders with pain are very common and could be explained by the frequency of gynecological pathologies such as endometriosis and uterine fibroids, as well as the high frequency of vaginismus.[24-25] On the other hand, arousal disorder occurs last, given the hormonal profile of women in this age group.

For women aged 50-67 years (8% of the population), the main sexual dysfunction was desire disorder, present in 93.5% of cases, followed by arousal disorder, found in 72% of cases. These results are similar to those of other studies.[20, 26-30]

In women with gynecological malignancies, desire disorders were present in all cases. In addition to the high frequency of sexual dysfunction, the mean Locke and Wallace score in this category was 80.5, indicating serious problems at the couples' level. Similarly, the mean SF-36 quality-of-life score was 52.5, reflecting a perception of impaired quality of life.

Risk factors of sexual dysfunction

Age

In this study, women aged ≥ 40 years were twice as likely to develop sexual dysfunction (OR= 2.1, p=0.03, CI=95%).This association was also found by Jaafarpour et al(OR= 2.23).[33]In a study by Singh et al, conducted in India and looking at the sexuality of 149 female participants, the risk was estimated to be multiplied by 11 for women aged ≥ 40 years.[16]

Source of information about sexuality

We found that women who had no source of information on sexuality were more predisposed to have problems in their sexual lives (OR= 2.7, CI=95%, (0.877-5.45)). Very few studies have evaluated female sexual function based on the source of information on sexuality. However, in the Tunisian study conducted by Ben Thabet *et al*. women's ignorance of many aspects of their sexuality was very well highlighted (55% of incorrect answers) and largely explained by the shameful and sacred nature of the subject.[34] On the other hand, Bleakley et al studied, in 2009, how different sources of information on sexuality affected the sexual behavior of adolescent girls.[35]The sources of sought-after of information were friends, parents (especially mothers), and the media.[35]

Parity

There was an association between the number of children a woman had and her sexual function. Parity greater than three increased the risk of sexual dysfunction (OR= 1.45, 95%, CI, 0.666-3.16). This association has been found in several other studies investigating female sexuality. According to a study published by Zheng *et al* in 2020, women with children are at greater risk of sexual complaints.[36] This could be attributed to the unrealistic perceptions of postpartum recovery and adjustment difficulties. Another reason for this finding could be the insufficient knowledge of the postnatal period, inability to identify the primary signs of depression, and a tendency not to seek help.

Endometriosis

Patients with endometriosis are at high risk of sexual dysfunction. Jia et al estimated that this risk is multiplied by 3.4[37], and Pérez *et al*[38] have shown that the risk is multiplied by 2,38 in their meta-analysis evaluating the effect of endometriosis on female sexuality.

Determinants of sexual dysfunction in these patients were the stage of endometriosis, degree of pelvic pain, and degree of deep infiltration of endometriosis.[37-39]

Gynecological cancers

We found that gynecological cancer patients had a 3-fold greater risk (OR= 3.11 p=0.005 IC=95% 0.962-10.6) of developing sexual dysfunction than the general population. The negative effect of gynecological malignancies on sexuality has been the subject of several studies.

In a study published in 2022, Muhit *et al* estimated that women with a history of endometrial

cancer were 1.5 times more likely to develop sexual dysfunction, and those with cervical cancer were 1.35 times more likely (CI=95%).[40]In contrast, in a study conducted by Kowalczyk et al in 2016, it was estimated that the risk was multiplied by 4.1 (OR=4.1, CI = 95%) in patients who had undergone a mastectomy for breast cancer.[41].

Study strengths and limitations

Your study focused on the impact of gynecological pathologies on the sexual life of patients, even for benign pathologies. However, your study has some limitations. First, its cross-sectional design provided valuable information on the impact of gynecological pathologies on sexuality, but it did not capture changes over time or establish reliable relationships between variables. Similarly, the limited number of participants made it difficult to generalize the results and they should be interpreted with caution.

However, our study emphasized the importance of integrating sexological interviews into gynecology consultations. Indeed, the majority of patients appreciate discussing sexuality with their gynecologist. Our study determined the predictive factors of sexual dysfunction in gynecology consultations and therefore recommends specialized care for these patients.

Conclusion

Our study highlighted the importance of addressing sexuality in gynecology consultations since the majority of patients appreciated the opportunity to discuss sexuality during these consultations. Desire disorders are the main cause of sexual dysfunction. The main predictive factors for sexual dysfunction were: age> 40 years, endometriosis, gynecological cancer, and abnormal uterine bleeding. Thus, it's important to check these patients for sexual dysfunction and consult a clinical sexologist if needed.

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Authors' contributions

K.M, N.A and S.M contributed substantially in the conception and design of the study. N.A and B.A carried out the data collection. N.A analyzed and interpreted the data. I.L, K.M and F.B drafted the manuscript. R.B reviewed the manuscript critically for important intellectual content. All authors read and approved the final manuscript and agreed to be accountable for all aspects of the work in ensuring that questions related to the accuracy or integrity of any part of the work are appropriately investigated and resolved.

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Conflict of interest statement

The authors declare that they have no competing financial interests or personal relationships that could have appeared to influence the work reported in this paper.

Availability of data and materials

The data are not publicly available due to ethical restriction. The datasets generated and/or analyzed during the current study are available from the corresponding author on reasonable request.

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