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Short Communication

Taking History to Deal with Female Sexual Dysfunctions

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Sexuality is a hidden topic and not discussed adequately in different parts of the world but it affects the quality of life in every aspects [1,2]. Sexual history taking is thereby an important part in health assessment and subsequent treatment of sexual dysfunctions but it is impeded in women because of different reasons. An online survey of 3807 healthy volunteers revealed that 40% of respondents did not discuss sexual health matters with their clinicians [3]. In assessing this component difficulties remain on both sides. From healthcare providers' part sources of hesitance remain (i) lack of training and skills to deal with patient concern; (ii) embarrassment when talking about sex; (iii) concern about offending or embarrassing the patient; (iv) underestimating the prevalence of sexual dysfunctions; and (v) underestimating the impact sexual complaints have on a patient's health [3]. Reasons for physicians being uncomfortable in sexual history taking in another study revealed extreme age; fear of offending; deficit communication; not relevant; not trained; time constraints; and knowledge gap [2]. Nusbaum and colleagues found that 14% to 17% of women talked about their sexual complaints to their doctors [4]. Regardless of age group patients were nearly twice as likely as the physician to discuss the sexual issues and majority of women in each age category refrained themselves to ask about sexual concerns because of fear of embarrassing the physician or they lack interest in this matter [4]. Addressing sexual health problems worth to be a routine part of comprehensive health visit of a woman but most women had never spoken with their doctor about sex. Many women want their health care provider to open the dialogue about sex despite being hesitant to initiate this discussion. Initiating the query regarding sexual health provides acknowledgment and prioritizes the role that sexual health plays in overall well-being and gives the woman the opportunity to discuss issues and concerns that she may otherwise not disclose [5]. Assurance of confidentiality, safe and nonjudgmental environment, placing patient-friendly educational materials in waiting and examination rooms and training staff, modified intake forms to include questions about sexual health facilitates discussion of these issues [5]. At the same time, it should be kept in mind that perceiving a health care provider uncomfortable, disinterested, or reluctant, communication about sexual health can be hindered [5]. Gynecologists are often the first health care provider a woman turns to when seeking help for sexual problems but many other disciplines serve the same regard. It is important to facilitate the interview in a culturally sensitive manner and with the well-balanced mixture of open-ended and direct questioning to reach an accurate diagnosis and the development of an appropriate treatment plan [5]. Ensuring adequate time is an important factor and if there remain time constraints return visits should be arranged. Areas to be covered with a complaint in sexual health include [6-8]:

- Nature of the problem
- Degree of distress
- Lifelong versus acquired
- Situational versus generalized
- Frequency of the problem
- Past history of sexual problems
- Partner issues: Numbers, changing, intensity of relationship, partner's attitude
- Partner sexual problems or concerns
- Treatment history: Current &/ previous, response, compliance
- Sexual and relationship history

    a. First sexual experiences
    b. Family attitudes toward sex
    c. History of sexual violence or trauma
- Relationship history
    a. What have past relationships been like?
    b. Nature and duration of current relationship
    c. Marital/cohabitation status
    d. History of partner abuse/violence
- Psychosocial history
- Cultural, religious, family-of-origin, and/or societal beliefs or values
- Work/finance
- Children
- Life stressors: Current or enduring
- Health history
    a. Psychiatric history: Mood and anxiety disorders, Psychotic disorders, Eating disorders and body image disturbance, Substance use
    b. Medical history
- Sexually transmitted infections, Cancer (esp. breast cancer and gynecological cancers)
- Disease or surgery of the reproductive organs
- Neurological disorders (e.g., multiple sclerosis)
- Endocrine disorders (e.g., diabetes, hypothyroidism, hyperprolactinemia)
- History of spinal cord or traumatic brain injury

Drug History: Current medication use (e,g., antidepressants and mood stabilizers (selective serotonin re-uptake inhibitors (SSRIs)), anticonvulsants, hormones and hormone antagonists (hormonal contraception, anti-androgens, gonadotropin-releasing hormone (GnRH) agonists), antihypertensives (beta-blockers, alpha-blockers, diuretics), cardiovascular agents, and histamine receptor blockers).

As there is no health without sexual health clinicians should dig out the issue those may affect and affected by the sexual health. For proper exploration, a good history is obligatory. This article may guide the clinicians as a baseline to address the sexual complaints and excavate the untold sufferings.

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Conflict of Interest

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