Healthcare professionals' experiences of discussing sexual function with menopausal women using a vaginal pessary

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BACKGROUND: Pelvic organ prolapse is a common condition with high prevalence among postmenopausal women, many of whom are sexually active. A vaginal pessary is an effective, nonsurgical treatment alternative for well-selected, motivated patients and those unfit for surgical management. Open discussion on sexual function is a crucial part of counseling in these women to ensure that they are fitted with the most appropriate pessary and minimize complications.

OBJECTIVE: This study aimed to explore healthcare professionals' experiences of discussing sexual function with postmenopausal women with pelvic organ prolapse receiving vaginal pessary management in a urogynecology clinic.

STUDY DESIGN: Semistructured, in-depth qualitative interviews were conducted in a tertiary university teaching hospital in England with an established urogynecology department. The sample comprised 10 volunteers (7 female and 3 male, consisting of 3 consultants, 1 advanced nurse practitioner, 2 clinical nurse specialists, and 4 specialist registrars). All volunteers were experienced in managing women with prolapse, including inserting and removing vaginal pessaries and discussing sexual intercourse and intimacy.

RESULTS: Postmenopausal women were found to be reluctant and embarrassed to engage in open discussion on sexual intimacy, which can be improved by building trust. Being seen by female healthcare professionals, having a female chaperone, and using appropriate interpreters (in cases of language barriers) significantly improved women's willingness to discuss sexual issues.

CONCLUSION: The study demonstrated that postmenopausal women found it difficult and were hesitant and embarrassed to openly discuss sexual issues, which is important in choosing the most suitable vaginal pessary. This problem can be alleviated by building trust between healthcare professionals and patients, by healthcare professionals remaining sensitive to patients' ethnic and cultural backgrounds, and by respecting women's choice of healthcare professional.

Key words: pelvic organ prolapse, postmenopausal women, sexual dysfunction, sexual intimacy, vaginal pessary

Introduction

Pelvic organ prolapse (POP) is a common condition affecting >30% of women aged up to 60 years and >50% of women by the age of 80 years.[1] Wu et al[2] (2009) estimated that by 2050, the number of women with POP will increase by 46% because of increased life expectancy. Similarly, sexual dysfunction among women increases with advancing age. Over 50% of women with POP have bothersome symptoms that affect urinary and gastrointestinal systems, often having a significant negative impact on quality of life and sexual intimacy.[3] Some women with POP frequently avoid vaginal intercourse because of embarrassment, dyspareunia, or fear of accompanying urinary or fecal incontinence.

Pelvic floor muscle exercises and vaginal pessaries are the first line of treatment in symptomatic women and those who are unsuitable for surgery, with positive effects including symptom relief and improved urinary incontinence, sexual function, and body image.[3,4] However, vaginal pessaries may unmask stress incontinence in some women. There is a range of pessaries available for symptomatic prolapse in cases where vaginal penetration is possible and well-tolerated.[4,5] However, space-occupying pessaries such as cube or donut pessaries and those with stems such as Gellhorn pessaries will limit penetration and consequently be unsuitable for sexually active women. Previous studies have focused on patient choice of healthcare professionals (HCPs), lack of skill and knowledge of HCPs on vaginal pessaries and sexual function in menopause, and poor counseling and communication.[6–9] This study investigated HCPs' professional lived experiences of discussing intimate issues with postmenopausal women with POP.

Design

This qualitative study was conducted per interpretative phenomenological analysis (IPA) principles. A semistructured interview was used to investigate the

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Why was this study conducted?

This study aimed to gain insight into healthcare professionals' (HCP) experiences of discussing sexual function with menopausal women with pelvic organ prolapse (POP). It also attempted to identify factors preventing menopausal women with POP from having open discussions about sexual issues and factors that could promote such discussions.

Key findings

Postmenopausal women with POP requiring a vaginal pessary are reluctant and embarrassed to discuss sexual intimacy. Building trust between HCPs and postmenopausal women would improve openness to discussing sensitive intimate issues. To this end, providing postmenopausal women with choice of HCP and appropriate interpreters when necessary would be beneficial.

What does this study add to what is known?

This study focused on HCPs' experience of discussing sexual intimacy with postmenopausal women with POP requiring a vaginal pessary.

experiences of HCP volunteers managing women with POP and their experiences of inquiring about the sexual intimacy of these women. The interview was conducted by the lead researcher using a simple questionnaire to investigate their experiences of inquiring about sexual intimacy during consultation with postmenopausal women with POP who opted for pessary treatment. We focused on postmenopausal women because of the increased prevalence of POP and sexual dysfunction in this age group along with significant barriers to sexual healthcare access.[10] To capture the experiences of all HCPs in the unit, we excluded sexual inquiry for postmenopausal women who opted for surgery because only 3 consultant volunteers performed surgery for POP, whereas all of the volunteers routinely conducted vaginal pessary management. There was no preceding hypothesis. Rather, the aim of the study was to investigate the experience of HCPs in discussing sexual intimacy with postmenopausal women with POP managed with pessaries and the impact of culture and ethnicity on how these women discuss the subject.

Recruitment

A total of 12 HCPs working in the gynecology department were invited by letter and email to participate in the study. All are experienced in treating women with prolapse with vaginal pessaries after appropriate counseling. Information about the study was provided to each volunteer, who then signed an informed consent form before the interview. A total of 10 volunteers (7 female and 3 male, consisting of 3 consultants, 1 advanced nurse practitioner, 2 clinical nurse specialists, and 4 specialist registrars) were interviewed. Two participants were excluded because they were on leave. These 10 volunteers were a representative sample of the urogynecology staff experienced in treating women with POP. Participation was anonymized (ie, no volunteer knew the others in the study), and all the data collected were anonymized.

HCPs who were not involved in treating women with POP or who did not work in the urogynecology department were excluded.

Ethical issues and processes

Ethics approval was obtained from the local National Health Service (NHS) Research Ethics Committee (Sandwell and West Birmingham Hospitals NHS Trust) before starting the study. Participation in the study was voluntary, and the research was conducted following the appropriate scientific and professional integrity standards.

Data collection

Data on assessment and management of postmenopausal women with POP were collected via semistructured interviews in accordance with the study's methodological design and with the goal of recording interviewees' "lived experience" of history taking. The interviews were conducted using established protocols for semistructured interviews centered around the following 4 core areas:

1. What questions do you ask your postmenopausal women with POP before deciding on what type of vaginal pessary to insert?
2. What issues do you discuss before inserting a vaginal pessary in postmenopausal women with POP?
3. Do you regularly ask patients about these issues you highlighted?
4. Are there factors that influence the way you ask these questions?

Each interview started with a basic question to gather demographic information before proceeding to specific questions. The researcher transcribed all recorded interviews verbatim.

Analysis

Analysis was conducted in accordance with IPA to ensure that the human experience and its meaning for the individual were explored. The interview transcripts were subjected to a 3-stage process of analysis: (1) initial transcript review and familiarization, (2) identifying and noting emergent themes, and (3) connecting and collating emergent themes.

Results

Many volunteers, especially male volunteers, described patients looking and feeling embarrassed when discussing sexual issues, with some not making eye contact, looking at chaperones, or expressing frustration. Some volunteers expressed their embarrassment of having to ask women about sexual history, especially when the woman is accompanied by a family member such as a husband or a child. Some volunteers reported taking sexual history at the time of examination away from accompanying family members.

Four main themes emerged from the interviews: (1) building trust between HCPs and patients, (2) patients feeling embarrassed when discussing sexual issues, (3) patient preference for female HCPs, and (4) barriers to sexual inquiry due to ethnic and cultural background and use of an interpreter.

Building trust between healthcare professionals and patients

Many volunteers felt that women were more open to discussing sexual issues once trust was established, and that seeing the same HCP at subsequent consultations was important. They felt that patients preferred seeing the same HCP because a familiar face helped build trust, put the patient at ease, and encouraged openness on sensitive issues. This was exemplified by the following statements:

> "I think subsequent consultations are definitely more straightforward . . . they are more open and honest. . . ."

> "Once you have seen a patient a couple of times, you definitely have a much better rapport . . ."

> "Some patients don't volunteer information that they are sexually active. . . . It's mainly at the second consultation."

> "It may be at the second consultation you find out they are in fact sexually active, and the pessary inserted prevents them from this."

> "I think if initially they are a little bit reserved, they are generally a bit happier to discuss intimacy at follow-up visits."

Patients feeling embarrassed when discussing sexual issues

All the male volunteers reported that many women were reluctant or embarrassed to discuss sexual issues. In contrast, many female volunteers felt that women were often happy to see them, especially if the previous consultation was with a male HCP. All the volunteers stated that they had no difficulties in discussing sensitive sexual issues and used different techniques involving direct or indirect questioning. One female volunteer stated that she had to find ways to break the ice before initiating discussions about sexual intimacy. Two of the 10 volunteers who were female felt that they did not have the time to discuss sexual issues in the clinic adequately, as indicated in the following statements:

> "Sometimes, they are shy and do not want to discuss sexual intimacy . . . it is a very difficult and private topic."

> "Some patients are offended by being asked if they are sexually active . . . the older generation in particular."

> "Rather than asking the question directly, I will circumvent it by introducing the treatment options and see if they choose the necessary option."

> "Some patients say, 'You know we are not really sexually active that much, but . . .'"

Patient preference for female healthcare professionals

Three of the 7 female volunteers felt that being a female HCP influenced the women's openness to discuss sexual issues during consultation. Some female HCPs described seeing the relief on the patients' faces when they entered consultation rooms and saw them. All of the male volunteers reported that some women would refuse to see male HCPs. In addition, 1 HCP reported that the patient would not maintain eye contact and would instead be talking to the female chaperone. The following statements exemplified these tendencies:

> "I have lots of patients who made comments like they are glad they are seeing a woman."

> "Some of these postmenopausal older women don't even want to be seen by a male."

> "I don't want to come across as sexist or anything, but being female does help."

> ". . . they tend to forget about you and talk to the nurse."

> "They bring up issues that they couldn't discuss initially because maybe it was a male doctor . . ."

> "They are always happier to see us nurses. . . . we have a rapport with them, and they get to trust us."

Three of the nurses stated that they often noticed that some patients who previously saw consultants, regardless of the consultant's sex, were more comfortable talking to the nurses. Furthermore, these nurses considered that they had a stronger rapport with patients and found that patients opened up to them more easily about sexual intimacy than they did with doctors. One male volunteer reported that patients often looked at the nursing staff or female chaperone in the consultation room when they were responding to questions instead of looking at him.

Barriers due to ethnic and cultural background and use of interpreter

Eight of the 10 volunteers (2 male and 6 female) felt that women of Asian, African/Caribbean, and certain religious backgrounds were often embarrassed to discuss sexual issues during consultation. Two of the doctors expressed frustration with relying on an interpreter to correctly relay the information, especially when it involved sexual intimacy, because they sometimes noticed discomfort among some interpreters when discussing sexual issues with the patient. This was exemplified by the following statements:

> ". . . difficult to gain information from ethnic minority patients. . . . they were not forthcoming . . ."

> "Some with Asian and Black African-Caribbean background will laugh it off. . . . they will not mention it."

> ". . . you often see that the translator feels a bit awkward asking sensitive questions."

> "Asian women and women who do not speak much English find it difficult to discuss sexual issues."

> ". . . obtaining a sexual history when there is a language barrier can be difficult."

Discussion

With increasing life expectancy, it is expected that many sexually active women will spend a significant part of their life in menopause, with up to 80% experiencing sexual dysfunction.[11] In a

systematic review, Athey et al[12] found that over 37% of women (aged 60−79 years) had pelvic floor disorders, with up to 50% reporting sexual dysfunction.

This study focused on sexual inquiry during consultation with postmenopausal women with POP who opted for vaginal pessary management. Compared with premenopausal women, sexual dysfunction and POP increase significantly with advancing menopausal status, along with complex medical complications, which may render some older women unfit for surgery.[12,13] Carvalho et al[6] highlighted the disparity in accessing sexual healthcare between postmenopausal women and women of reproductive age. They highlighted lack of confidence among HCPs in discussing sexual function with postmenopausal women and fear of causing offence as some of the barriers to sexual healthcare access among postmenopausal women. There is increasing appreciation of the impact of sexual function on mental health, relationship satisfaction, and overall happiness. Hence, the topic of sexual intimacy during menopause has gained increasing importance. However, discussing sexual intimacy remains a taboo in many cultures, with both women and some HCPs feeling embarrassed to discuss it.

Given that some postmenopausal women with POP are unsuitable for surgery and may require long-term vaginal pessaries, it is imperative to choose the most suitable vaginal pessary and institute appropriate follow-up management. Minor complications such as discomfort, pain, odor, discharge, bleeding, and excoriation have been reported.[10,13] Although major complications are rare, they are usually due to long-term wear and neglect, which may lead to impaction or incarceration, fistulas, and malignancy.[10,13] Vaginal estrogen is often used along with vaginal pessaries by some HCPs to reduce complications resulting from vaginal atrophy and dryness in menopausal women, although data on its efficacy remain limited. Bulchandani et al[10] evaluated the differences in complications between postmenopausal women using vaginal pessaries with and without vaginal estrogen and concluded that the use of estrogen with vaginal pessaries may result in fewer complications. However, Chiengthong et al[14] reported that the addition of vaginal estrogen did not reduce pessary complications or bacterial vaginosis among postmenopausal women. In their systematic review, Ai et al[15] concluded that although the concomitant use of vaginal estrogen with pessaries may reduce bacterial vaginosis in menopausal women, there is no consensus on whether it reduces pessary complications.

There is a paucity of data on lived experiences of HCPs in discussing sexual function with postmenopausal women with POP who required vaginal pessaries. This study focused on this area because previous studies concentrated primarily on HCP skills and patient experiences and preferences.

The findings of our study confirmed those of previous studies concluding that discussing sexual issues remains difficult and sensitive and requires trust between the patient and their HCP.[6,16] Many volunteers in our study highlighted the negative impact of short consultation times, which hindered building trust with the patient during the first consultation. They also stressed the importance of patients seeing the same HCP in subsequent follow-up visits.

There is a dearth of data on barriers to sexual inquiry, such as HCPs' attitude, poor training, inadequate counseling, and lack of knowledge of sexual intimacy in the menopause.[5−9] All the volunteers in our study were fully trained and experienced in initiating and openly discussing sexual issues with women of all ages in a sensitive and supportive manner. We found that women were reluctant to talk, felt embarrassed, and often did not make eye contact, with 1 volunteer commenting that a patient simply laughed when discussion on sexual intimacy was initiated. The use of validated sexual health questionnaires, such as the Pelvic Organ Prolapse/Urinary Incontinence Sexual Questionnaire, IUGA-Revised (PISQ-IR),[16] that are completed by patients before appointments may considerably reduce the embarrassment associated with sexual inquiry during consultation.

These findings confirm those of previous studies concluding that a significant number of women prefer female HCPs[8,9] for reasons such as religious and cultural beliefs and feeling embarrassed having a male HCP looking "down below." In our study, many female volunteers reported that their sex positively contributed to having open discussions on sexual function with patients. In contrast, male volunteers reported that many patients were reluctant to open up about sexual issues and often preferred to talk to female chaperones.

Although the positive impact of professional interpreters on quality of care and patient outcomes is well-documented,[17,18] some interpreters may be embarrassed while interpreting sensitive sexual issues, as demonstrated in this study. The patient must feel comfortable with the interpreter, who should be appropriately matched (eg, a female interpreter fluent in the same dialect), independent, and respectful of confidentiality. In the United Kingdom, professional interpreters are recommended over family members to ensure confidentiality, as most women would find disclosing sensitive information to family members embarrassing.

Strengths and limitations

This study focused primarily on HCPs' lived experiences of discussing sexual intimacy with postmenopausal women who require vaginal pessaries for POP.

The study provides valuable insight into HCP experiences of sexual discussion with postmenopausal women in a multiethnic setting. However, these findings reflect individual volunteers' perceptions, and future research should examine whether they align with patients' perceptions. The study is limited to a group of HCPs from a single center and cannot be generalized. Nonetheless, the reported experiences are likely to be similar to those of other HCPs in other units. Furthermore, the proportion of male and female volunteers (3 male and 7 female) may introduce bias, especially in a gynecologic setting.

Conclusion

Sexual intimacy is an important aspect of satisfactory relationships and has an impact on quality of life during menopause. History of sexual intimacy is an important aspect of assessment of postmenopausal women before insertion of a vaginal pessary. A holistic person-centered approach to treating postmenopausal women with POP is essential not only to achieve the desired aim of correcting the prolapse but also to ensure satisfactory sexual intimacy, improve quality of life, and ensure compliance. Respecting patient preferences regarding HCPs and ensuring adequate time for consultation and appropriate professional interpreters when necessary can enhance trust between HCPs and patients, facilitate open discussion on sensitive sexual issues, and improve patient satisfaction. ■

CRediT authorship contribution statement

Monica Quinlan: Investigation, Formal analysis, Data curation, Conceptualization. **Victor Olagundoye:** Writing – review & editing, Writing – original draft, Supervision.

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