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Managing Women with Sexual Dysfunction: Difficulties Experienced by Malaysian Family Physicians

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Abstract
Recognizing barriers to managing sexual issues makes it more likely that effective ways to overcome them will be found. In Malaysia, where discussion of sexual issues is taboo, sociocultural factors may influence how physicians manage patients with these types of problems. This article focuses on the challenges encountered by 21 Malay family physicians when women experiencing sexual problems and female sexual dysfunction (FSD) attended their clinics, an uncommon occurrence in Malaysia, despite their high prevalence. This qualitative study employed a phenomenological framework and conducted face-to-face in-depth interviews. Three main barriers to managing women with sexual problems were identified that can hinder assessment and treatment: insufficient knowledge and training; unfavorable clinic environments; and personal embarrassment. Some barriers were associated with physician characteristics but many were systemic. These were further evaluated using social cognitive theory. Professional attitudes appear important as those physicians with an interest in managing women’s health seemed to make greater effort to explore issues further and work to gain trust. Physicians who appeared indifferent to the impact of FSD showed greater reluctance to find solutions. Systemic issues included unfavorable clinical settings, lack of training, and lack of local evidence. Any strategy to address FSD needs to be underpinned by appropriate policies and resources.

Keywords Female sexual dysfunction · Physicians · Primary care · Sexual health · DSM-5

Introduction
The inability of physicians to manage sexual problems raised by women is a common finding in the research literature and has been associated with screening (Harsh, McGarvey, & Clayton, 2008; Pauls et al., 2006), diagnosis (Alarcão et al., 2012; Auwad & Hagi, 2012), counseling (Humphery & Nazareth, 2001) and treatment (Bekker et al., 2009; Gott, Galena, Hinchliff, & Elford, 2004). For example, despite strong agreement about the importance of screening for female sexual dysfunction (FSD), the proportion of physicians actively participating in any screening varies according to their specialty, their country of practice, and their training (Alarcão et al., 2012; Harsh et al., 2008). Screening for sexual difficulties has been found to occur in little more than one in 20 urologists (Bekker et al., 2009) with the highest prevalence, nearly 80%, found in a survey of 150 British urogynecologists (Roos, Thakar, Sultan, & Scheer, 2009). However, a similar survey among Arabic urogynecologists found less than one in seven (13%) regularly screened women (Auwad & Hagi, 2012). It was postulated that the probable reason for this discrepancy in screening rates in the same medical specialty was the strong cultural taboo around the topic, which also possibly contributed to unfamiliarity with screening tools (Auwad & Hagi, 2012).

Three published reviews, confined to British or older population groups, have explored how health professionals deal with sexual difficulties in the women they treat (Bauer, McAuliffe, & Nay, 2007; Dyer & das Nair, 2013; Hinchliff & Gott, 2011). Two common barriers to effective management by physicians were cultural factors and lack of relevant knowledge. Culture-associated problems affecting physicians management of FSD...
described in the literature include: difficulties in addressing sensitive issues with limited time or resources (Dyer & das Nair, 2013); concerns about causing offense leading to negative responses from patients and staff (Gott et al., 2004); and concerns about sexualizing consultations without patient consent (Bauer et al., 2007; Dyer & das Nair, 2013).

Lack of knowledge is another common barrier to the effective management of sexual problems. In their review, Dyer and das Nair (2013) found several knowledge areas that concerned British physicians including: lack of knowledge or awareness; lack of training or experience; difficulty in communication about sexual issues with other health professionals. Hinchliff and Gott (2011) concluded that lack of knowledge and training led to failure to diagnose, and inappropriate referral for elderly people.

Diagnosis of sexual problems in women can also be highly contentious largely due to the potential for overdiagnosis when “normal” human experiences become seen as “medical problems,” a concern exacerbated by the involvement of the pharmaceutical industry (Graham, 2016; Moynihan, 2003; Tiefer 2001, 2012). While such fears are valid, significant emotional, physical and relational issues are raised by women with their physicians that are associated with problematic sexual experiences including lack of sexual desire or arousal, difficulty with orgasm, or pain during sexual intercourse (Tiefer, Hall & Tavris, 2002). FSD is a medical term, currently defined as “a group of disorders that are typically characterised by a clinically significant disturbance in a person’s ability to respond sexually or to experience sexual pleasure” (American Psychiatric Association, 2013, p. 423). FSD includes disturbances in sexual response leading to either, or combination of, “Female Orgasmic Disorder,” “Female Sexual Interest/Arousal Disorder” or “Genito-Pelvic Pain/Penetration Disorder.” The blurred boundary between sexual difficulties (or problems) and sexual dysfunction could be a possible consequence of the social construction of gender identity and sexuality, where sociocultural environments play a key role (Bussey & Bandura, 1999).

In Malaysia, gender identity and the expression of sexuality are sharply delineated culturally and reinforced by another sociocultural construct, the Malay identity, which is defined by legislation (Federal Constitution, 2010). To be Malay, one must accept the traditional culture, Adat, and the Islamic religion. Studies have shown that women associated with more “traditional” cultures emphasize their culture rather than their personal or sexual needs (Backus & Mahalik, 2011; Weiss, Freund, & Wiese, 2012). Sexual problems in marriage have particular significance in Malaysia, where they were attributed to be the possible consequences of their actions (outcome expectancy). According to SCT, a sense of control facilitates decision-making, goal-setting and helps adapt to different situations (Bandura, 2002; Luszczynska & Schwarzer, 2005).

The lack of knowledge of FSD among less experienced medical practitioners and concerns about its prevalence in Malaysia raises questions about the decision-making and adaptations to clinical practice of more experienced physicians. What do family physicians know about FSD and its management? What barriers do family physicians face in providing effective care for FSD? To address these questions interviews were conducted with experienced family physicians in Malaysia.
Method

Participants

All family physicians in the public sector were identified through the Ministry of Health and Family Medicine Specialist Association (FMSA) websites. The study was advertised on the FMSA website and committee members alerted members. Invitation letters were sent directly to physicians’ offices in two sites, the Kelang Valley (urban area) and Kelantan state (suburban and rural areas) to capture a wide range of FMS experiences (see the recruitment flowchart in Fig. 1).

Procedure and Measures

We conducted in-depth interviews with 21 family physicians, 5 males and 16 females, from West Malaysia. Participants were either FMS who had treated women with sexual problems for at least 1 year, or who had worked as a FMS for at least 3 years, or were physicians who had practiced medicine for at least 10 years. Participant profiles are presented in Table 1.

The study was approved by the Human Ethics Committee of La Trobe University, the Research Registry and Economic Planning Unit, Malaysia, the Ethics Committee, University Malaya Medical Centre, the Research Ethics Committee, Universiti Sains Malaysia, and the Research Ethics Committee, Universiti Kebangsaan Malaysia Medical Centre.

Interviews were conducted by the first author. Each interview lasted approximately one hour and was audiotaped. The
interviews covered the physician’s knowledge of sexuality and dysfunction their experiences with assessing and treating FSD, and any barriers encountered when managing patients with sexual problems. The barriers identified by the physicians are the focus of this article.

The interviews were transcribed verbatim and pseudonyms used to maintain confidentiality. All transcriptions were transferred to the ATLAS.ti® program for analysis. Coding was done by the first author who is a Malay family physician and was a Ph.D. student during that time. The initial process of thematic analysis began simultaneously with data collection. The first five encoded transcripts were discussed with two co-authors, who have expertise in qualitative research. The initially developed code book included preliminary codes created from our readings of the literature and new codes generated from discussion of the transcripts.

Analysis began with continuous reading and rereading of each transcript until meaning was derived from each paragraph of text and repeated patterns of meanings were discovered to make sense of participants’ stories and as a group (Fereday & Muir-Cochrane, 2006; Liamputtong, 2013). New codes were generated during these readings and added to the code book to ensure all similar understanding. Next, axial coding was used with different codes combined and adjusted to precise themes within and across participants’ narratives (Liamputtong, 2013; Minichiello, Aroni, & Hays, 2008).

To ensure rigor of the findings, meticulous discussion between the authors occurred to ensure themes used fitted with existing codes and quotations used. If necessary, new codes were developed and discussed. The peer review method was used to ensure credibility of codes and themes presented in this paper (Liamputtong, 2013). All coders agreed on the final themes and sub-themes. Member checking was used to ensure accuracy of the interviewing data (Liamputtong, 2013) with interview transcripts and emerging themes made available to participants for comment and confirmation by email to ensure that “true” meanings were maintained. Those who did not reply were contacted by phone to discuss matters of potential disagreement. Fortunately, all agreed with our analysis.

**Results**

Three main barriers to managing women with sexual problems were identified by the physicians: insufficient knowledge and training; unfavorable clinic conditions; embarrassment (Table 2).

**Insufficient Knowledge and Training**

The physicians perceived that they lacked necessary education and training to initiate discussions about FSD or to treat women with sexual problems. Inadequate training was highlighted by all physicians as the most important limitation in their ability to talk about sexual health issues generally, but especially to talk about sexual dysfunction with women. Two female FMS responded as follows. Huda, a interested in chronic diseases, said, “Lack of training, for me, myself,” and Amira, interested in health prevention said, “So, in terms of training, there is so much lacking.”

| Table 1 Profile of family medicine specialists (FMS) involved in the study, n=21 |
|---------------------------------|---------------------|-------------------|
| Variables                       | Range    | Mean (SD) | N (%) |
| Age                             | 31–54 years | 42 (5.2) | –     |
| Sex                             | Male     | 5 (24)    | 16 (76) |
|                                  | Female   |           | –     |
| Year in practice as FMS         | 1–16 years | 6.6 (4.2) | –     |
| Practice area                   | Kuala Lumpur | 7 (33)  | –     |
|                                  | Selangor | 2 (10)    | –     |
|                                  | Kelantan | 12 (57)   | –     |
| Postgraduate qualifications     | Master of family medicine (USM) | 14 (67) | –     |
|                                  | Master of family medicine (UKM) | 2 (10)  | –     |
|                                  | Master of family medicine (UM) | 4 (19)  | –     |
|                                  | FRACGP   | 1 (5)     | –     |
| Subspecialty/fellowships/special interest | Women’s/and sexual health | 5 (24)  | –     |
|                                  | Men’s/and sexual health | 2 (10)  | –     |
|                                  | Adolescent and child health (sexual health) | 3 (14) | –     |
|                                  | Prevention and screening | 4 (19)  | –     |
|                                  | Cardiovascular/DM/chronic diseases | 4 (19) | –     |
|                                  | Dermatology | 2 (10)   | –     |
|                                  | Mental health | 1 (5)    | –     |
| Training                        | Sexual history only | 5 (24)  | –     |
|                                  | History and diagnosis of FSD | 11 (52) | –     |
|                                  | Management of FSD | 4 (19)  | –     |
|                                  | Psychotherapy and counseling | 1 (5)  | –     |
| Sexual health priority          | High     | 6 (29)    | –     |
|                                  | Medium   | 9 (71)    | –     |
|                                  | Low      | 6 (29)    | –     |

**USM** Universiti Sains Malaysia, **UKM** Universiti Kebangsaan Malaysia, **UM** Universiti Malaya, **FRACGP** The Royal Australian College of General Practitioners
Lack of adequate education and training led to questions as to whether FSD was a real problem, but also meant physicians did not feel confident or were reticent to deal with patients with FSD.

Assumption that FSD Not a Priority

Most physicians remarked that their lack of exposure to managing FSD was because it was given low priority in their medical training and in health policies. FSD was not included in either undergraduate or postgraduate syllabuses. Those physicians who reported difficulty introducing the topic with patients also pointed to the lack of attention FSD received in the community. For example, one male physician, Zamani, said that priority was given to diseases that created greater health burdens or were leading causes of death.

As a family medicine specialist, we have so many things to learn in four years that probably, we cannot focus on it. We have the communicable and the non-communicable diseases, which are more important. (Zamani, 46 years, male; special interest: men’s health)

Several physicians pointed to the absence of any awareness campaign. Forty-three-year-old male FMS, Hakimi, with an interest in dermatology remarked, “Sexual disorder is not a priority, even in the Ministry of Health.”

When asked about the high prevalence of FSD in Malaysia, some physicians said that the Ministry of Health should do something to equate FSD to male sexual dysfunction (MSD), but others felt that it was not feasible to add new programmes to current workloads. There was broad agreement that FSD should be treated by those interested in the field. The reticence of Malay women themselves also provided little incentive to incorporate consideration of FSD into consultations. Male physician, Izani, remarked:

Women also do not portray this as the main issue for them. Unless there is a demand from women that they want this to be given priority, then people will give attention to the issue. (Izani, 43 years, male; special interest: preventive medicine)

Low Confidence Levels

Limited knowledge and training on FSD were reflected in the low level of confidence physicians displayed when talking about dealing with FSD patients. Female physician Alina expressed the difficulties she and her colleagues experienced.

We usually feel difficulty in asking, because we do not know what to do next. If we ask, we get to know about other issues and do not know how to proceed or settle it. (Alina, 39 years, female; special interest: women’s and sexual health)

Inexperience in providing FSD treatment was common to all physicians. Some shared their uncertainty about providing effective care, which was labeled as “experimentation.” Hanim, a female FMS interested in women’s health said: “With my limited knowledge, I managed them according to the (possible) causes by trial-and-error.”

Table 2 Experience in managing women with sexual dysfunction

<table>
<thead>
<tr>
<th>Themes</th>
<th>Sub-themes</th>
<th>Sub-subthemes</th>
<th>Others/outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Barriers</td>
<td>Insufficient knowledge and training</td>
<td>1. Assumption FSD not a “priority disease”</td>
<td>Low priority of policy makers and educators:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>2. Low level of confidence</td>
<td>lack of training in undergraduate teaching</td>
</tr>
<tr>
<td></td>
<td></td>
<td>3. Imbalance between FSD and MSD</td>
<td>Low confidence to treat</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Male and female SD treated differently:</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Inadequate teaching, lack of awareness programmes, ineffective treatments</td>
</tr>
<tr>
<td></td>
<td>Unfavorable clinical settings</td>
<td>1. Difficult to build rapport in clinical environments</td>
<td>Shared rooms, manual medical records and dispatch process, gender differences, and poor clinic facilities</td>
</tr>
<tr>
<td></td>
<td></td>
<td>2. Time constraints</td>
<td>Limited time for screening, assessment, or focus on secondary complaints, little counseling or self-education</td>
</tr>
<tr>
<td></td>
<td></td>
<td>3. Few treatment options</td>
<td>Lack of medications and knowledge about psychological therapy</td>
</tr>
<tr>
<td></td>
<td></td>
<td>4. Lack of expertise</td>
<td>No skilled health team in area</td>
</tr>
<tr>
<td></td>
<td>Embarrassment</td>
<td>1. Doctor embarrassment</td>
<td>Unable to converse freely</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Worried about offending others and self</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Reluctant to develop knowledge in sexual health</td>
</tr>
<tr>
<td></td>
<td></td>
<td>2. Consequences of patient embarrassment</td>
<td>Difficult to identify FSD patients</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Difficult to discuss FSD and sexual matters</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Difficult to treat sexual problem</td>
</tr>
</tbody>
</table>
For those who considered FSD to be mainly psychological in origin, lack of training in sexual counseling and therapy limited their ability to treat patients, perpetuating a cycle of inexperience in managing FSD.

**Imbalance Between FSD and MSD Treatments**

Physicians were confident dealing with male sexual dysfunction (MSD); well-trained educators in MSD were available and many pointed out that MSD is taught in medical courses, with continuous medical education programmes available because of community demand. One female FMS interested in health prevention, Amira, reported, “Every year we have a topic to be discussed on male sexual problems because we have expertise in it.”

Some physicians remarked that MSD was given special emphasis because of evidence of its direct link to comorbid diseases, especially cardiovascular diseases. The long-term effects of FSD were not as clear. One said,

> It is difficult to correlate women’s sexual dysfunction and some diseases—not like male sexual dysfunction, that we can easily relate to certain other diseases. (Izani, 43 years, male; special interest: preventive medicine)

A few others saw FSD as a new disorder less well known to the community or to physicians than MSD, where attention had been driven by the introduction of phosphodiesterase type 5 (PDE5) inhibitor into Malaysia.

Female sexual dysfunction is rather new in medicine. I myself don’t have enough knowledge. I remember the first time Viagra came out; people made jokes and lots of noises about it. Now it is a norm. FSD is something new for the community to accept…just give it time. (Azhana, 53 years, female; special interest: chronic disease)

**Unfavorable Clinical Settings**

Two issues related to clinical settings were raised as barriers to effective care for women with FSD directly related to professional practice: difficult clinical environments, and the therapeutic options available. Issues affecting rapport included the clinical environment and time constraints. Therapeutic options were restricted by limited medical treatments and insufficient expertise.

**Difficult Clinical Environments**

It is not unusual in primary care clinics in Malaysia for concurrent use of clinical rooms by two or more physicians. Physicians remarked that such clinical environments inhibited communication, impeded trust-building and rapport-building and were not conducive to discussions about sexual dysfunction. Male physician Zamani described his frustration with arrangements that were unfavorable to sexual history-taking.

> I don’t think that the patients who come to see us, entering the room, seeing another physician there, with another patient and with a few other family members, would be willing to talk about their sexual problem. (Zamani, 46 years, male; special interest: men’s health)

Apart from the challenge of building rapport in such environments, confidentiality can be difficult to maintain and is made worse by the use of manual medical records. One female physician with interests in adolescence and sexual health, Nurul, nominated two other conditions adversely affecting confidentiality: how medical records are transferred and the lack of continuity of care.

Confidentiality was particularly important when “same gender” preferences arose limited physician numbers and high demand also made it difficult to facilitate preferences for female-to-female consultations, which some felt could also affect disclosure.

> When I see female patients, I call a female nurse to join in. I believe patients won’t actually share as much as they would if they were with a female physician. A lot of stories that I got were quite different, or brief, as compared with those told by a female physician. (Zamani, 46 years, male; special interest: men’s health)

**Time Constraints**

The physicians saw 20–30 patients each day, averaging only 5–10 min with each person. Most physicians declared that this was insufficient time to elicit information about sexual problems, which were more likely to be raised later in consultations.

> We don’t have time to talk about this because normally the issue of female sexual dysfunction will be [come out as] the last issue. (Izani, 43 years, male; special interest: preventive medicine)

Accordingly, most physicians had opportunity to do little other than concentrate on the first complaint a patient presented, based on the assumption that this would be the most important. Lack of time meant that issues that arose late in consultations would generate follow-up visits, rather than immediate action.

> If I feel it is really a problem, I will give another appointment to settle it. I think I’m the one who did not prioritise it because it was not the chief complaint. (Huda, 42 years, female; special interest: chronic diseases)
Almost all the physicians accepted that there was little time to screen for FSD. When asked about availability of a screening questionnaire in her clinic Alina replied,

We don’t have a proper screening questionnaire for FSD. I just ask informally—if they have a problem, I hope they will tell me. (Alina, 39 years; special interest: women’s and sexual health)

Some physicians felt that implementing FSD screening was not appropriate in busy clinics, but could be used in women’s health clinics, or for referrals to specialized clinics. Sarah suggested:

If we want to make this mandatory for all women, honestly we …don’t have time to do so. Unless in a special clinic or if we are interested in it. (Sarah, 52 years, female; special interest: addiction medicine, women’s and sexual health)

For physicians such as Hakimi, a male FMS interested in dermatology, the context of busy clinics meant that staff had no time for initial assessment or for training and professional development. Hakimi said, “In daily practice, we have got so many things to do, and we also do not have enough time educate ourselves to tackle this kind of problem.”

Few Treatment Options

Despite acknowledging that they knew little about FSD, physicians were aware of the lack of effective treatments available, which most associated with medications. Physicians identified this factor as potentially discouraging them from initiating discussions about sexual problems with female patients. Unlike male sexual dysfunction, the disorders suffered by women were seen as not wholly medical, and no pharmaceutical treatment could be offered.

We don’t have a lot of medication for treating female sexual problems. But we have this booming industry for treating male sexual problems. (Amira, 39 years, female; special interest: prevention)

One male physician pointed out that if medications or commercial interests of drug companies were available it would make physicians more aware of FSD disorders.

We know that there is not much effective medication to treat this condition and most CME (continuous medical education) classes were pharmaceutically driven. When there is a new drug available, the pharmaceutical companies will come in and sponsor the talks to highlight the issue. Unfortunately, not for FSD. That’s why we don’t even know the solution for it. (Izani, 43 years, male; special interest: preventive medicine)

Lack of Expertise

The lack of pharmaceutical options, reinforced by insufficient expertise in FSD, further reduced the chance of receiving effective treatment. One physician bemoaned the inadequacy of the expertise in FSD in Malaysia, despite its reputation for having one of Asia’s best healthcare systems. Lack of training for healthcare practitioners, in general, worsened the situation, and judgments about sexual health issues by many physicians were influenced more by socialcultural issues than medical understanding.

Despite very good accessibility, the problem with the health care system in Malaysia is that we don’t have enough competent people actually to manage it in the first place. Medical assistants and community health nurses are also not well trained, which probably just ‘brushes out’ this problem. Many may have said, “Oh, this case is so simple” or “Oh, we are Muslim or Malay, we just accept it.” (Zamani, 46 years, male; special interest: men’s health)

Some physicians acknowledged that the lack of expertise in Malaysia was not due to a lack of training opportunities in women’s health issues, as the Government enables all primary physicians to choose their area of specialty training. One female physician underwent training in a Western country, but found that FSD was not well-covered and so did not skill her in treating FSD.

In fact, when I went for training [overseas], they did not talk about orgasm, satisfaction, no. I learnt about menopausal women, infertility, PCOS [polycystic ovarian cysts], and other gynae problems. Not so much of female sexual dysfunction. (Sarah, 52 years, female; special interest: addiction medicine, women’s and sexual health)

The psychological aspects of FSD require more than medical knowledge as some physicians pointed out, but sexual health services in Malaysia generally do not have the sorts of specialist help from counselors, psychologists, sexologists and other related specialties that are needed for success. It all largely falls to primary care physicians.

Someone who has been trained in counselling obviously does a better job than us, but we don’t have them in our clinic. (Amira, 39 years, female, special interest: prevention)

Embarrassment

Embarrassment was a common response raised by the physicians when talking about FSD. Physicians identified embarrassment as a barrier for effective responses to FSD for themselves as health professionals and in their interactions with patients.
Professional Embarrassment

Physicians identified three main areas where professional embarrassment arose related to FSD. Physician embarrassment impeded development of the professional skills needed for FSD, inhibited discussions between colleagues and affected the conduct of patient consultations.

Some physicians admitted that their own shame prevented them from developing this area of practice but all reported embarrassment in talking about sexual problems. Female physician Syuhada nominated sociocultural background as the reason Malay physicians had difficulty in discussing sexuality or even searching for relevant information about FSD.

We can seek knowledge from elsewhere...on the internet, it is widely available, but being uncomfortable with the subject, I don’t think we will be very active in seeking out knowledge to help our patients with this problem. (Syuhada, 43 years, female; special interest: dermatology)

Another physician, Izani, felt the consequences for anyone talking about sex in public quickly changed from embarrassment to fear, because of “labelling” by society and that this adversely affect a physician’s professional career.

When someone talks about sex, people may label him or her as a sex maniac, crazy about sex, and so on. So that’s our people, and even us as physicians are reluctant to talk about sex openly, and we are mostly not interested in specialising in it. (Izani, 43 years, male; special interest: preventive medicine)

Physicians described themselves as “shy,” “timid,” or “uncomfortable” if they ever needed to initiate discussions about sexuality and many physicians revealed that they could not talk publicly about sex. A few felt that other physicians looked down on those that tried to do so. Female physician, Aina, who graduated from a medical school outside Malaysia, remarked:

I did try to discuss with my colleagues about how to deal with sexual issues, but I could feel that many of them did not want to talk about this; they were not open about it. Even if patients want to talk about this (with them) the physician rebuffs them, so it is very hard for patients to open their mouths again to other physicians. (Aina, 39 years, female; special interest: child and sexual health)

One important consequence of the paucity of professional discussion and professional development about FSD was poor knowledge of treatment options discussed earlier.

There were several ways that the physicians felt that embarrassment affected how patient consultations were conducted. Almost all physicians admitted to feeling uncomfortable discussing sexual problems with patients and said they were afraid of insulting or shaming them. Huda, a female FMS and another graduate of a Western medical school said that the Malay culture and values that she known from childhood still significantly influenced her practice and made her more conservative when dealing with sexual issues.

I think I’ve got a lot of barriers because I was brought up in this community where sex or sexuality is a taboo. I myself hardly ever ask my patients whether they have sexual problems or not. (Huda, 42 years, female; special interest: chronic disease)

Concern about the embarrassment caused to themselves, to patients and to others, particularly patients’ spouses, impeded communication.

Physicians sometimes want to ask, but are afraid of asking beyond the limit that causes patients to be embarrassed, as this will disturb the rapport between them. Perhaps that’s why some physicians don’t even ask for a sexual history. (Nurul, 46 years, female; special interest: adolescent and sexual health)

Physicians also felt unsure as to how and when they could elicit private information, even in clinical consultations. Uncovering private stories of FSD was an intimidating task, even in female–female consultations. One female physician, Natasya, shared her feelings about the difficulty of finding appropriate words to use. She pondered,

How to make the conversation like taking a medical history, but not like a man and a woman talking about sex. With men it is actually much easier, “Can you have an erection?” With women, I don’t know how to ask about (sexual functions) in Malay. (Natasya, 41 years, female; special interest: preventive medicine)

Culture and religion were identified by a number of physicians, particularly males, as the source of their embarrassment in talking about sexual problems with Malay women.

Patient Embarrassment

While physician embarrassment affected consultations, patient embarrassment was seen by the physicians as an even greater barrier to effective care of FSD. Patient embarrassment was seen as contributing to three main difficulties: identifying patients with FSD and sexual matters; and difficulty in treating sexual problems.

Difficulty in Identifying FSD Patients Doctors realized that a major issue with FSD was that many women saw their sexual experiences as the norm rather than as a problem and did not seek help. Even if women recognized a problem, they were more likely to consider it a social issue, not a medical one.
Because of taboo, not many women admit having a problem because they don’t think they have a problem. (Huda, 42 years, female; special interest: chronic disease)

Doctors also pointed out that in the sociocultural construct of Malay communities, sexual issues are seen as natural processes of life, and this suppresses the ability of women to talk about changes in their sex lives. Women can fear that their doctor would not believe them or that their reputation as a “good wife” would be ruined.

They don’t even know whether the doctors will give their problem a “put-down” or not, like “Yes, (a certain doctor would say) this is just a usual thing, so no need to see them.” Perhaps they feel afraid the doctor will say that their condition is not a medical illness, or they feel shy because they believe they are the only person to have it. (Nurul, 46 years, female; special interest: adolescent and sexual health)

Age-related sexual problems were another reason for not seeking medical help. Doctors told me that as women age, they are usually less interested in sexual intimacy with their husbands and more likely to confine themselves to basic prayers to achieve the religious reward. Within the conservative culture of Malays, sexual activities for older women are not seen as essential.

Many don’t know this is actually a disorder; they think it is just a natural process of missing things when getting older, and this makes them not relate it to any diseases. They don’t know there are actually treatments for it. (Ayuni, 39 years, female; special interest: women’s health)

One physician with a special interest in sexual health, Aina, felt that women might ignore sex problems if they saw sex only as part of the role of a wife to please her husband. Aina felt that this means many women disregard changes to their sexual function if it does not interfere with this sex role. In these cases, women had other important and enjoyable functions to perform that helped them to overcome any emotional instability that might arise from the absence of pleasurable sex. Motherhood was one such role.

If they cannot enjoy their relationship with their husband, (and) they still have kids, they just give attention to their kids, and they usually get a lot of relief. (Aina, 39 years, female; special interest: child and sexual health)

However, the doctors revealed that some women became conscious of their sexual needs when problems arose. Due to embarrassment, rather than seeking professional help they try to self-educate by searching for information from magazines. This was one reason for late presentation for treatment. In these cases, the problem would have grown despite the women’s efforts to find solutions on their own. Sarah shared one patient’s story:

Every time they wanted to make love, his wife said it was painful. They did nothing except they just read. They did not know where to get help or treatment. This problem was sensitive, so they just continued like that for a few years. (Sarah, 52 years, female; special interest: addiction medicine, women’s and sexual health)

Physicians believed that the lack of information and absence of awareness programmes about sexual health meant that women with problems often did not know where to go, unlike the treatment options for other health conditions where information was easily found.

Physicians reported that embarrassment led women to try to self-educate by searching for information from magazines and other sources. Female physician Nurul believed that the problem of FSD was significant in the community because she received many anonymous questions about FSD through her online blog. Nurul felt that the nature of the problem and poor sexual health promotion meant people did not know an appropriate place to seek help.

There are a lot (of women) actually (having sexual problems from the online question and answer sessions), but we just can’t get them to come forward. So we don’t have patients (in the clinic). Apart from taboos, they do not even know where to go, or which physicians are qualified (interested) to treat them or at least willing to hear their stories. (Nurul, 46 years, female; special interest: adolescent and sexual health)

Physicians were also aware that traditional medicines were often preferred treatments for illnesses, including sexual problems in Malaysia and felt that preference for traditional treatments was not countered by effective health promotion campaigns and provided a way to avoid embarrassment. Nurul also explained how without such campaigns, traditional beliefs drove patients to use traditional medicine first: “Because of all these, perhaps that’s why they try to find alternative ways. Some women use traditional medicine like Jamu (or herbs).”

“Jamu” (or herbs) was a traditional medicine that several physicians referred to in interviews, as a “the well-known” medicine to maintain women’s beauty and general and sexual health. The physicians believed that women felt comfortable using Jamu because they did not need to tell anybody about their sexual problems.

The physicians felt that women need a trusted person to overcome the cultural barrier of embarrassment. One FMS interested in women’s health, Hanim, shared her experience with friends who needed help but were reluctant to see a physician not known to them.

Barriers to effective care continued even when problems were identified that physicians associated with patient
embarrassment. A significant challenge for treatment arising from patient embarrassment occurred if a woman had not told her partner about her problem. One male FMS interested in men’s health, Zamani, reported that while some women would readily disclose their stories with him, they had not discussed the issue with their husbands and did not want their husbands to know, making treatment difficult: “They refuse to talk to their husbands, so this will cause even worse problems.”

Female physician Nurul gave an example of a negative effect arising from a culture of pleasing others, called jaga hati in Malay, which occurs in husband–wife relationships and in physician–patient relationships. The culture of pleasing prevented a wife from telling her husband how she felt about him directly. She hoped that the physician would act on her behalf to explain the problem to him, though the same cultural phenomenon created difficulty from the physician’s point of view.

Male physician Zamani suggested that obstacles to offering treatment to women with FSD became much greater when women did not value their sexual lives and when multiple causes for their problems existed.

I don’t think they see their problem as a priority, to get treatment, and also they don’t think it is actually important; but for men, it is probably quite straightforward when they have a dysfunction. (Zamani, 46 years, male; special interest: men’s health)

Discussion

This study was motivated by concerns about the prevalence and significant social impact of FSD in Malaysia and sought to address questions about the knowledge and management of FSD by experienced family physicians. We also sought to identify barriers to effective care for FSD and to seek understanding of our findings using social cognitive theory. The findings from this study strongly suggest that solutions to the problems of FSD in Malaysia lie with better preparation of individual family physicians and with broader systemic or societal change.

The Malay family physicians in our study revealed little experience in managing women with sexual problems including sexual dysfunction. Some suggested that, unlike other aspects of their clinical practice, the management of FSD should be differentiated and only done by those physicians with an interest in it. This response reinforced the finding that Malay physicians in this study like physicians in other parts of the world (Gott et al., 2004; Ribeiro et al., 2014), do not regard female sexual dysfunction as important as other health issues or as important as male sexual dysfunction.

We also found similarities with other studies in terms of the types of barriers healthcare professionals face in managing FSD. These included personal barriers such as poor knowledge and training and feelings of embarrassment (Auwad & Hagi, 2012; Bauer et al., 2007; Dyer & das Nair, 2013) and systemic barriers such as poor clinical environments, limited consultation times and limited resources when sexual health problems were identified (Alarcão et al., 2012; Gott et al., 2004). SCT proposes that while humans are shaped by their environments they are also active agents and can make choices about what actions to take. When consulted by women with sexual problems or dysfunction, the family physicians in this study were affected by the strong external environmental stimuli that exists in Malaysia (Adat culture, Islamic religious understandings, and the priorities of the Ministry of Health), but could also make choices about how they would act (Bandura, 1986).

The impact of the external environment in Malaysia is significant and affects not only physicians but also by women experiencing sexual problems. The poor levels of knowledge about sexual function and embarrassed responses of the physicians in this study mirrored the knowledge and behavior of Malay women seeking care (Muhamad, 2017) and probably explained the high level of empathy. However, it is worrying that in a professional group, the external environment also adversely affected their medical interest in FSD and their willingness to address potential problems. Similar findings have been found among gynecologists and primary physicians in both developed and in Middle East countries (Abdolrasulnia et al., 2010; Alarcão et al., 2012). An important finding from our study was that two distinct choices among the family physicians in terms of their approach to women with sexual problems could be identified, which we attributed to either “interested” or “indifferent” physicians.

The interested physicians were those with better understanding of sexual health, in particularly sexual dysfunction, obtained either through short courses or self-reading. Despite inadequacies in their knowledge, this group were more aware of the possibility of problems and were alert to indirect cues from their patients and prioritized sexual cases (Humphery & Nazareth, 2001; Roos et al., 2009). They worked to overcome embarrassment and to gain trust. They asked sexual health questions of their patients, discussed such issues with them and gave counseling, before referring to a suitable specialist.

Interested physicians also recommended that policy makers run sexual health courses for all physicians and primary care physicians and design better workplaces that provided proper privacy to enable women to disclose sexual problems (Humphery & Nazareth, 2001; Roos et al., 2009).

The indifferent physicians described sexuality in similar ways to Malay women (Muhamad, 2017) and revealed uncertainty in their understanding of FSD, which resulted in lack of concern about identifying women with sexual problems. Behaviors consistent with Adat—a culture of silence around sexual issues, the absence of appropriate words, fear of upsetting others—were evident. Such behaviors limit their capacity to be identified or address cases of FSD in their clinics and means that their experience with FSD is non-existent or
minimal. These behaviors are consistent with others reported by Auwad and Hagi (2012), Bauer et al., (2007), and Dyer and das Nair (2013).

Indifferent physicians also underestimated the prevalence of FSD in their community (Pauls et al., 2006). The absence of FSD in the medical curriculum or in professional development training signaled its low priority as found elsewhere (Gott et al., 2004) and justified lack of knowledge of the topic by the physicians but also likely contributed to feelings of discomfort and under confidence (Alarcão et al., 2012). The importance of early diagnosis and the role of primary care physicians in reducing delays in treatment were underrecognized by this group (Humphery & Nazareth, 2001).

However, regardless of their interest in FSD, most physicians in this study acknowledged needs for increased awareness of FSD and training for physicians, and wanted better sexual health services in primary care practice. Such changes, they claimed, would be most effective with top-down directives from policy makers, which is consistent with findings from a systematic review (Dyer & das Nair, 2013).

Breaking Down Barriers

In Malaysia, the involvement of family physicians in sexual health is increasing but challenging. There has been wide acceptance of the role of physicians in male sexual health but many barriers to the provision of effective treatment for FSD still need to be overcome. Breaking down these barriers will require physicians to rethink their professional role in this area and to address the inadequacy if their current preparation. However, for sustainable change, broader systemic support is required. Measures previously suggested by Azar, Bradbury-Jones, and Kroll (2013) in their discussion paper looking at women’s help-seeking for problems in their sexual lives offer some guidance. Women need to be informed about sexual health to know that they can address problems when they occur.

First, physicians and policy makers need to acknowledge the prevalence of FSD in the Malay community and its significant social and health impact (Ishak, Low, & Othman, 2010; Sidi et al., 2007). Physicians need to reflect on how their attitudes and practices in regard to the provision of sexual health services, particularly to women have been influenced by Adat, traditional understanding of Islamic teaching, and the curriculum of their medical schools. In this study, we witnessed significant lack of knowledge, skill and confidence related to the management of FSD among experienced physicians.

The systemic changes required will need the involvement of the medical profession, the Ministry of Health and universities. These institutions will play a significant role if sexual health is to be upgraded to be included as part of comprehensive health and well-being of the community. Female sexual health, including FSD, should be introduced to undergraduate and postgraduate curricula. FSD also needs to be included as a vital component of women’s and mental health programmes in primary care.

Training about FSD is needed for family physicians and other healthcare providers (Gott et al., 2004; Humphrey & Nazareth, 2001). Bringing in expertise from outside Malaysia and Islamic scholars to correct misinformation may raise awareness among physicians and the wider community.

FSD could be alleviated in Malaysia and even prevented if there was increased awareness in the community and among healthcare providers. Culture and religious taboos are important influences on physicians in regard to FSD. Interventions addressing sociocultural issues and evidence-based strategies will strengthen physicians’ knowledge and confidence levels. Policy makers need these strategies to address FSD in Malaysia.

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References


