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ORIGINAL ARTICLE

Discussing sexual concerns with chronic low back pain patients: barriers and patients' expectations

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Abstract This study aims to explore patient's concerns when discussing sexual problems caused by chronic low back pain with their healthcare provider. It also aims to identify factors influencing and limiting such communication. A cross-sectional analysis of 100 consenting chronic low back pain sexually active patients was carried out. Patients answered questions on their disease characteristics and sex life. They also mentioned prohibitions of discussing sex with their healthcare provider and their expectations of such discussion. Factors influencing patient's experiences were analyzed. Median of chronic low back pain duration was 36 (24–72)months and back pain intensity using visual analogical scale (0–100 mm) was 50±10.7 mm. Eighty-one percent of our patients complained of sexual problems, 66 % have never discussed the subject with their healthcare provider. Barriers which prevent discussion on sex include the taboo character of the topic, inappropriateness of visit conditions, and patient disinterest in sex. Ninety-three percent of patients expressed the need of sexual problems' management in chronic low back pain consulting. Seventy-four percent expected information and advice from their healthcare provider about recommended intercourse positions so as to avoid pain. Thirty-three percent of patients wanted their partner to be involved in the discussion and 81 % preferred talking with a healthcare provider of the same gender. Ability to communicate on the topic was associated with the decrease of patient sexual satisfaction and limited by patient illiteracy. Our study evidences that sex discussion between patient and healthcare provider is restricted by several barriers and that patients expect more involvement from their healthcare provider on the subject. Illiteracy and level of sexual satisfaction seem to be the strongest factors influencing this communication.

Keywords Barriers · Chronic low back pain · Communication · Expectations · Patient · Sexuality

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Introduction

Chronic low back pain (CLBP) is a current condition and a major public health problem in society which causes considerable disability [1]. In addition to its functional and psychosocial impact, CLBP contributes to decreases in libido and sexual satisfaction [2, 3].

Available literature recognizes that sexuality is a key contributor to patient's quality of life and well-being. However, despite a highly disrupted sex life in some CLBP patients, discussion of sex problems between patient and healthcare provider remains a delicate and rarely investigated subject [4]. Sexual effects of CLBP are often underestimated due to barriers preventing communication between the physician and the patient about sexuality. Several personal and organizational factors were recognized as possible barriers [5]. The lack of healthcare provider's preparation, training, privacy, and time was associat ed with fewer conversations about sexual dysfunction [6]. Nevertheless, patients still expect the healthcare provider to approach the subject of sex by providing general information and adopting a reassuring support and educational role, which may result in less patient fear and more optimism for her/his sex life [6, 7].

The purpose of this study was to investigate CLBP patient's perceptions about barriers preventing discussion of sex problems related to CLBP with the healthcare provider. It also tried to identify patient expectations from their healthcare provider so as to improve their sex life. It also aimed to identify factors influencing this communication.

Patients and methods

Patients

We have included in this cross-sectional study patients with CLBP seen in outpatient clinic at El Ayachi Hospital. Informed consent was obtained from all patients and the local medical ethics committee approved the study. "LBP" was defined by pain, muscle tension, or stiffness localized below the costal margin and above the inferior gluteal folds, with or without leg pain (sciatica) [1]. "Chronicity" was established by the persistence of pain beyond 3 months of symptoms. We have included sexually active patients who are able to have erotic experiences and responses. "Sexually active" was defined by the ability to have sexual interest and to experience sexual attraction and intercourse by vaginal penetration. Patients with no active sexual life and patients already operated or suffering from other comorbidities (diabetes, cardiovascular diseases, neurological problems, depression, sexual disorders as erectile dysfunction, or anorgasmia) which could disturb sexuality were excluded from this study.

After explaining the objectives of the study, the respondent was asked for her/his signed consent to participate in the study. Only consenting subjects were finally interviewed. Verbal consent, where the participant is illiterate, was obtained in the presence of and countersigned by a literate, independent witness confirming that all the relevant information was provided to the research participant in an understandable manner.

One hundred twenty patients were recruited. Twenty patients refused to participate. Fifty men and 50 women were finally included.

Methods

The high percentage of illiteracy in our population resulted in the data being collected by a rheumatologist using a "face-to-face" interview. The interview was anonymous and respected patient's privacy. Patients were asked to answer questions on their socio-demographic characteristics (age, gender, educational level, and profession) and features of CLBP (disease duration, pain intensity during the last week assessed by visual analogical scale (VAS, 0–100 mm)) and function disability assessed by the Arabic version of the Oswestry Low Back Pain Disability Questionnaire ranging from 0 to 100 % with highest scores indicating maximum disability [8]).

To explore the impact of CLBP on sexuality, we established five questions:

- Sexual disturbance (yes/no),
- Decrease of libido (yes/no),
- Decrease of sexual satisfaction (yes/no),
- Painful intercourse position (yes/no), if yes, which position
  - Sidelying (yes/no),
  - Prone (yes/no),
  - Supine (yes/no).
- Back pain triggered by intercourse (yes/no).

To investigate patient's perceptions of discussing sexual problems with their healthcare provider, we established four questions:

- Have you already broached the subject with a healthcare provider? (Yes/no).
- What was the nature of this communication (simple information, medical advice to resolve sexual problems caused by CLBP, or referral to a sexologist)?
- Patients' satisfaction level about discussing sexuality with their healthcare provider using a VAS (0–100 mm).
- Barriers preventing free discussion of sexual problems: taboo character of sexuality (patient shame, apprehension of healthcare provider's reaction), visit conditions inadequacy (lack of privacy and/or lack of time accorded), and patient's priority for CLBP management.

Patients were asked to communicate expectations of their healthcare provider when discussing sexual matters. To avoid multiplicity of collected answers, we have chosen the following possibilities of responses:

- The healthcare provider should integrate systematic management of sexual problems in CLBP consulting;
- The healthcare provider should give sufficient information and advices concerning recommended intercourse positions so as to avoid pain;
- Partner should participate in this communication;
- The healthcare provider should be of the same sex as the patient to avoid embarrassment when discussing sex life.

To identify factors influencing this communication, we compared patients who have already discussed their sex life with their healthcare provider with those who have never broached the topic.

Statistical analysis

The Statistical Package for Social Sciences software (SPSS Inc., version 15, Chicago) was used for data processing and data analysis. Descriptive statistics included range, mean, and standard deviation for interval variables and frequency and percentage for categorical variables. Group comparisons were

carried out by independent samples Student's *t* test for interval variables and the χ^2 test for categorical variables. For CLBP duration, *U* test of Mann–Whitney was used. Multivariate logistic regression using stepwise automated methods was used to examine factors influencing sexual communication. The odd ratios (ORs) were calculated for each explanatory variable. A *P* value of less than 0.05 was considered statistically significant.

Results

CLBP patient's characteristics are summarized in Table 1. Fifty percent of patients were female. Forty-five percent of patients were illiterate. Median of CLBP duration was 36 (24–72) months and back pain intensity using VAS (0–100) was 50± 10.7 mm. Eighty-one percent of our patients complained about sexual problems. Impact of CLBP on patient's sexuality is shown in Fig. 1. Supine was the most pain generating intercourse position and then prone and sidelying (89.9, 24, and 6.3 %, respectively). Sixty-six percent of patients have never discussed their sexuality with their healthcare provider. The nature of any previous communication was informative in 26 % of cases and advisory in 8 % of cases. No patient suffering from sexual dysfunction had been referred to a sexologist. Mean patient satisfaction in discussing sex life with the healthcare provider was 40±10.8 mm.

According to patients who never discussed sexual concerns with their healthcare provider, barriers of free discussion on the topic were, in order of decreasing importance, taboo character of the subject (patient shame (n=35) and apprehension of the healthcare provider's reaction (n=28)), inadequacy of visit conditions (lack of privacy (n=23), lack of time recorded (n=4)), and patient's priority for CLBP management (n=10) (Fig. 2).

Table 1 Patients and chronic low back pain characteristics

Characteristics	N=100
Age (years)	43.28±7.5
Female (%)	50
Profession (yes) (%)	49
Educational level	
Illiterate (%)	45
Male[a]	13 (26)
Female[a]	32 (64)
University (%)	15
Age of apparition of CLBP (years)	38±7.4
CLBP duration (months)[b]	36 (24–72)
Back pain intensity (VAS, 0–100 mm)	50±10.7
Functional status (Oswestry, 0–100 %)	41.6±15.5

VAS visual analogical scale, *CLBP* chronic low back pain

[a] Number and percentage

[b] Median and quartiles

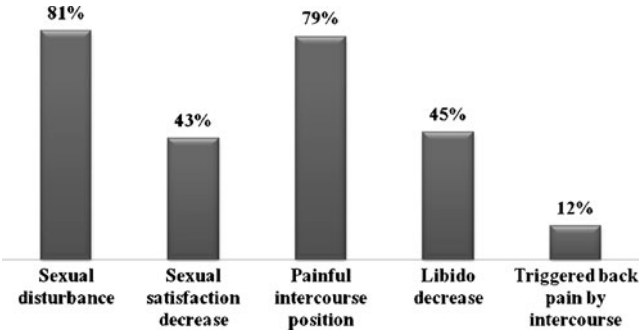

Fig. 1 Sexual problems caused by CLBP

Patients' expectations from their healthcare provider to improve their sexual lives are figured in Table 2. Painful intercourse positions and sexual satisfaction decrease were prevalent in the group of patients who had already broached the subject with the healthcare provider. Illiterate patients were prevalent in the group who had never broached the subject with their doctor. Men talked about their sexuality more than women (Table 3).

Illiteracy ([OR=1.07; CI (95 %), 1.020–1.313]) and decrease of sexual satisfaction ([OR=0.65; CI (95 %), 0.474–0.891]) were the strongest factors influencing communication about sexual problems (Table 4).

Discussion

Our study highlights CLBP patients' embarrassment in discussing sexual problems with the healthcare provider. It also identified patients' expectations of healthcare providers when attempting to improve their sex life. Our results confirm that sex as a taboo subject is the biggest barrier to free communication on the topic. Patients expect their healthcare provider to be more involved in management consulting of sexual problems caused by CLBP. Ability to talk freely about sexual matters was influenced by patient's educational level and sexual dissatisfaction.

This study shows that CLBP was responsible not only of painful intercourse position but also of a decrease of sexual

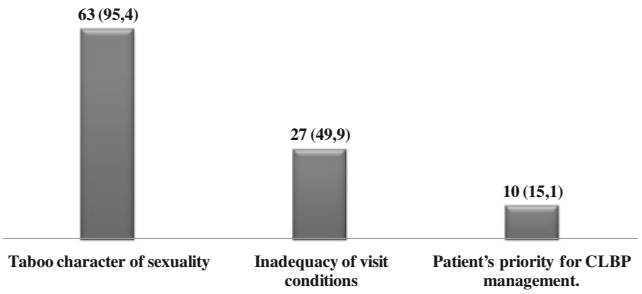

Fig. 2 Barriers preventing free discussion of sexual problems (n=66)

Table 2 Patients' expectations of their healthcare provider when discussing sex life

Patients' expectations	N=100
Healthcare provider should integrate systematic management of sexual problems in CLBP consulting (%)	93
Healthcare provider should give sufficient information and advice concerning recommended intercourse positions so as to avoid pain (%)	74
Patient's partner should participate in this communication (%)	33
Healthcare provider should be of the same sex as the patient to avoid embarrassment when discussing sex life (%)	81

Table 4 Multivariate analysis of factors influencing sexual communication by logistic regression analysis

	OR	95 % CI	P value
Male gender	1		
Female gender	0.32	0.091–1.192	0.09
University level	1		
Illiterate	1.2	1.020–1.313	<0.0001
Back pain intensity	0.97	0.678–1.400	0.9
Sexual satisfaction decrease	0.65	0.474–0.891	0.007
Painful intercourse position	2.46	0.527–11.480	0.2

satisfaction and libido. Despite the high impact of CLBP on our patient's sex life, only 46 % of them have already discussed the subject with their healthcare provider. Lack of proper communication has been reported generally in chronic disabilities [9–11] and also in CLBP patients [6, 7]. In our study, information had been provided by the healthcare provider in 26 % of cases and medical advice was given to 20 % of patients. Surprisingly, despite varying sexual problems (painful intercourse position, back pain triggered by intercourse, sexual dissatisfaction, and decrease of libido), no such suffering patient has been referred to a sexologist.

For the majority of patients, sexuality remains a difficult topic to discuss [12]. Social taboos continue to limit individual sexual expression, and talking about sex is largely influenced by patients' socio-cultural context [12]. Moroccan society continues to be overwhelmed by social taboos [13]; for a long time, even mentioning sex was considered shameful and taboo [14]. According to a previous study, confusion between sexual education and sexual freedom among Moroccans has led to worry over discussing sexuality [14]. Without healthcare provider prompting, patients are reluctant to air sexual concerns [4, 15]. Meystre-Agustoni identified that patients want their healthcare provider to initiate discussion about their sexual problems [4]. Hoekstra shows that many patients who experience problems with their sex life do not discuss it due to lack of healthcare provider initiation of the discussion. If healthcare providers fail to start the dialogue, the problem remains [5].

In our setting, some 25 % of patients consider that visiting conditions are neither adequate nor appropriate to nurture such conversation. Addressing sexual issues requires a comforting and secure atmosphere in which patients can easily discuss their problems [16]. Previous studies report that time constraints often lead physicians to neglect inquiry about sexual functioning [4, 17–19]. Most of the patients expect to discuss their sex life with their healthcare provider [17]. Circumstances, in which consultations are usually carried out, often in the presence of a nurse or physiotherapist, do not encourage routine enquiry about such intimate matters [17]. Practical solutions should therefore be taken so

Table 3 Univariate analysis of factors influencing sexual communication

	Patients who have already broached sex life with their healthcare provider (n=34)	Patients who have never broached sex life with their healthcare provider (n=66)	P value
N	34	66	
Sexual disturbance	29 (85.3)	52 (78.8)	0.5
Age	42.3±8.5	43.8±7	0.3
Male gender	27 (79.4)	23 (34.8)	<0.0001
Female gender	7 (20.6)	43 (65.2)	
University level	8 (23.5)	7 (10.6)	0.08
Illiterate	4 (11.8)	41 (62.1)	<0.0001
Back pain intensity	50.7±10.6	40.7±1.6	0.003
Disease duration	48 (24–72)	36 (24–81)	0.6
Functional status	41±15.2	41.9±15.7	0.8
Painful intercourse position	31 (91.2)	48 (72.7)	0.03
Sexual satisfaction decrease	4.3±2	3.1±1.7	0.004

as to improve consulting conditions and to devote the sufficient time for discussing sexual problems related to CLBP. As recommended by the World Health Organization, sexual health management is not based only on providing information and advice but also on patients referral to a specialized consultant, if necessary [20]. Similarly, McInnes reported a PLISSIT-type approach model to help physicians tackle the subject of sexuality [21]. The PLISSIT model, developed in 1976, is divided into four levels: P (permission), the physician introduces the subject of sexuality and encourages the patient to discuss his sexual difficulties; LI (limited information), information about the sexual impact of the disease should be provided and the different types of treatment available; SS (specific suggestion), suggestions may include specific documents on the impact of the chronic disease on sexuality and/or various therapeutic possibilities; and T (intensive therapy), requires specialist (psychologists, psychiatrists, or sexologists) intervention networking with the physician treating the associated chronic disease [21].

In our context, sexual health management is still restricted to sexually transmitted diseases and erectile dysfunction. There is a need to create a national program in order to widen sexual health management to encapsulate chronic diseases which could disturb sexuality. A large part of patients would like their partner to participate in communication on sexual matters. Seeing the patient and partner together allows the healthcare provider to assess the effectiveness of the couple's general communication and their ability to discuss sexual concerns [22]. A majority of patients emphasized their preference to discuss their sex life with a healthcare provider of their own gender. This point has already been studied by Burd et al. who reported that patients experience greatest discomfort when talking with opposite gender healthcare providers [23]. It could be helpful to consider the impact of healthcare provider and patient gender on communication about sexual problems.

Moreover, our study shows that illiteracy severely limits the ability to talk freely about sexual problems. This finding concurs with those of van Gleen et al. and Witting et al. [24, 25]. A higher educational level may increase the ability to freely express sexual difficulties. Patients who have already broached sexual matters with their healthcare provider were also sexually dissatisfied. Experiencing sexual dissatisfaction and frustration related to CLBP may induce patients to consult with a healthcare provider which in turn can provide them an opportunity to express their sexual problems. No data relating to this point were found in literature.

Some limitations in our study should be noted. First, we have collected perceptions of patients by a face-to-face interview. Writing answers was preferable; however, the high percentage of illiterates in our population meant that this was unobtainable. Second, sexual life is shared between patient and her/his partner. It would be more interesting to assess the partner's point of view in this study. Finally, communication is between patient and his healthcare provider. Further studies of healthcare providers' experiences are needed to have a global view on the subject. Despite these limits, this study delivers a precious glimpse of the point of view of CLBP patients regarding limiting factors and expectations of communication about sexual concerns with their healthcare provider.

Conclusion

This study identifies not only that talking about sexual concerns is restricted by numerous barriers but also that patients expect more involvement from their healthcare provider on the matter. There is a need of an active participation of practitioners to manage sexual problems of CLBP patients. Moreover, communication on sexual matters should be in appropriate conditions that respect patient's privacy and intimacy, preferably with the patient's partner being present. Interestingly, the educational level of patients had a great impact on talking freely about sexuality. Further studies including the point of view of patients' partners and healthcare providers should be planned in order to give a full perception of communication about sex life in CLBP patients.

Disclosures None.

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