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Translating Sexual Dysfunction: Does Language Impact Clinical Discussion Of Painful Sex?

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Abstract

Objectives: Dyspareunia and sexual dysfunction are estimated to affect up to 22% and 43% of women respectively. There is concern that these statistics do not depict the true prevalence and that these conditions are frequently undiagnosed and untreated. By 2060, Latinos will make up 30% of the total population in the United States. As our patient population becomes more diverse, we need to ensure that our healthcare practices accommodate the changes.

Methods: We surveyed a convenience sample of 107 English and 71 Spanish-speaking women, aged 18–45, at university affiliated clinics to identify the prevalence of dyspareunia and sexual dysfunction within our community. Additionally, we wanted to identify the rate that clinicians discuss painful sex with patients to identify if language impacted communication. The surveys collected data on subjective reporting of pain with sex and objective identification of sexual dysfunction with the Female Sexual Function Index (FSFI). Additional questions identified if subjects discussed pain with their clinician. These questions were analyzed between languages across all domains.

Results: A greater prevalence of both dyspareunia and sexual dysfunction were measured in our study population compared to prior reports (37.79% and 54.71% respectively). Spanish-speaking women had significantly lower self-reported dyspareunia (28.99%), but scored significantly lower on the FSFI, qualifying for sexual dysfunction (63.24%). Spanish-speakers discussed painful sex significantly less compared to the English cohort, but the overall discussion rate was only 17.26%.

Conclusions: This pilot data demonstrates a need for further research on language as a barrier to communication about sexual function in clinic.

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Author Contribution:

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BRIEF SUMMARY

We identify a higher prevalence of dyspareunia and sexual dysfunction among our population of English and Spanish-speaking patients. Spanish speaking women show a discordant pattern of low personal reporting of dyspareunia, but more FSFI questionnaire scores qualifying for sexual dysfunction. Spanish-speaking patients discuss painful intercourse with a healthcare provider significantly less than English-speaking patients.

ONE-LINE SUMMARY

Spoken-language and culture appear to constitute a barrier for identifying, reporting, and discussing sexual pain.

Keywords

Dyspareunia; Sexual Dysfunction; FSFI; Spanish; Hispanic

Introduction:

In the US population it is estimated that sexual dysfunction affects up to 43% of women and dyspareunia impacts up to 22%^{1,2}. However, estimates may not capture the true prevalence of these conditions due to the fact these issues can go unreported by patients^{3,4}. At times, differences in cultural backgrounds may impact the perceived need for seeking care.

Dyspareunia, a specific type of sexual dysfunction, has been studied across a wide range of ages with subjects as young as 15^{3,5}. Prior surveys in the US showed that 21% of women aged 18–29 reported dyspareunia, while only 8% of women aged 50–59 reported pain¹, with an increased risk ratio of 9.3 when comparing younger cohorts to older ones⁶. Sexual function can fluctuate throughout pregnancy as well and women can experience pain with intercourse for up to a year post-partum and longer⁷. This is important because dyspareunia can greatly impact quality of life for women and has been linked to other comorbidities, such as anxiety and depression⁸.

It is imperative to consider the patient population when assessing the impact of these conditions within a community. By the year 2060, it is estimated that 28.6% of the US population will be Hispanic⁹, which will increase the number of Spanish-speaking patients in the population. This is important because these encounters frequently require interpreters if the practitioner is not fluent in Spanish. This can lead to limitations in the clinical encounter through omission of dialogue or patients censoring themselves for privacy due to reduced connectivity with the practitioner¹⁰. In order to improve access to care, we need to better understand the true prevalence of sexual dysfunction and dyspareunia among patients of different cultures and identify how many are having their sexual function addressed in clinic.

We hypothesized that Spanish-speaking patients will be asked less frequently about dyspareunia compared to English-speakers. We proposed a survey of English and Spanish-speaking women to identify the prevalence of sexual dysfunction and dyspareunia within our community and the rate that women discuss painful sex with their healthcare provider. The

goal of this study was to identify if language and cultural effects were a potential barrier to communication in clinic. This information is to be elucidated through subjective as well as standardized objective assessments. The goal is to improve how we address sexual function in clinic and improve how we connect with our ever-evolving patient population.

Materials and Methods:

This study was a cross-sectional survey. We utilized a convenience sample, enrolling patients who presented to either the University of Kansas Obstetrics and Gynecology Outpatient Resident Clinic or the JayDoc Free Health Clinic. Both clinics offer care to the same patient population, and neither were pelvic pain or minimally-invasive surgery clinics. All women between the ages of 18–45 who could read, write, and fluently speak only English or Spanish were eligible for enrollment. The age was set to narrow the study to reproductive-aged women. Pregnant women were not excluded from the study.

All subjects were verbally consented and given an electronic tablet to complete the survey through REDCap¹¹, which was available in both English and Spanish. All surveys were collected anonymously. Subjects were offered a \$10 gift card as compensation for their time. The study was set up to include a minimum of 100 primarily Spanish speaking and 100 English speaking patients. These were collected on a first-come, first-serve basis. Due to time constraints, we had to limit the study to 178 who completed the interview questionnaires (107 English, 71 Spanish). Only 2 English and 14 Spanish speakers declined to participate (2% and 16% respectively). One Spanish Speaking patient was disqualified due to inability to read Spanish fluently. The patients were approached about participation at check-in and tablets were provided for them to complete the survey at their convenience during the office visit.

The survey was comprised of three sections and total of 38 questions. The first section collected demographic information including parity with mode of delivery, surgical history, presence of pain with intercourse and the validated Visual Analogue Scale (VAS) for pain. The second section was the validated Female Sexual Function Index (FSFI) questionnaire, which is comprised of multiple choice question covering sexual function over the past four weeks¹². A validated Spanish version was utilized. The final section contained multiple-choice questions about clinic encounters specifically addressing discussion of painful sex with healthcare providers, who initiated the discussion, if an interpreter was present and the validated Patient Global Impression of Improvement (PGI-I) if treatment options were offered and followed after the discussion.

The data from the REDCap survey was analyzed using SAS software (version 9.4)¹³. Descriptive statistics were utilized for demographic information. The prevalence of sexual dysfunction and dyspareunia was identified for each language cohort. Sexual dysfunction was identified with a FSFI score <26.55. Domain scores were calculated for each of the six FSFI sections as well. Lastly, the rates of discussion were calculated for each cohort. The domains were analyzed between groups and compared using parametric methods. Language associations were done using Chi-Square while prevalence comparisons were done using

parametric analysis and t-tests. A p-value less than 0.05 was considered statistically significant for all analysis.

Results:

A total of 178 women were consented for our study with 107 English surveys and 71 Spanish surveys. Table 1 presents the demographics of our subject population. English-speakers identified primarily as white (59.62%) and most Spanish-speakers identified as Hispanic (94.29%). There was no significant difference in the sexual activity between language groups, but more women in the Spanish-speaking cohort were pregnant ($p < 0.01$).

Table 2 demonstrates the prevalence of dyspareunia and sexual dysfunction. Dyspareunia was reported by 43.69% of English-speakers and 28.99% of Spanish-speakers ($p = 0.05$). The mean FSFI score for the English and Spanish cohorts were 22.91 and 19.65 respectively ($p = 0.05$) with a greater percentage of Spanish-speakers' receiving a dysfunctional score < 26.55 ($p = 0.07$). The range of the FSFI score was 1.8–35.6. There was no significant difference in the FSFI pain sub-scores between groups, but arousal and lubrication sub-scores were significantly lower in the Spanish-speaking cohort ($p < 0.01$ and $p = 0.02$ respectively).

The measured rates of discussion are shown in Table 2. The English cohort discussed painful intercourse 22.22% of the time with a healthcare provider compared to 10.14% of the time in the Spanish cohort ($p = 0.04$). There was no significant difference in who initiated the discussion between groups. For discussions with Spanish-speakers an interpreter was present for 85.71% of the encounters.

A chi-square sub-analysis between subjective pain responses and objective FSFI dysfunction scores was completed for patients who identified as Hispanic or Non-Hispanic. For subjects who identified as Non-Hispanic, the correlation between subjective pain reports and FSFI scoring was significant: 64.29% who reported pain had dysfunctional score and 30.77% did not report pain had a dysfunctional score ($p < 0.01$). However, this was not reproducible in those who identified as Hispanic: 57.89% and 61.29% respectively ($p = 0.76$). Additional analysis was completed for Hispanics controlling for primary language spoken; which showed 54.55% of English-speaking subjects reporting pain compared to 28.36% of Spanish-speakers ($p = 0.03$). FSFI scores indicating dysfunction were 45.45% of English-speakers and 63.64% of Spanish-speakers ($p = 0.13$).

An additional chi-square analysis controlling for pregnancy status showed no significant difference regarding sexual activity and pregnancy ($p = 0.74$) or FSFI scores and pregnancy ($p = 0.56$). Of non-pregnant subjects, 43.80% reported dyspareunia compared to 22.45% pregnant patients ($p < 0.01$).

Discussion:

There is paucity of data related to comparisons of dyspareunia and sexual dysfunction between different ethnicities, especially English and Spanish-speaking women. Our study measured the prevalence of these conditions within our patient population. We were able to

identify that significantly more English-speaking women subjectively report problems of dyspareunia, but more of the Spanish-speakers have objective scores for sexual dysfunction. There is a discrepancy between the Spanish-speakers reporting of dyspareunia and their scores on the FSFI, which may reflect a differing perception on sexual function. Prior studies of women suffering from vaginismus and pain with sex had dysfunctional FSFI scores and lower pain domain scores ¹⁴. Our Spanish-speaking cohort follow these patterns and it is possible that they experienced dyspareunia, but did not respond positively to the subjective dyspareunia question. Our subgroup analysis of ethnicity demonstrated that the Hispanic subjects did not have a significant correlation between self-reported vaginal pain and FSFI scores. In contrast, the patients identifying as White had a significant pattern for prediction. When we further analyzed the Hispanic group by primary language spoken, Spanish-speakers reported pain less, and proportions of dysfunctional FSFI scores were higher. This further reinforces that possibly language contributes to the discord between perceived pain and sexual dysfunction. Knowing that the FSFI was validated for Spanish-speaking patients thus the equivalence of its results in theory should be similar to that of the English speaker version. However, we noticed that the correlation with what is reported as sexual pain subjectively differed. We suspect that at times, word usage and inclusivity in different languages may vary and their connotation may as well.

We hypothesized that Spanish-speaking women would have lower rates of discussing painful sex in clinic as compared to English-speakers. Our findings supported this hypothesis. Prior studies have demonstrated that the use of interpreters can hinder clinical encounters due to the loss of privacy or miscommunication by unqualified translators ¹⁵. Frequently a certified interpreter is not used if a family member is present to interpret which can create limitations as well ¹⁰. It is important that healthcare providers take these factors into account when they interview patients. Furthermore, discussion rates were low for both language cohorts and it is important for clinicians to initiate discussions relating to pain with sex with all patients.

Overall this study measured a higher prevalence of dyspareunia and sexual dysfunction among our subjects than is estimated in literature ³. This supports the concept that dyspareunia and sexual dysfunction frequently go undiagnosed. Sexual dysfunction can greatly impact the quality of life for patients. By missing diagnoses in our patient population, we are missing opportunities to provide treatment. Based on our results, less than a quarter of women discussed painful sex with their healthcare provider. This is significant because it highlights a potential obstacle in accurate diagnosis and care, while offering an opportunity for improvement in clinical encounters. Intake forms are frequently used to assess sexual health in clinics ¹⁴; however, it is important that we diversify the languages they are offered in so as to allow for a better understanding of how language and culture influence women's perspectives in communicating about sexual function.

This study was limited by the sample size and should be treated as pilot data for further research. Although the patients are nearly matched 2:3 (71 Spanish : 107 English), we did not achieve adequate power. A total of 362 subjects are required to detect significant differences in the number of women reporting dyspareunia with an alpha of 0.05 and 80% power. This is based on calculations using the mean of 22.91 (English-speakers) and 19.65 (Spanish-speakers) with a conservative standard deviation of 11.04. Although we limited the

assessment to non-menopausal patients to reduce confounders as well as sample size, this could constitute a weakness in that it may not be truly representative of the population. Furthermore, we included the postpartum patients in the non-pregnant patients, although their scheduled follow-up was typically scheduled at 6 weeks postpartum and this would likely be around the time of initiation of intercourse or healing of a laceration would have nearly concluded. However, another limitation is that the antepartum visits could have focused more on the pregnancy itself when the interaction with the provider occurred and this could have resulted in less questioning about dyspareunia. Additionally, patients who could not read the survey on their own were disqualified from enrollment. This excluded illiterate patients from the study and limits the generalizability to a larger patient population. A strength of the study is that each of the university-affiliated clinics provide care to patients from a range of socioeconomic backgrounds, making the results representative of patients from a variety of education levels and financial backgrounds. While more Hispanic patients were pregnant compared to the non-Hispanic cohort, analysis for confounders showed pregnancy status per se did not impact sexual activity or subjects' FSFI scores.

The goal of our research was to identify if communication with Hispanic patients posed a limitation in diagnosis and treatment of sexual dysfunction. Our research demonstrated a greater prevalence of dyspareunia and sexual dysfunction as well as low rates of discussion about painful sex in clinic in the Hispanic patient population. Future work should be tailored to specifically address the discord between subjective responses of dyspareunia and FSFI scores in our Spanish cohort. This could be done with more qualitative methods and focus groups.

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Table 1:

Demographics of survey subjects

	<i>Overall n=178 N (%)</i>	<i>English- speakers n=107 N (%)</i>	<i>Spanish- speakers n=71 N (%)</i>	<i>p-value *</i>
Age (mean ± SD)	30.63 (6.88)	29.27 (6.76)	32.66 (6.59)	<0.01
Race				<0.01
White	64 (36.78)	62 (59.62)	2 (2.86)	
Black	13 (7.47)	13 (12.50)	0 (0.00)	
Hispanic	85 (48.85)	19 (18.27)	66 (94.29)	
Asian	4 (2.30)	4(3.85)	0 (0.00)	
Other	8 (4.60)	6(5.77)	2 (2.86)	
Fertility status				0.46
Pre-menopausal	118 (67.82)	74 (71.15)	44 (62.86)	
Post-Menopausal	2 (1.15)	1 (0.96)	1 (1.43)	
Didn't know	54 (31.03)	29(27.88)	25 (35.71)	
Sexually active in past 4 weeks				0.31
No	50 (29.07)	27(26.21)	23 (33.33)	
Yes	122 (70.93)	76 (73.79)	46 (66.67)	
Currently pregnant				<0.01
No	122 (70.93)	95 (92.23)	27 (39.13)	
Yes	50 (29.07)	8(7.77)	42 (60.87)	
Gestation in weeks (mean ± SD)	22.00 (12.08)	11.13 (9.75)	24.07 (11.44)	<0.01
Total pregnancies (mean ± SD)	2.10 (1.84)	1.40 (1.57)	3.14 (1.73)	<0.01
Total births (mean ± SD)	1.49 (1.54)	0.94 (1.21)	2.31 (1.62)	<0.01
Vaginal	1.74 (1.51)	1.29 (1.19)	2.14 (1.66)	<0.01
Cesarean	0.69 (1.14)	0.64 (1.07)	0.74 (1.21)	0.63
History of pelvic surgery *				0.54
No	143 (82.18)	87(83.65)	56 (80.00)	
Yes	31 (17.82)	17 (16.35)	14 (20.00)	
Survey location				<0.01
Resident Clinic	101 (60.12)	72 (72.73)	29 (42.03)	
JayDoc Free Clinic	67 (39.88)	27 (27.27)	40 (57.97)	

* p<0.05 significant

Table 2:

Main outcomes

	<i>Overall</i> <i>n=178</i> <i>N (%)</i>	<i>English-speakers</i> <i>n=107</i> <i>N (%)</i>	<i>Spanish-speakers</i> <i>n=71</i> <i>N (%)</i>	<i>p-value</i> *
Subjective dyspareunia				0.05
No	107 (62.21)	58 (56.31)	49 (71.01)	
Yes	65 (37.79)	45 (43.69)	20 (28.99)	
VAS score (mean ± SD)	5.43 (2.20)	5.20 (2.22)	5.95 (2.11)	0.21
FSFI score (mean ± SD)	21.60 (10.81)	22.91 (10.52)	19.65 (11.04)	0.05
Desire sub-score	2.30 (1.53)	2.44 (1.50)	2.09 (1.56)	0.15
Arousal sub-score	3.42 (2.03)	3.77 (2.00)	2.90 (1.98)	<0.01
Lubrication sub-score	3.80 (2.34)	4.15 (2.27)	3.26 (2.35)	0.02
Orgasm sub-score	3.44 (2.29)	3.68 (2.24)	3.08 (2.35)	0.10
Satisfaction sub-score	3.98 (1.88)	4.04 (1.91)	3.89 (1.84)	0.63
Pain sub-score	3.85 (2.41)	4.06 (2.36)	3.54 (2.46)	0.17
Dysfunctional FSFI (score = <26.55)				0.07
No	77 (45.29)	52 (50.98)	25 (36.76)	
Yes	93 (54.71)	50 (49.02)	43 (63.24)	
Discussion of pain with clinician				0.04
No	139 (82.74)	77 (77.78)	62 (89.86)	
Yes	29 (17.26)	22 (22.22)	7 (10.14)	
Discussion initiation				0.86
Patient	11 (37.93)	9 (40.91)	2 (28.57)	
Clinician	9 (31.03)	6 (27.27)	3 (42.86)	
Both	9 (31.03)	7 (31.82)	2 (28.57)	
Interpreter present for discussion				<0.01
No	23 (79.31)	22 (100.00)	1 (14.29)	
Yes	6 (20.69)	0 (0.00)	6 (85.71)	
Treatment for dyspareunia				1.00
No	7 (24.14)	5 (22.73)	2 (28.57)	
Yes	15 (51.72)	12 (54.55)	3 (42.86)	
Dyspareunia not present	7 (24.14)	5 (22.73)	2 (28.57)	
PGI-I score (mean ± SD)	2.73 (1.10)	2.92 (1.08)	2.00 (1.00)	0.21

*
p=<0.05 significant