



P R I S M S E C T I O N

(Patients' Revelations as Insightful Studies of their Management)

- Infertility And Sexual Dysfunction During Treatment: A Guide For The Family Physician

INFERTILITY AND SEXUAL DYSFUNCTION DURING TREATMENT: A GUIDE FOR THE FAMILY PHYSICIAN

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ABSTRACT

This article explores the role of the family physician in helping couples cope with sexual difficulties in the context of their infertility experience and treatment. Sexual dysfunction can be pre-existing or as a result of infertility investigations and treatment. The initial workup in general practice consists of taking a good history and performing a physical examination. This can help exclude medical conditions that may cause sexual dysfunction. The PLISSIT (Permission, Limited Information, Specific Suggestions, Intensive Therapy) method can be used to facilitate discussions about sexual concerns.

Keywords; Sexual Dysfunction; Infertility

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PATIENT'S REVELATION: WHAT HAPPENED?

Mr. T, a 34-year-old lecturer and his wife, a 32-year-old-teacher, have been married for the past 8 years. They have been trying to conceive for the past 6 years and are on follow-up with the fertility specialist. Mr. T has type 2 diabetes mellitus (DM) diagnosed 4 years ago at a restructured hospital where he is still being managed. Mrs. T is on follow-up with the gynaecologist for irregular menstruation and diagnosed to have polycystic ovarian syndrome. Her tubal assessment was done and found to be normal. Both Mr. and Mrs. T are obese with a Body Mass Index of over 30kg/m². The gynaecologist referred Mrs. T to me as she was diagnosed with type 2 DM during the initial workup for obesity in my clinic. They both have well-controlled DM with glycated haemoglobin (HbA1c) below 6.5 percent, and are on oral metformin only.

It was obvious during consultation that Mrs. T usually takes on a passive role and allows her husband to do most of the talking. Presently they are both staying with Mrs. T's parents who have been putting a lot of pressure of the both of them to have children. When Mrs. T was diagnosed with type 2 DM, she started to experience low mood and decided to put on hold trying to conceive until she is able to come to terms with her diabetes. We addressed her concerns and fears about having diabetes during pregnancy. She wanted to try lifestyle measures to lose weight for a few months before trying to conceive. Her mood improved after a few counselling sessions with a psychologist and starting an exercise programme.

One day, Mr. T came alone to see me in the clinic and he looked worried. Initially he was hesitant to confide but after gentle coaxing he managed to divulge that for a few months he experienced low libido and had difficulty sustaining an erection during intercourse. He claimed it was due to work stress and he wanted me to prescribe him Viagra. He later acknowledged during the consult that the emotional pressures of trying to conceive and having timed intercourse were the real reasons for his symptoms. His symptoms were further compounded when he was told that he had low sperm count and teratozoospermia and oligospermia a year ago by the gynaecologist. Since then he had been trying to improve his sperm count by exercising and trying to lose weight. A few months ago he had an ankle sprain and was unable to exercise for a few weeks. This setback caused his weight to increase again much to his frustration. He also felt disappointed that his wife was putting off trying for a child for now and did not want to start treatment as suggested by the specialist. They were quarrelling more, recently, and had intercourse only once a month. He confided that he found it humiliating to have to produce a sperm sample for a repeat analysis in the clinic, so he avoided going back to the clinic for review.

Mr. T still had early morning erections. He masturbated up to twice a week and had successful erections and ejaculations when doing so. In the clinic his blood pressure was 120/75mmHg and pulse rate was 72 per minute. Examination of his cardiovascular system was normal; there were no abdominal or renal bruits and lower extremity pulses were well felt. The examination of his genitourinary system was normal. There was no hypospadias or phimosis and his testes were normal in volume. The skin and hair distribution over the lower limbs were normal and there was no evidence of vascular insufficiency. The free testosterone and prolactin levels measured by his specialist were normal.

Mr. T felt relieved when I reassured him that his symptoms were due to the stress of trying to conceive leading to his performance anxiety. Initially he was not keen to discuss his problems with his wife, as he did not want to add to her worries. Mr. T was also not keen to see the psychologist, as he felt uncomfortable sharing his personal details with yet another healthcare provider. Finally he was convinced to bring his wife to the clinic. During the following consultation, both of them agreed to share and validate their emotions and fears. During this session, Mrs. T was moved to learn of her husband's problems. She shared that she felt like a failure because of her inability to conceive. The process of anticipation, waiting and eventual disappointment eroded into her self-esteem and self-confidence. When she first learnt that she had type 2 DM, she was worried that if she did manage to conceive, there would be additional risks to the baby due to this condition. Mrs. T also admitted that she also suffered from decreased

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sexual desire and lower levels of sexual satisfaction, due to repeated failures in trying to conceive.

They both agreed to take their minds off trying to conceive for the next three months so as to try to make reparations to their relationship. I provided them with some specific suggestions to improve intimacy without the pressure of intercourse, for example taking up a hobby together or setting aside time every week to go on dates. I also provided them with step-by-step instructions on sensate focus therapy technique¹ which has been shown to successfully help couples to rebuild the trust and intimacy within their relationship.

During the follow-up consultation 6 weeks later, they were both happier and more relaxed. Both of them lost some weight from lifestyle modifications and reported they felt generally less stressed. They now had intercourse once a fortnight with increased sexual satisfaction. Although the episodes of sexual intercourse were not as frequent as when they first got married, I reassured them that even gestures like holding hands, cuddling together and just taking time to talk to each other can serve to build emotional intimacy. Mrs. T's menstruation had started to be more regular in the past three months. We discussed more about the pregnancy related preparations. These included switching from metformin to insulin should she conceive, pre pregnancy dietary advice, folate supplementation and having close follow-up with the specialist. I managed to address their queries on diabetes, pregnancy, as well as fertility treatment options over the course of their visits and they both were to continue follow-up with the specialist and myself.

GAINING INSIGHT: WHAT ARE THE ISSUES?

As family physicians we are probably in the best position to deal with our patients' sexual concerns. Our strength also lies in the fact that we often have longitudinal relationships with patients over time and look at the maintenance of health issues, preventive health and can handle multiple problems at one time. In addition, we often have both partners as patients.² Fertility treatment and investigation can take a toll on a couple's sexual relationship and paradoxically pose an obstacle in their efforts to conceive.

We can also offer ongoing counselling and support to couples. There are a few issues that are important to address during our assessment:

1. As a family physician (FP) to Mr. and Mrs. T, I adopted a unified approach in obtaining a detailed medical history which includes sexual history and psychosocial issues. Couples may have a preexisting sexual dysfunction leading to the absence or reduction of coital sex. I chose to evaluate them together as well as separately. Each person may choose to reveal information, which their partner is unaware of, such as previous pregnancy or sexually transmitted disease. Important topics which I addressed included the frequency

and timing of intercourse, and the use of lubricants or other products that may impair fertility. There may be medications that affect sexual function that the patient or partner needs to take as part of treatment. A comprehensive clinical examination of both partners was undertaken to rule out medical conditions that may affect their fertility as well as general health.

2. Majority of these sexual problems can be addressed in general practice simply by giving patients information, making brief and practical interventions, and even by just giving reassurance about the normal physiology of the human sexual response. Couples often do not need a referral if they are counselled appropriately by their family physician.
3. Family physicians have a role in the care of women of reproductive age such as Mrs. T. In addition to identifying and educating her regarding the risks of diabetes and obesity to her and her future baby, we need to help her accept her medical condition and advise her to implement lifestyle interventions to reduce these risks.³

STUDY THE MANAGEMENT: HOW DO WE APPLY IN OUR CLINICAL PRACTICE?

Infertility as defined by the World Health Organization (WHO), is "the inability of a sexually active couple to achieve pregnancy despite unprotected intercourse for a period of greater than 12 months." It is estimated that almost 72.4 million couples worldwide have had problems with fertility. Singapore has one of the lowest total fertility rates in the world, at 1.2 per female in 2011. Approximately one out of seven couples are afflicted with infertility and this is a contributing factor to Singapore's low total fertility rate.⁴

Evaluation of infertility generally begins after 12 months, but it can be initiated earlier if infertility is suspected based on history or if the female partner is older than 35 years. Sexual dysfunction occurs when there are disturbances in sexual desire and/or psycho-physiological changes associated with the sexual response cycle in men and women. This can occur separately in the woman or the partner or concurrently.

The diagnosis of infertility can have a powerful impact on a couple's sexual relationship and cause sexual problems and psychological issues such as anxiety, depression, and relationship issues.⁵ In this couple's case the sexual dysfunction began after they started undergoing tests for infertility. Infertility treatments can be stressful, intrusive, and emotionally demanding. As part of infertility treatments, couples may need to have sex at certain times, even if they do not feel like it. All of these things can have a negative impact on a couple's sexual relationship and may lead to sexual dysfunction. The stress caused by the need for the male to "ejaculate on demand," can result in situational, psychogenic erectile dysfunction. Both partners may also have less sexual desire.

As family physicians, we should proactively address the sexual health of our patients. It is also useful to counsel the patient together with the partner as it helps give us a broader picture of the couple and their issues. All too frequently, patients will wait for the opportunity to discuss a sexual health problem; many are too embarrassed to bring it up during consultation. Through continuity of care and rapport, the trust gained will allow our patients to confide in us, their family physicians, with greater ease. PLISSIT (Permission, Limited Information, Specific Suggestions, Intensive Therapy) is one of the models that can be used to initiate discussions about sexual dysfunction and its management.⁶

Many women consider normal sexual function to be the traditional desire-arousal-orgasm process. For patients experiencing the stress of infertility, as in this case, family physicians can alleviate sexual concerns by reassuring them that experiencing low desire when stressed is normal. For women who expect to feel desire for sexual stimulation, we can reassure them that desire can encompass a need for emotional intimacy through sexual activity rather than a need for sexual activity itself.⁷

In assessing male patients, we need to be aware as family physicians that erectile ability is just one aspect of normal male sexual function. There are four phases of the male sexual response cycle, which are: (1) desire; (2) arousal (erectile ability); (3) orgasm; and (4) relaxation. During the evaluation of the patient's sexual function problem, we should clarify which phase is primarily responsible for the patient's symptoms as disorders and dysfunction may occur in one or more of these phases.⁸ In Mr. T's case he had problems mainly in the desire phase and also decreased sexual satisfaction.

In our primary care clinic setting where we see both the patient and the partner, we should acknowledge that men and women experience infertility differently. Women are more likely to experience depression and anxiety symptoms. They tend to take a more active role in medical treatment, and respond more poorly following treatment failure. With regard to counselling services, women have more positive attitudes towards seeking psychological help than men and they are more likely to seek couple counselling for general distress. Men, on the other hand, are more likely to distance themselves from the pain of infertility and use more problem-solving strategies. When the husband feels that he cannot fix his partner's problems, he is often left feeling helpless and frustrated while his spouse is left feeling emotionally invalidated.⁹ Our role as family physicians is to facilitate the communication process, guide our patients, and use appropriate interventions to alleviate the stress. In doing so we can improve quality of life within the couple relationships during the process of infertility treatments.

The physician-patient therapeutic alliance can only be forged through continuity of care, effective communication, and convincing the patient that we want the best for them. In this case, we need to ensure that there is no misinformation about diabetes in pregnancy and the emphasis of a good prognosis with good control.¹⁰ Time, sympathy, empathy, and

encouraging words do go a long way in winning the trust and cooperation of patients. Addressing the patient's unresolved fears and questions plus setting the expectations for patient participation is key. We should also formulate a management plan with team care members and specialists to ensure coordinated efforts and optimisation of patient care.

CONCLUSION

Infertility is a major life event for couples and frequently represents an important stressor on the couple's self-esteem and sexual life in general. As family physicians we are able to help in integrating a psychosocial and sexual history into the initial medical workup of infertile couples. The PLISSIT model is useful in initiating discussion regarding sexual problems and it is important to be open, empathic and non-judgemental in our approach. For couples that experience sexual problems due to the stress of infertility investigations and treatment, family physicians can help reduce anxiety by giving advice and simple interventions in the clinic on ways to improve intimacy. Communication is important so that the feelings the patient and partner are experiencing are validated and they feel understood and accepted. The overall outcome should focus on distress reduction and improving sexual well-being of the patient and partner. We also need to actively counsel diabetic female patients of reproductive age who are keen to conceive on lifestyle measures whilst being mindful of their emotional well-being. Continuity of care and a multidisciplinary approach is key in successful self-management and good outcomes.

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