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# Approach to sexuality and sexual dysfunction by reproductive doctors in France.

Abord de la sexualité et des dysfonctions sexuelles par les  
médecins de la reproduction en France.

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## Summary:

Numerous studies have examined the negative impact of medically assisted reproduction (MAR) on patients' sex lives. It appears necessary to question patients and sometimes to counsel them about management for their sexual and reproductive health.

In this study prospective, quantitative, multicenter trial conducted from December 2018 through February 2019, we contacted the offices of all clinical MAR centers registered with the *Agence de la Biomedecine* (Biomedical Agency) to obtain a list of email addresses of the doctors working there and sent them questionnaires. We received 171 responses.

The respondents were very predominantly women (89%), and their median age was 34 years (range: 28-64). Overall, 56% always discussed sexual function during their first consultation, 30% often, and 14% sometimes. We compared two groups: the "regular discussion" (RD) group, which included the doctors (n=147) who responded "always" and "often". The "occasional discussion" (OD) group included those (n=24) who responded "sometimes". The RD group discussed scheduling sexual relations less often than the OD group ( $P=0.029$ ). The RD and OD groups differed significantly in their rates of questions about the frequency of sexual relations ( $P=0.04$ ) and about problems of penetration ( $P=0.025$ ) and desire ( $P=0.041$ ); the RD group asked more often about all of these topics. In the RD group, 37% of the respondents had a sex therapist working at their center, and in the OD group, 21%, while respectively 9% and 17% did not know to whom or where to refer these patients, and 93% and 75% thought a sex therapist with expertise in MAR would be useful at their center.

This study shows deficiencies in the management of sexual dysfunctions in MAR patients. Some actions that might improve the situation include: the creation of a directory of sex therapists, the creation of job lines at MAR centers for sex therapists specialized in this field, and the development of patient brochures and questionnaires.

Key words:

Sexual health, sexual function, medically assisted reproduction, reproductive medicine, sex therapy

## I. Introduction

In 2015, the European Society for Human Reproduction and Embryology (ESHRE) issued guidelines for the management of patients undergoing medically assisted reproduction (MAR) (Gameiro, 2015), paying special attention to the sexual dysfunction of these couples. An association between the unfulfilled desire for a child has been associated with sexual problems in infertile couples (Wischmann, 2013). Infertility can be considered simultaneously as a cause or consequence of sexual dysfunctions (SDs). The most recent reviews of the literature (Wischmann 2013, Mimoun 1995, Kerneis 2004, Huyghe 2013, Piva 2014, Mendonça 2017, Bechoua 2016, Peng 2011, Coëffin-Driol 2004) report that infertility is perceived as a damaging experience for both members of the couple, although its repercussions vary according to sex (Coëffin-Driol 2004). Male infertility threatens self-esteem (Reder 2012) and provokes feelings of guilt, shame, and personal and sexual inadequacy. These problems can lead to SDs that are often transient (Chevret-Méasson 2007); erectile dysfunction and psychogenic impotence are not rare (Drake

1979). Moreover, men describe a decrease in the frequency of sexual relations (Coëffin-Driol 2004) and accordingly an overall diminution of both libido and sexual satisfaction. Sexual relations during the preovulatory phase, which leave no room for spontaneity, inhibit men: the expectations of their partners and of the medical profession can induce "reproductive performance anxiety." The announcement of chromosomal abnormalities and sperm anomalies can cause them to doubt their masculinity (Huyghe 2013). Infertility thus engenders disinvestment in sexual relations within the couple. Female infertility can induce an obsessive desire for pregnancy: the woman may subordinate her sexual function to her desire for pregnancy, with sexual relations aimed at procreation and therefore necessarily occurring during the preovulatory phase (Coëffin-Driol 2004). Women report less frequent sexual relations, with less foreplay, and experience less sexual desire and pleasure during these relations. SDs such as dyspareunia, vaginismus, or inhibition of desire have often been observed (Reder 2012). The areas of sexual function most strongly affected by female infertility are lubrication, orgasm, and sexual satisfaction (Mendonça 2017). Health care professionals specialized in reproduction and human sexuality should be able to help couples with SDs and help them to attenuate the sexual repercussions of the diagnosis and treatments of infertility. These professionals must therefore discuss sexual functioning with their patients. We decided to examine how reproductive medicine specialists in France discuss sexual functioning with MAR patients.

## II. Material and methods

### 1. Study design

We conducted a prospective quantitative, descriptive, multicenter study from December 1, 2018, through February 15, 2019, aimed at including all certified

reproductive medicine specialists (DESC, a certificate of specialized studies in reproductive medicine) or the equivalent (practiced reproductive medicine before the creation of the DESC) in France (metropolitan and overseas) working in an MAR clinical center certified by the *Agence de la biomédecine* (ABM).

## 2. Data collection

We contacted the 110 MAR centers authorized by the ABM in metropolitan France and in the overseas districts and obtained from them the email addresses of the physicians practicing reproductive medicine. There are estimated to be 392 of these specialists in France. Our study is based on the responses to a questionnaire that they completed on a dedicated website. The 16-item questionnaire was anonymous (Appendix 1).

## 3. Principal and secondary assessment criteria

The principal objective of the study was to assess the approach to sexual function and SDs by reproductive medicine specialists in France. The secondary objectives of this study were to examine the various aspects of sexual function mentioned by the respondents to their patients, assess the different obstacles these specialists could encounter in dealing with their patients' sexual functioning, describe the different SDs considered, examine the types of sex therapy available in MAR centers, and study the perceived utility of a reference to sex therapists for patient care.

## 4. Statistical analyses and ethics.

Responses to the question about raising the issue of sexual function at the first consultation enabled us to classify the doctors into two groups: physicians asking about sexual function regularly (RD), i.e., those who responded "yes, always" or "yes,

often", and those physicians asking about sexual functioning occasionally (OD): those who answered "sometimes" (no respondents answered "never"). This classification was also used for the comparative analyses. The qualitative variables are expressed as frequencies and percentages and compared with a Chi-square test. The quantitative variables are expressed as medians, with their 5th and 95th percentiles, and compared by a Mann-Whitney test. A *P*-value less than 0.05 was considered statistically significant. The study was reported to the National Commission on Data Protection (CNIL) as declaration number MR4: 2209020v0.

### III. Results:

#### 1. Description of the study population

In all, 171 reproductive medicine specialists participated in our study, for a response rate of 43.6%; 89% were women. The respondents' median age was 34 years (range: 28-64). Figure 1 depicts the distribution of the initial specialties of the doctors who responded.

#### 2. Approach to sexual functioning

In all, the RD group comprised 147 doctors who reported that they regularly raise the question of sexual function during the first consultation ("always" *n*= 95, "often", *n*= 52), 24 occasionally (OD group), and zero never. There was no significant difference between the RD and OD groups for age or sex. The medical gynecologists (MGs) did differ significantly from the other specialists, with 94% of the former raising this topic at the first consultation (*P*=0.002). The obstetrician-gynecologists also differed significantly from the other specialists, with 75% of the former also raising the subject at the first consultation (*P*=0.002). During the follow-up, we observed a significant difference between the RD and OD groups concerning their discussion of

sexual functioning for scheduling sexual relations: 72% in the RD group versus 91% in the OD group ( $P=0.029$ ).

There was no significant difference between the two groups in the obstacles encountered by the doctors. (Figure 2).

### 3. Sexual dysfunctions sought

The sexual problems asked about most often in both groups were the frequency of sexual relations and erectile dysfunction (Figure 3). On the other hand, desire disorders were asked about less often. The RD and OD groups differed significantly in asking about: desire disorders (42% versus 21%,  $P=0.041$ ), penetration disorders (53% versus 29%,  $P=0.025$ ), and frequency of sexual relations (99% versus 83%,  $P=0.04$ ).

### 4. Management available in the different MAR centers

When an SD was observed, most of these doctors working in reproductive medicine said that they referred their patients to a sex therapist in private practice; this response did not differ significantly between the RD and OD groups ( $P=0.495$ ). Moreover, 9% of the RD group and 17% of the OD group did not have the names of sex therapists to whom they could refer their patients; this difference was not significant ( $P=0.199$ ). (Figure 4).

### 5. Proposed management

We asked about their interest in having a sex therapist available onsite to whom they could refer MAR patients. Both groups were globally favorable (93% for the RD group, 75% for the OD group), although the rate was significantly higher in the RD group ( $P=0.018$ ). Respondents were also asked about the usefulness of

supplementary tools to aid in SD diagnosis. Both groups were very favorable to the different suggestions (with no significant difference between the groups). These suggestions included an explanatory brochure for couples undergoing MAR ( $P=0.052$ ), a simple questionnaire for couples ( $P=0.424$ ), and a directory of local sex therapists to improve referrals ( $P=0.481$ ).

#### IV. Discussion

The principal objective of our study was to examine how physicians specializing in reproductive medicine broached the question of sexual functioning with their patients. The 171 responses we received showed that doctors asked about sexual functioning quite frequently during the first consultation. They most often raised this subject then to assess the potential fertility of the couple's sexual relations (frequency, erectile dysfunction, and ejaculation). Then during follow-up, 75% of the doctors mention sexual relations in terms of "scheduling them", which thus becomes a part of the treatment for infertility: the medical profession imposes a highly medicalized dimension to the couple's sex life (Collier 2010). Sex loses its recreational and erotic functions and is subordinated to the procurement of a pregnancy (Coëffin-Driol 2004). Sexual relations focus on intravaginal ejaculation (Mimoun, 1995) during the preovulatory phase. This loss of spontaneity can have negative consequences on the couples' marital and sexual relationships over the longer term. These adjustments of sexual relations to produce a pregnancy can lead to SDs ( Huyghe, 2013).

In the RD group, 53% of the doctors asked about penetration disorders, compared with 29% in the OD group. Even though they are rarely the cause of infertility (Mimoun, 1995), it nonetheless seems surprising that half of the RD group

and two thirds of the OD group did not routinely inquire about them. A recent meta-analysis focused on SDs in women( Mendonça, 2017) reported that infertility is associated with an increase in these SDs. The areas of functioning most strongly affected by female infertility are lubrication, orgasm, and satisfaction. As the lack of lubrication can induce dyspareunia (Coëffin-Driol, 2004), it appears essential to ask about it, especially as the use of lubricants can be toxic for spermatozoa ( Huyghe, 2013). Asking about relations without ejaculation (including with ejaculation pre- or post-penetration) is also essential because that is a situation in which a sex therapist can be extremely helpful (Huyghe, 2013).

In the RD group, 41.5% of the respondents asked about desire disorders, compared with 21% of the OD groups ( $P=0.041$ ). Couples consulting for MAR have been trying to become pregnant for at least 12 months; this has necessarily led them to adapt their sex lives to optimize the likelihood of pregnancy. Many studies have shown that while sexual pleasure is maintained (Coëffin-Driol 2004, Reder 2009, Ohl 2009) for both sexes, desire is impaired (with a loss of spontaneity and diminution of both foreplay and positional variation). Older publications mentioned an overall diminution of libido and sexual satisfaction (Chevret-Méasson, 2007). At the same time that sexual pleasure and spontaneity are subordinated to the desire for pregnancy, couples using MAR must cope with a narcissistic injury and a feeling of failure (Peng, 2011). Their objective is to have a child, sometimes at the price of their well-being or even of their relationship (separations during the MAR process or after failure). Should MAR succeed, it is important that this committed couple become a parental couple (Mazoyer, 2012).

We therefore note that the French doctors working in reproductive medicine who participated in our study ask about the most "standard" SDs that may impair

procreation (even though the response rate of the OD group is somewhat troubling, especially concerning erection and ejaculation). We can regret that the approach to sexual function at MAR visits is reduced to the expression of the simplest of potentially fertilizing sexual relations (frequency of intravaginal ejaculation). We can also deplore the lack of training in sex therapy during medical training, especially in the specialties leading to reproductive medicine. Such pedagogical support might make physicians more at ease with the subject, with asking questions about sexual function, and especially with not reinforcing the dissociation between pleasure and reproduction.

According to both groups, lack of time was the principal obstacle to asking questions about sexual function: 55% for the RD group and 58% for the OD group. Another obstacle was respect for the couple's privacy, already invaded, according to 33% of the RD and 50% of the OD groups. Some doctors are also afraid of increasing the patients' distress by asking intrusive questions, but the response rate to studies of the sex lives of infertile couples proves that patients want to be asked (Reder 2012, Ohi 2009). Couples can then allow themselves to express the fears and distress that they would not have mentioned spontaneously. Ohi et al. (2009) have concluded that if medical team systematically asks couples to talk about the SDs engendered by infertility, more couples seek psychological support and sex therapy. Not knowing to whom they should refer these patients impeded 21% of the doctors in the RD group and 29% in the OD group from asking questions about the patients' sexual function. This underlines the importance of creating a network with different specialists to offer patients a more appropriate, individualized, multidisciplinary management.

In summary, asking about SDs, informing couples, and suggesting management strategies (by sex therapists or by reproductive medicine specialists themselves, as 16 of our respondents felt they were capable of handling this) could help to improve our patients' sexual relations, emotional relationships, and well-being as well as the success rate of MAR treatment (Mendonça, 2017).

## V. Conclusion

Infertility is associated with an increase in SDs among men and women. Our study highlights the need to improve our diagnostic and management strategies to improve our patients' QoL. We should be able to help these couples, including by attenuating the SDs that may occur with diagnosis and treatment. Many solutions can be proposed to help these doctors manage SDs: establish a directory of local sex therapists, create jobs for a reference sex therapist in MAR centers, integrate standardized questionnaires into the MAR consultation, and include a short course about the principal SDs in the training of doctors working in reproduction. Appropriate sex-therapy management could enable couples to reconsider their sexual function as recreational and not solely procreative. Consequently, our objective must be to help couples to minimize the impact of MAR on their sex lives and thus improve their sexual health and overall QoL.

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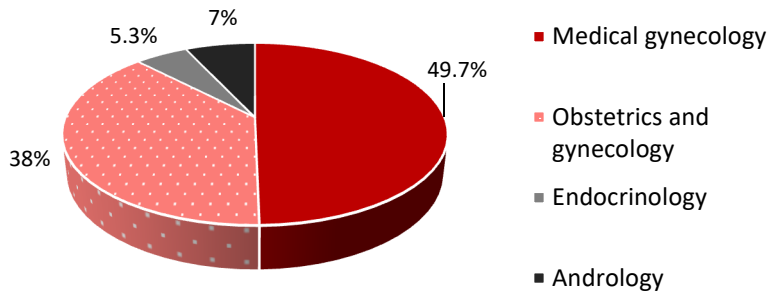
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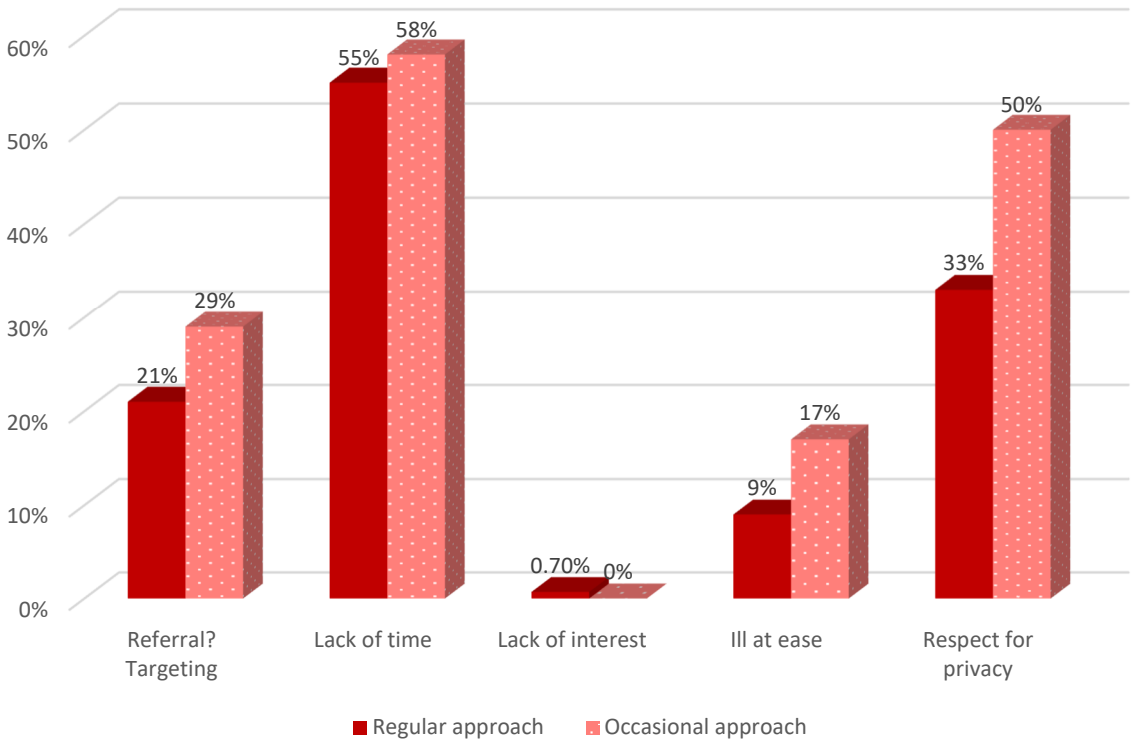
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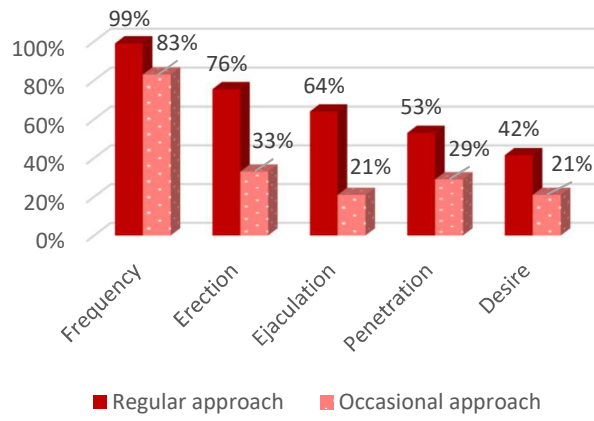
**Figure 1: Specialties of the participating doctors**



**Figure 2: Obstacles to discussing sexual function.**  
No significant difference between the groups.



**Figure 3 : Sexual dysfunctions sought**



**Figure 4 : Management available in the different MAR centers**

