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Patient-Centered Outcomes and Treatment Preferences Regarding Sexual Problems: A Qualitative Study Among Midlife Women

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ABSTRACT

Background: Sexual dysfunction is common in midlife women and can have a significant negative impact on quality of life. Although treatments exist, there is little research on which sexual function outcomes and treatments midlife women prefer.

Aim: To better understand the sexual function outcomes that were most important to sexually active women 45 to 60 years old and the types of treatments they would prefer from individual interviews and focus groups.

Methods: Twenty individual interviews and three focus groups (N = 39) were led by a trained facilitator, audio recorded, and transcribed. Two investigators developed a codebook, and the primary investigator coded all data. A second investigator coded five randomly selected interviews to ensure intercoder reliability. Codes relating to outcomes and treatment preferences were examined to identify central themes.

Results: The mean age was 52.8 years (range = 45–59). When asked what they would want a sexual dysfunction treatment to do, women sought solutions to specific sexual problems: low desire, vaginal pain and dryness, and decreased arousal or ability to achieve orgasm. However, when asked about the most important aspect of their sex life, most women indicated emotional outcomes, such as enhanced intimacy with their partner, were most important to them. Most women preferred behavioral over pharmaceutical treatments, citing concerns about side effects. These women felt that behavioral treatments might be better equipped to address physical and psychological aspects of sexual problems.

Clinical implications: This study highlights the importance of considering not only physical but also emotional outcomes when evaluating and treating sexual dysfunction in midlife women. It also emphasizes the importance of developing behavioral treatments in addition to pharmaceutical treatments.

Strengths and Limitations: By using a qualitative approach, this study allowed women the time and space to speak their own words about their experiences with sexuality at midlife. In addition, different racial and ethnic groups and menopausal statuses were represented. Limitations include limited generalizability, as is true for most qualitative research. In addition, although most women did endorse sexual problems, we did not exclude women with no sexual complaints.

Conclusions: Midlife women value physical and emotional outcomes with regard to sexual function. Many midlife women in this sample expressed a preference for behavioral approaches over pharmaceutical approaches for the treatment of sexual dysfunction. **Thomas HN, Hamm M, Hess R, et al. Patient-Centered Outcomes and Treatment Preferences Regarding Sexual Problems: A Qualitative Study Among Midlife Women. J Sex Med 2017;XX:XXX–XXX.**

Key Words: Patient-Centered Outcomes; Female Sexual Function; Female Sexual Dysfunction

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INTRODUCTION

Sexual function can be conceptualized as an individual's ability to participate in and experience pleasure from sexual activity; it includes *physical domains* (physical arousal/lubrication, orgasm, pain) and *psychological domains* (subjective arousal/desire, satisfaction). Sexual function is a key component of overall quality of life and well-being for adults across the lifespan.[1,2] However, sexual dysfunction is common in women, particularly at midlife, and can have a significant negative impact on quality of life and relationships. Forty-three percent of women report at least one sexual problem,[3,4] and the prevalence of sexual dysfunction is highest at midlife (approximately 45−60 years of age).[4] Women with sexual dysfunction have significantly lower quality of life and general happiness,[1,2,5,6] and low sexual satisfaction is associated with worse marital quality.[7]

Treatments for female sexual dysfunction have been developed and tested. However, sexual function is a multifaceted concept, and there is a lack of consensus about which sexual function outcomes are most important to women. Initially, the Food and Drug Administration recommended the number of satisfying sexual events over 4 weeks as the primary outcome in pharmaceutical clinical trials. Experts have questioned whether this is a meaningful outcome for women, and many have recommended the use of multidimensional patient-reported outcome instruments instead.[8−10] Although experts have voiced their recommendations, there is little existing research in which patients have voiced their preferences for sexual function outcomes. Quirk et al[11] and Rosen et al[12] used individual interviews in the development of the Sexual Functioning Questionnaire and the Female Sexual Function Index, respectively, but their reporting on the results of the interviews is somewhat limited. Flynn et al[13] published results from focus groups used in the development of the Patient Reported Outcomes Measurement Information System (PROMIS) Sexual Function and Satisfaction Measures. In this study, participants emphasized the importance of interpersonal intimacy to sexual function and satisfaction. However, these focus groups were limited to individuals with cancer.

In addition, the outcomes that are most important to midlife women might differ from those of younger women. For example, evidence suggests that as women age, physical aspects of sex, such as lubrication and orgasm, become less important and emotional aspects, such as intimacy with one's partner, become more important.[14,15] Further, although older models of sexual response focused on physical response, such as the achievement of orgasm, newer models of female sexual response have proposed that physical *and* emotional satisfaction are important outcomes of sexual activity for women.[16] This physical and emotional satisfaction can facilitate increased receptivity to sexual stimuli in the future. Follow-up studies exploring whether newer models resonate with women have been mixed. In some studies, women with sexual dysfunction were more likely to identify with newer models,[17,18] whereas another study showed that women might endorse older *and* newer models depending on the situation.[19] More recently, there have been calls for composite models that integrate aspects of older and newer models.[20]

In addition, there is little research exploring what *types* of sexual dysfunction treatments women prefer. More research has focused on the development of pharmaceutical treatments, but pharmaceutical options have faced challenges of modest efficacy and adverse effects.[21] Women's preferences with regard to pharmaceutical vs non-pharmaceutical treatments have not been well studied.

To develop treatments that will improve midlife women's health and quality of life, we require a better understanding of the outcomes and treatments that matter most to them. In this analysis, we used a phenomenological approach with 20 individual interviews and 3 focus groups of sexually active women 45 to 60 years old to better understand (i) the sexual health outcomes that were most important to them and (ii) the types of treatments they would prefer. Because the existing literature regarding these subjects is limited, exploratory research using qualitative methods is appropriate.

METHODS

Study Sample

Study participants were recruited from the general population of Pittsburgh, Pennsylvania using online and newsletter advertisements, fliers, and a research registry. The recruitment materials stated that this was a research study to gain a deeper understanding of what is most important to midlife women's sexual satisfaction (recruitment text is in supplementary materials). They were screened for eligibility over the telephone after giving verbal assent to form a convenience sample; women were eligible if they were 45 to 60 years old and had been sexually active with a partner (male or female) at least once in the prior 12 months. Women were given the option to participate in an individual interview or a focus group.

Individual Interview and Focus Group Conduct

Interviews and focus groups were conducted from December 2014 through May 2015 face-to-face in a private research office by a facilitator with extensive experience in qualitative research and sensitive topic areas such as sexuality (M.H.). The primary investigator (H.T.) was present in the corner of the room at focus groups taking notes. Each interview and focus group lasted approximately 60 to 90 minutes. We used interviews and focus groups because focus groups can uncover new themes because of group dynamics, and interviews allow us to hear the perspectives of women who do not wish to discuss sexuality with a group.

An introductory script encompassing the study's purpose and all elements of informed consent was read to participants at the start of each session. This included information on the purpose of the study, that participation was voluntary, that individuals could choose to leave the study at any time, and that participants could speak as much or as little as they feel comfortable doing.