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Patterns of help-seeking in women when problems arise in their sexual life: a discussion paper

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Aims and objectives. To explore patterns of help-seeking in women who have sexual dysfunction and the implications for nursing practice.

Background. Female sexual dysfunction is a common problem that is under-reported and untreated. Barriers to help-seeking reported in existing literature relate to the perception among many women that sexual dysfunction is: part of the normal ageing process; not bothersome or does not exist; an issue that health professionals are reluctant to address; a taboo subject. However, little is known about patterns of help-seeking in women with sexual problems. This leaves a potential gap in nursing knowledge regarding appropriate, supportive strategies.

Design. Discursive inquiry framed theoretically by Vogel's model.

Methods. A literature review was undertaken by searching relevant databases. A combination of keywords was used to identify peer-review papers relating to women's help-seeking behaviour for sexual dysfunction. Vogel's model was used as a framework to extract relevant information from the papers and structure the discussion.

Results. Vogel's model comprises four steps: encoding and interpreting, generating options, decision-making and evaluation of behaviour. Using this stepwise approach helped elucidate the complex mechanisms associated with help-seeking in a structured manner. The key issues associated with help-seeking intention are concerned with women's personal awareness of and interaction with the environment.

Conclusions. Vogel's model offers a new approach to understanding the dynamics that underpin women's decisions to seek professional help when sexual concerns arise and also provides a useful framework for nurses to consider women's specific sexual concerns.

Relevance to clinical practice. Implications for nursing practice are focused on public awareness, women's empowerment and the provision of effective sexual health care. Because sexual dysfunction is a global phenomenon, it is likely that the discussion in this paper will be relevant to an international, nursing readership.

Key words: dysfunction, help-seeking, nursing, problem, professionals, sexual, women

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Aims

The purpose of this paper is to explore patterns of help-seeking in women who have sexual dysfunction and the implications for nursing practice.

Background

Female sexual dysfunction is defined as sexual desire, aversion, arousal, orgasmic and pain disorders accompanied with distress and interpersonal difficulties (American Psychiatric

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Association 2000). In this paper, female sexual dysfunction is used interchangeably with sexual problems, concerns or issues to reflect the wide variety of clinical and psychosocial aspects related to this condition. The problem is recognised as a public health concern (Gruszecki *et al.* 2005, Moreira *et al.* 2005a). Female sexual dysfunction is indiscriminate and affects women across cultures and age groups (Nicolosi *et al.* 2004, Nusbaum *et al.* 2004), although it is known to increase with age (Valadares *et al.* 2008, Rosen *et al.* 2012b). The causes are multifactorial and include clinical (e.g. health conditions, medications) (Hinchliff & Gott 2004), physiological (e.g. hormonal, menopause) (Graziottin & Leiblum 2005) and psychosocial (e.g. anxiety and depression, stress, partner-related) (Rani 2009, Hinchliff *et al.* 2010) factors. Although sexual dysfunction is not life threatening, for many women this experience is associated with significant physical, psychosocial and relationship problems (Laumann *et al.* 1999, Kadri *et al.* 2002, Safarinejad 2006). In turn, this exacerbates distress, therefore creating a vicious circle (Bancroft *et al.* 2003).

During the last two decades, sexual health has been prioritised on the international health agenda and the field of sexology has witnessed spectacular changes. However, female sexual dysfunction is not yet adequately addressed. It is often overshadowed by other reproductive health concerns like maternal health and sexually transmitted infections (Gott & Hinchliff 2003). It is still under-recognised and undertreated (Bagherzadeh *et al.* 2010), and recommendations or protocols about the way women might manage this condition do not really exist (Moreira *et al.* 2008a,b). Another layer of complexity is added because women in many countries avoid discussing sexual issues because it is a 'taboo topic' (Safarinejad 2006, Wendt *et al.* 2009). Although a recent study in the United States suggested that 53% of women sought professional help for sexual dysfunction (Rosen *et al.* 2012a), the Global Study of Sexual Attitudes and Behaviors (GSSAB), on the other hand, showed that only 7–22% did so (Moreira *et al.* 2005a) – yet a substantial proportion would like to do so (Berman *et al.* 2003, Danielsson *et al.* 2003). Instead, most women rely on informal help and lack confidence in professional support (Donaldson & Meana 2011). Moreover, health professionals dismiss individuals' sexual concerns (Gott & Hinchliff 2003). Despite the potential for nurses and other health professionals to support women, many are left untreated, without help.

The concept of 'help-seeking behaviour' has been described as being overused but undertheorised (Mackian *et al.* 2004). Some progress has been witnessed and many models have been developed to support a better understanding of the pathways to seek help. Yet, little is known about the factors that determine the decision-making process to seek help and the role that professionals, particularly nurses and midwives, play in supporting women who have sexual problems (Berman *et al.* 2003, Vahdaninia *et al.* 2009). Considering this limitation, there is a need to adopt or develop a theoretical model of help-seeking in order to understand how people engage with healthcare systems, rather than simply make use of services (Mackian *et al.* 2004). This is particularly important in the area of sexual health where most literature has been concerned with capturing the extent of the problem, the characteristics of help-seekers and services providers, and less with the mechanisms that may explain why some women seek help and others do not.

Design

This is a discursive paper that is framed around the 'Information-Processing Model of the Decision to Seek Professional Help' developed by Vogel *et al.* (2006) (see Fig. 1). To our knowledge, there is no framework or model that specifically seeks to explain help-seeking behaviour for sexual concerns. Vogel's model seems particularly well suited to be applied to the field of sexual health as it has been used in other sensitive research areas of interpersonal and emotional relevance, such as marital counselling and mental health. Thus, we use the framework to discuss the qualitative and quantitative literature regarding help-seeking behaviour for female sexual dysfunction.

Methods

An extensive literature review that dated from 1990 to August 2012 was conducted to identify empirical studies about help-seeking behaviour for female sexual problems. Ovid MEDLINE(R), Embase, PsycINFO, CINAHL and Google Scholar were accessed as well as reference lists of articles. Unpublished documents were not included due to the large scope of the review. To select articles, a methodo-

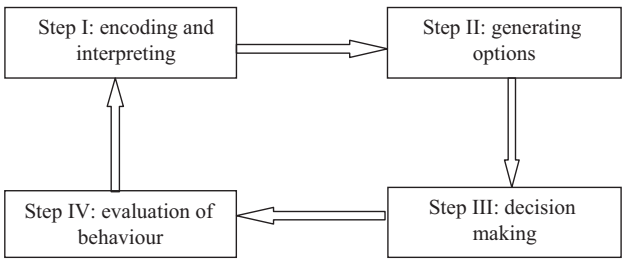

Figure 1 Information-processing model of the decision to seek professional help (Vogel *et al.* 2006).

logical search strategy was developed using either Mesh terms or headings or keywords relevant to the topic. All relevant publications in English were retained and analysed. Study designs were quantitative and qualitative, focusing on women aged 18 years and over. Vogel's model was used as a framework to extract relevant information from the papers.

Discussion

Encompassing self-efficacy and social-cognitive theories, Vogel's (2006) model examines individuals' awareness about their environment and coping abilities to respond to it. It suggests four information-processing steps that are necessary for an individual to perceive the existence of a problem, make sense of it, decide on the way to deal with it and act accordingly. These steps are (1) encoding and interpreting, (2) generating options, (3) decision-making and (4) evaluation of behaviour.

In the first step, individuals encode and interpret internal and external cues. These cues constitute relevant stimuli in terms of personal awareness or feedback from others to perceive a problem and make sense of it. This is mainly influenced by the meaning one attributes to a problem. In step 2, options are generated based on the previous step and current goals. It depends on an individual's ability to recognise the presence of a problem as well as its consequences and the necessity of addressing it to get relief. This implies the elaboration of specific goals with manageable tasks (Heppner & Krauskopf 1987). In the third step, the individual makes a decision based on generated options and goals and develops an action plan for implementation. This step also includes anticipated outcomes, weighing-up costs and benefits of the course of action most likely to produce the intended outcomes. Typically, it is impossible to account for all factors that may influence the outcome. When unanticipated problems arise in the process, help-seeking may stall. This means that seeking professional help might not happen, even if a person intends to pursue it. Lack of awareness about benefits and costs, previous experiences, feeling of self-efficacy, anxiety and stigma are among the obstacles that obstruct the evaluation of best decision-making. This is also largely influenced by sociocultural, racial and gender role models and expectations. In the last step of Vogel's model, individuals evaluate the outcome of their behaviour and accordingly make subsequent decisions. It explains the previous attempts to deal with a problem and the reasons for which people might seek help or not, as well as their different behavioural options.

Although the processing model is developmental, it is neither chronological nor inclusive. This means that people might shortcut the decision-making process and adopt a habitual behavioural pattern. Yet, the model is developmental where individuals move from one step to another. The model's origins lie within the field of mental health. However, it has subsequently been used in relation to sexual health. Fitter *et al.* (2009) used the model as the theoretical basis for their qualitative study to understand couples' discussion of their sexual or relationship difficulties with primary healthcare professionals. However, we are the first to use the model to assist understandings of help-seeking for female sexual dysfunction. In the following, we will apply Vogel's model to discuss the literature on sexuality and help-seeking.

Step I: encoding and interpreting

Referring to Vogel's model, this step focuses on the perception of sexual dysfunction by encoding and interpreting internal (own feelings and perception) and external (feedback of others) cues. These cues stimulate women to realise the existence of a dysfunction (encoding) and to make sense of it (interpretation). The meaning and significance of the dysfunction determine its perception. In this respect, Fitter *et al.* (2009) argued that sexual and/or relationship difficulties are perceived differently based on people, time and circumstances. Women are not necessarily aware about the nature and severity of sexual dysfunction. They do not necessarily see it as a symptom of an 'illness' (Raffi 2007, Feldhaus-Dahir 2009) nor do they clearly attribute it to either a physical or psychological 'health' condition (Fitter *et al.* 2009, Vahdaninia *et al.* 2009). Rather, many choose to ignore the seriousness of the condition hoping that it will resolve spontaneously, or they perceive it as inevitable or normal part of ageing (Brock *et al.* 2006, Donaldson & Meana 2011). Because sexual dysfunction is not life threatening, women might not feel the urge to seek treatment or might consider the dysfunction as untreatable (Berman *et al.* 2003, Nicolosi *et al.* 2006a). Consequently, they avoid seeking help. Failing the encoding and interpreting process might lead to a deterioration of a distressing health condition (Vogel *et al.* 2006).

When women do seek help, they may embark on gathering information anonymously or from partners and friends as their most important source of support (Catania *et al.* 1990, Moreira *et al.* 2005b,c). However, these sources may not always be accurate and may lead to misunderstandings (Bagherzadeh *et al.* 2010). Based on Vogel's model, limited or inaccurate information (incomplete encoding) leads to erroneous assumptions, which in turn can produce shortcutting decisions. The taboo nature of sexuality does not

encourage women to talk openly and understand their sexual concerns (Wendt *et al.* 2009). This is further complicated by the lack of approachability of sexual health services and professionals' negative attitude towards sexual health. Consequently, women might adopt maladaptive, rather than adaptive, interpretation of sexual dysfunction and might not take the right decisions (Dunn *et al.* 1998, Zakhari 2009). This could be understood in the second step of this model, generating options.

Step II: generating options

In the second step, options to address and solve the perceived sexual dysfunction are generated, based on women's encoding and interpretation of the problem. According to Cameron *et al.* (1993), if the problem is not seen as severe enough or changeable, it does not necessarily generate a response. This means that the emergence of a symptom is not important by itself; it is rather its interpretation as being sufficiently severe to trigger help-seeking. There is evidence that women seek professional help when they perceive sexual dysfunction as distressing, persistent and threatening (Mercer *et al.* 2003, Maserejian *et al.* 2010, Reed *et al.* 2012). This is specifically true for women who complain of lubrication difficulties (Laumann *et al.* 2009) or vaginismus (Kadri *et al.* 2002). Postmenopausal women, or those who have regular medical follow-up due to chronic medical conditions, are more conscious about their sexual dysfunction and more at ease to discuss it with healthcare providers (Mercer *et al.* 2003, Shifren *et al.* 2009).

Another key component in triggering help-seeking is personal relevance, which in turn may reflect normative expectations. The wish for satisfying sexual intercourse and a concern about normality may lead women to seek medical help (Tsao 2002, Maserejian *et al.* 2010). Research has demonstrated that this holds true for women who: care about femininity/sexual self (Maserejian *et al.* 2010); are dissatisfied with sexual functioning (Moreira *et al.* 2008a, Laumann *et al.* 2009); and perceive sex as an important part of overall life (Moreira *et al.* 2005a, 2008b). Other triggers include higher education levels (Moreira *et al.* 2008b) and the presence of a partner (Kadri *et al.* 2002, Safarinejad 2006, Mitchell *et al.* 2009). Based on Vogel's model, goals to manage the situation might be obstructed by barriers. For example, low self-confidence about sexual performance, inability to reach orgasm and lack of sexual interest may be linked to low self-esteem and reduced motivation and willingness to seek professional help (Moreira *et al.* 2005a). Considering sex as an embarrassing topic is another barrier (Nicolosi *et al.* 2005, Buvat *et al.* 2009). The personal context in which women live, including children and family circumstances, stressful life events and difficulties, appears also to hinder professional help-seeking (Fitter *et al.* 2009). It is useful for nurses, midwives and other health professionals to be aware of such barriers (Bogart *et al.* 2011, Taylor & Gosney 2011).

Other inhibitors are related to the availability, effectiveness and affordability of sexual health resources. Many women do not know where to go or who to refer to for help (Bagherzadeh *et al.* 2010, Maserejian *et al.* 2010). Sexual health services are not systematically and adequately offered and health professionals might not be aware about the way to handle patients' sexual concerns and tend to overlook this part of women's life (Dunn *et al.* 1998, Gott *et al.* 2004, Yildiz & Dereli 2012). For instance, nurses and midwives who aspire to deliver holistic patient care have an integral role in promoting sexual health. Many barriers prevent professionals from being actively involved in sexual health assessment and management in their daily practice (Magnan *et al.* 2005, Magnan & Reynolds 2006, Quinn *et al.* 2012). Women assume that professionals lack the knowledge, necessary skills and time to discuss sexual concerns, and many women are afraid that professionals will dismiss their sexual health needs out of embarrassment or lack of interest (Sarkadi & Rosenqvist 2001, Julliard *et al.* 2008). In addition, lack of regular access to health care and problems with affordability of care are other barriers to professional help-seeking (Moreira *et al.* 2005a). This is mainly reported by women where healthcare systems do not sufficiently cover individuals' healthcare needs, particularly those related to sexual needs (Nicolosi *et al.* 2006b). Women with limited financial resources may place other needs that ensure their own and their families' survival over their sexual health. The problem is less likely to occur with women who have higher incomes and medical insurance (Maserejian *et al.* 2010). Opting for professional help-seeking reflects women's perception of available and affordable resources (Mercer *et al.* 2003). It also reflects women's self-efficacy to generate options and set achievable goals although the literature does not explain the way options are generated (Vogel *et al.* 2006).

Step III: decision-making

In this step, the person makes decisions by weighing-up the costs and benefits. Many personal and social barriers, particularly those bound up with social norms, might obstruct the decision-making process and its implementation. As an issue that is inherently laden with normative judgments, sexual dysfunction is no exception. Research has shown

that women may be more reluctant than men to disclose their sexual concerns (Nusbaum *et al.* 2004, Laumann *et al.* 2009, Kadri *et al.* 2010). This is not necessarily indicative of a lack of interest in sexual issues. In part, it reflects cultural norms that emphasise the personal nature of the topic that ban it from female discourse. As a consequence, it is not easy for women to reveal sexual concerns to professionals (Elnashar *et al.* 2007, Julliard *et al.* 2008, Rashid *et al.* 2011) even if they are associated with severe problems (Julliard *et al.* 2008, Wendt *et al.* 2009). In many patriarchal and conservative cultures, female sexual interest and pleasure are taboos and women's sexual needs are not recognised (Kadri *et al.* 2010). Under certain circumstances, sexual desire is actively suppressed through sociocultural practices, such as genital mutilation, which is estimated to stand at 90% among Egyptian women (Elnashar *et al.* 2007). In contrast, findings from the GSSAB reveal that in many countries there is no gender difference regarding the association between low self-esteem, reduced sexual performance and the tendency to seek help (Moreira *et al.* 2005d, 2006).

In contemporary societies, public debates and legal and moral challenges about contraception, abortion and feminist-driven discourses about women's sexuality have produced unprecedented openness over the past 40 years (Newson 2007). The epoch is witnessing societal shifts in sexuality with a reprioritisation around many factors including the uncoupling of sex from reproduction and marriage (Hawkes 1996), the medicalisation of sexual problems and behaviour (Tiefer 1996, Hart & Wellings 2002), the increasing ageing population that has been recently recognised as being sexually active (Katz & Marshall 2003) and awareness about the positive impact of sexuality on quality of life [American Association of Retired Persons (AARP) 2005 in Hinchliff & Gott (2011)]. Media, particularly TV programmes and magazines, have contributed to changes about women's perception of their sexual function and the decision to seek help (Fitter *et al.* 2009).

Even though women's sexuality is interpreted within a moral framework that frequently still relegates it to the context of marital engagement (DeJong *et al.* 2005). This is especially the case in Muslim or Christian faith communities (Sharma 2008, Kadri *et al.* 2010). Here, sex is reduced to a marital duty, which is primarily geared towards satisfying a husband's needs. Women are valued through their reproductive status and their role as spouses and mothers rather than their sexual performance (DeJong *et al.* 2005). Within this context where social, religious and cultural practices intertwine to shape the concept of female sexuality, women's human rights are violated. Taboos around this topic act to maintain this traditional structure, particularly in conservative Muslim societies (Amado 2004, Elnashar *et al.* 2007). However, Islam is among the monotheistic religions that encourage women to enjoy sexual intercourse emphasising mutual attention and satisfaction during sexual relationship (Kadri *et al.* 2010). Based on that, one might consider that all Muslim women get sexual pleasure. However, this appears not to be the case, because there is high prevalence of female sexual dysfunction in countries with an Islamic majority population and a low prevalence of help-seeking (Safarinejad 2006, Elnashar *et al.* 2007). It is therefore important that nurses working in different countries and with different cultures and religions are cognisant of the influences of these on women's propensity to seek help.

The idea that sexual function declines over the life-course is more pronounced with middle-aged and older people. After menopause, they are often considered asexual by society, having little interest in sexual expression, unattractive or unable to have sex (Nazareth *et al.* 2003, Vahdaninia *et al.* 2009). For instance, nurses have the tendency to hold negative attitudes towards institutionalised, older residents (Mahieu *et al.* 2011). The negative messages and stereotypical representations about women may contribute to decreased self-esteem and likelihood of help-seeking (Newson 2007). Many older women have the same sexual concerns as younger ones and remain sexually active during their lifespan (Nusbaum *et al.* 2004). They perceive sex as crucial to their relationship and warrant medical treatment (Abdo *et al.* 2004, Nusbaum *et al.* 2004). Yet, they may not be able to assess the value of professional help because sexual dysfunction does not inevitably require medical assistance (Nicolosi *et al.* 2006a). People have the tendency to underestimate the effectiveness of health services and overestimate the costs. Perceiving few benefits prevents professional help-seeking (Vogel & Wester 2003, Vogel *et al.* 2005). Because sexuality is a private and sensitive topic, cost implications might be related to women's inability to disclose their sexual concerns (Elnashar *et al.* 2007, Julliard *et al.* 2008). Instead, they have the tendency to rely on informal help to avoid stigma, although this source of help might not be helpful (Donaldson & Meana 2011).

Step IV: evaluation of behaviour

Although the self-appraisal step is crucial in help-seeking process because it determines the subsequent decision, it is not commonly explored (Vogel *et al.* 2006). This step is a key factor in understanding why individuals adopt different health behaviours. It partly explains the different help-seeking patterns women with sexual dysfunction use,

focusing first on informal help and reflecting their dissatisfaction with service use (Moreira *et al.* 2005a, Vahdaninia *et al.* 2009). Professional help is usually used as a second choice after having failed with other sources (Lin 2002). For many, this experience is unpleasant, accompanied with disgust, devaluation, frustration and anxiety (Berman *et al.* 2003). This probably leads to poor sexual health outcomes (Bagherzadeh *et al.* 2010, Saunamaki *et al.* 2010).

Self-appraisal of improvements in health or satisfaction with services can of course influence future decisions and behaviours. This is determined upon the evaluation of benefits and disadvantages of help-seeking behaviour (Vogel *et al.* 2006). Most Iranian and Nigerian women were satisfied with their medical consultation (Vahdaninia *et al.* 2009, Aisuodionoe-Shadrach 2012). However, 59% of Egyptian women who received treatment for sexual dysfunction did not show any improvement (Elnashar *et al.* 2007). Although the consequent decisions of these outcomes were not examined in these studies, it is likely that a nonsatisfying outcome might push women to adopt avoidance coping behaviour.

The implication of this step is that evaluation is continuous throughout the process of decision-making. Nurses can assist women to explore this and to discuss how this process might affect them and influence their subsequent decisions. A discussion about their decisions and the outcome of their goals is recommended to overcome barriers and increase service use.

While the adoption of Vogel's approach to the understanding of help-seeking intention and behaviour has merit, it is nevertheless limited in several respects. Sociocultural, economic and service-related context factors cannot be fully accounted for by the model. For example, availability and accessibility of services may vary substantially between countries and service systems. Religious and cultural practices that differentially influence the degree of public and interpersonal discourses about sexuality and sexual concerns may also impact on the ways people cognitively encode situations, problems and behavioural choices. None of this is, or can be, fully explained by the model. Moreover, the model is quite linear and may not sufficiently reflect the influence of other cognitive variables, such as beliefs and attitudes, noncognitive variables such as fear, as well as situational and social influences on help-seeking decisions.

Conclusion

This paper offers a unique contribution to nursing knowledge by discussing help-seeking behaviour in relation to the information-processing model. Moreover, it does this is the context of international nursing by drawing on insights from across the globe. Understanding the process of help-seeking in women when problems arise in their sexual life offers nurses the possibility to plan interventions guided by theory, emphasising women's specific needs within their own environment.

Relevance to clinical practice

Appropriately addressing women's sexual health needs is important. All health professionals who care for women – particularly nurses, midwives and physicians – should pay special attention to female sexual needs and rights. Nurses and other health professionals need to (1) reconsider their beliefs and attitudes about sexuality, (2) recognise the importance of sexuality in human life regardless of age and gender, and (3) develop knowledge and skills in assessing, counselling and treating women with sexual dysfunction. Training is therefore important. Indeed, Kim *et al.* (2011) reported that training regarding sexual health care had a positive impact on nurses' attitudes towards patients compared to those who do not receive training.

It is also necessary to empower women to seek professional help and support. Women who are informed about sexual health and the commonness of dysfunctions might increase expectations and openness. Sexual health assessment and screening could be performed routinely as part of other examinations and assessments (Basson 2003). To support this, public health and education campaigns that target women of different age groups could provide information about different therapeutic options and the locations and times when these services are available. Nurses and health visitors working in community-based healthcare settings may be particularly suited as they often know the family to provide information and support who disclose sexual concerns. The campaign ought to be part of a large-scale programme, which addresses the needs of women in diverse community settings, including schools, universities and workplaces. Relying on social figures may serve to attract public interest and reach underserved population. Celebrity champions may be particularly well positioned to raise awareness across different groups in society. This approach has previously been used to promote awareness about male erectile dysfunction (Addis & Mahalik 2003). The assumptions behind public health education campaigns are that these would boost help-seeking among women. However, this needs to be examined in future research.

Finally, policy-makers need to consider affordability of services as the cost of a consultation impedes professional

help in some countries (Nicolosi *et al.* 2006b). In order to promote accessibility and reach minority populations, professionals should offer culturally sensitive services with respect to individuals' perceptions, values and beliefs without discrimination or judgment. Innovative method such as help-lines constitutes an efficient method for people to feel free in expressing their sexual needs and benefit from counselling (Papaharitou *et al.* 2005).

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Conflict of interest

The authors declare that they have no conflict of interests.

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