Psychosocial Factors and Therapeutic Approaches in the Context of Sexual History Taking in Men: A Study Conducted among Swiss General Practitioners and Urologists

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ABSTRACT

Introduction. Male sexual dysfunction is a common medical condition, which is addressed mainly from a biomedical perspective by Swiss general practitioners (GPs) and urologists as the results of part I of our study showed. A psychosocial orientation in sexual history taking (SHT) leads to a truly patient-centered approach and is crucial for improving therapy decisions related to sexual dysfunction.

Aim. To analyze to what extent Swiss GPs and urologists have a psychosocial orientation in SHT, and what therapeutic options they focus on when confronted with male sexual dysfunction.

Methods. A semistructured interview was developed and used in face-to-face encounters with 25 GPs and 25 urologists.

Main Outcome Measures. Content and frequency of interview responses.

Results. The GPs and urologists differed significantly from each other in 5 out of 22 psychosocial factors. Summarizing these psychosocial factors in four domains showed a difference between the GPs and urologists in only one domain. Both groups focus on an open conversation as their approach in SHT. No GP and only a minority of urologists based their diagnosis on criteria of the International Classification of Diseases (10th edition) (ICD-10) or Diagnostic and Statistical Manual of Mental Disorders (4th edition) (DSM-IV). The GPs and urologists differed significantly from each other in 4 out of 16 combinations resulting from the given therapeutic options and form of sexual dysfunction. The urologists focus more strongly on medication as a therapeutic option.

Conclusions. The results of part II additionally justify establishing guidelines and training resources related to SHT in Switzerland. Swiss physicians should be encouraged to apply a more psychosocial orientation in SHT. This will contribute to a better patient-centered approach with positive consequences on physicians' therapeutic decisions. Optimizing the approach in SHT and the choice of therapeutic options may better facilitate real sexual satisfaction for the patient and ultimately result in fewer health insurance costs. **Platano G, Margraf J, Alder J, and Bitzer J. Psychosocial factors and therapeutic approaches in the context of sexual history taking in men: A study conducted among Swiss general practitioners and urologists. J Sex Med 2008;5:2533–2556.**

Key Words. Psychosocial Orientation; Therapeutic Approaches; Sexual History Taking; General Practitioners; Urologists

Introduction

Male sexual dysfunction is a common medical condition, as epidemiological studies report [1–4]. Physicians involved in sexual history taking (SHT) seem to focus strongly on erectile dysfunction, which may be due mainly to the availability of specific medication for this condition such as phosphodiesterase type 5 (PDE5) inhibitors [5]. Studies reporting substantial prevalence rates for hypoactive sexual desire disorder and premature ejaculation suggest that these disorders should receive due attention in SHT [6–8]. Scientific data for the etiology and treatment of orgasmic disorder in males are still rather poor [9,10]. Many general practitioners (GPs) hesitate to address

sexual issues although patients would appreciate them initiating such a discussion [11–15]. GPs often refer patients with sexual problems to urologists [14] especially in cases where the effect of specific medication, such as PDE5 inhibitors, is limited. Little is known about the sexological skills and approach of urologists when confronted with patients for whom psychosocial factors are identified as the main cause of the sexual dysfunction [12,16–18]. Sexuality is a biopsychosocial phenomenon; therefore, we must be careful not to address male sexual problems only from a biomedical point of view [11]. This is not very helpful when psychosocial factors are identified as precipitating and/or perpetuating factors [19–21]. A psychosocial orientation, not only in SHT, is a key component of a patient-centered approach [12]. A patient suffering from a sexual dysfunction will, in any case, be affected on a psychosocial level because the biomedical and psychosocial factors interact in most cases in one direction or the other. A psychosocial orientation is also crucial for improving therapy decisions related to sexual dysfunction, so that physicians involved in SHT can work on enabling the patient to achieve genuine sexual satisfaction, rather than just mechanistically repairing the erectile function [11].

Our study examined different aspects of SHT with male patients by Swiss GPs and urologists. For this purpose, we developed a two-part semistructured interview to be used in face-to-face encounters with GPs in the greater Basel area and with urologists in six of the main urban areas in German-speaking Switzerland.

Part I of our interview aimed to determine how actively these physicians explore male sexual dysfunction, what they focus on, and how competent they feel in talking about and in treating male sexual dysfunction. Results have been reported in *The Journal of Sexual Medicine* [5] and are resummarized in the results section of this article.

Part II of our study was aimed at finding out if there was a difference between Swiss GPs and urologists in the exploration of given psychosocial factors related to SHT, to what extent the physicians demonstrated a psychosocial orientation in SHT, and what therapeutic approaches they focused on when confronted with male sexual dysfunction. In part II of this study, we examined the following two questions: (i) Do the two physician groups differ in terms of their exploration of specific psychosocial factors?, and (ii) Do the two groups differ in terms of their therapeutic approaches when treating hypoactive sexual desire disorder, erectile dysfunction, premature ejaculation, and orgasmic disorder?

Methods

Sample

To detect a significant difference between GPs and urologists, we estimated that a sample consisting of 25 GPs and 25 urologists was necessary.

Using www.medindex.ch, we generated a list of 217 male and female GPs in the greater Basel area. These 217 GPs were grouped as follows: male GPs, female GPs, GPs practicing in the city of Basel, and GPs practicing in the suburban (i.e., more rural) area around Basel. From these subgroups, 105 GPs were randomly contacted by mail and were asked to participate. Twenty-five GPs responded positively (10 male and 3 female GPs from the city, and 10 male and 2 female GPs from the suburban area).

The sample of urologists was also recruited using www.medindex.ch. A total of 69 board-certified urologists was identified in six of the main urban areas of German-speaking Switzerland. To ensure a sample drawn from across this entire pool, no randomization was applied. A total of 52 candidates had to be contacted in order to obtain 25 urologists willing to participate. The sample consisted of 12 urologists who were heads of urology departments and 13 urologists in private practice.

In all of Switzerland, there are 144 male and only 3 female urologists. Therefore, we decided to allow an all-male sample of urologists. Because five female GPs were willing to participate in the study, we decided to include them, which resulted in the gender distribution reported for the GPs.

Material

Appendix I shows the English translation of our entire semistructured interview. Part II comprises nine domains: (i) eight questions addressing *basics about patient's sexuality*; (ii) two questions addressing *fears and anxiety*; (iii) four questions addressing *sexual experience and behavior*; (iv) one question addressing *contextual factors*; (v) two questions addressing *approach and classification systems in SHT*; (vi) one question addressing *therapeutic approaches to hypoactive sexual desire disorder*; (vii) one question addressing *therapeutic approaches to erectile dysfunction*; (viii) one question addressing *therapeutic approaches to premature ejaculation*; and (ix) one

question addressing *therapeutic approaches to orgasmic disorder*. All questions were formulated with reference to the recommendations and guidelines on men's sexual dysfunction published in the inaugural issue of *The Journal of Sexual Medicine* [22], and the recommendations on the diagnosis and therapy of sexual dysfunction published by the German Academy of Sexual Medicine [23]. We included open and closed questions. The entire semistructured interview was validated by elaborating a final version in a continuous personal exchange with two of the main experts on sexuality issues in Switzerland (face validation), one of whom is a head physician at the University Hospital of Basel and the other an acknowledged expert on sex therapy in German-speaking Switzerland. The final version was pilot tested for content validity with a physician at the University Hospital of Basel who formerly worked as a GP.

Outcome Measures

Outcome measures for *basics about patient's sexuality* were based on questions 23–30, for *fears and anxiety* on questions 31 and 32, for *sexual experience and behavior* on questions 33–36, and for *contextual factors* on question 41 of the semistructured interview (see Appendix I).

Outcome measures for *approach and classification systems in SHT* were based on questions 19 and 42 of the semistructured interview (see Appendix I).

Outcome measures for *therapeutic approaches to hypoactive sexual desire disorder* were based on question 46, for *therapeutic approaches to erectile dysfunction* on question 47, for *therapeutic approaches to premature ejaculation* on question 48, and for *therapeutic approaches to orgasmic disorder* on question 49 of the semistructured interview (see Appendix I).

Procedure

The interviews were conducted by the first author, and took place from January 2005 to November 2006. The interviewer visited each participating physician at his or her practice and noted the answers concurrently on the response sheet. Each interview was audio recorded on tape for documentation purposes and to ensure accuracy and completeness. Informed consent was not required.

Statistical Analysis

For all tests performed, the alpha level was set at 0.05. SPSS 15.0 for Windows (SPSS Inc., Chicago, IL, USA) was used to analyze the data.

Basics about Patient's Sexuality/Fears and Anxiety/Sexual Experience and Behavior/Contextual Factors

Nonparametric tests (Mann–Whitney) were performed on each psychosocial factor for each domain. Then, we computed an overall score for each psychosocial factor and totalled the scores of the psychosocial factors per domain to obtain an overall score for each domain. These domain scores were then used as variables in a nonparametric test (Mann-Whitney) to identify potential significant differences between the GPs and urologists.

Approach and Classification Systems in SHT

Nonparametric tests (chi-square) were performed to determine any significant difference between the GPs and urologists.

Therapeutic Approaches to Hypoactive Sexual Desire Disorder, Erectile Dysfunction, Premature Ejaculation, and Orgasmic Disorder

Nonparametric tests (chi-square) were performed for each therapeutic approach and sexual dysfunction. Then, we computed a score for each therapeutic approach indicating the total number of times that the therapeutic approach was chosen as the therapeutic response for the four types of sexual dysfunction. These scores were then used as variables in a nonparametric test (Mann–Whitney) to identify potential significant differences between the GPs and urologists.

Results

The main demographic details of the sample are reported in Table 1.

Table 1 Sociodemographic details

	GPs (N = 25)	Urologists (N = 25)
Sex		
Male	20 (80.0)	25 (100.0)
Female	5 (20.0)	—
Marital status		
Single	2 (8.0)	1 (4.0)
Married	19 (76.0)	20 (80.0)
Divorced	3 (12.0)	4 (16.0)
Widowed	1 (4.0)	—
Mean age (SD) (years)	51.76 (8.07)	50.16 (9.15)
Mean experience in field (SD) (years)	15.90 (8.67)	14.40 (8.04)
Mean duration of interview (SD) (minutes)	49.20 (15.05)	58.60 (21.14)

Figures in parentheses = %, unless noted otherwise.
GPs = general practitioners; SD = standard deviation.

Table 2 Psychosocial factors asked about by physician in connection with SHT

	GPs (N = 25)			Urologists (N = 25)			
	Always	Depends on patient	Never	Always	Depends on patient	Never	*P**
Basics about patient's sexuality							
Concept of love	5 (20.0)	12 (48.0)	8 (32.0)	0 (0)	10 (40.0)	15 (60.0)	0.02
Concept of sexuality	7 (28.0)	11 (44.0)	7 (28.0)	5 (20.0)	12 (48.0)	8 (32.0)	0.57
Concept of fidelity	1 (4.0)	16 (64.0)	8 (32.0)	3 (12.0)	8 (32.0)	14 (56.0)	0.23
Target state	4 (16.0)	12 (48.0)	9 (36.0)	9 (36.0)	10 (40.0)	6 (24.0)	0.14
Sexual orientation	6 (24.0)	14 (56.0)	5 (20.0)	4 (16.0)	13 (52.0)	8 (32.0)	0.30
Contraception	7 (28.0)	13 (52.0)	5 (20.0)	5 (20.0)	8 (32.0)	12 (48.0)	0.09
Partner with sexual problem	10 (40.0)	12 (48.0)	3 (12.0)	11 (44.0)	12 (48.0)	2 (8.0)	0.69
Wish for child	5 (20.0)	12 (48.0)	8 (32.0)	6 (24.0)	14 (56.0)	5 (20.0)	0.41
Fears and anxiety							
Sexual fears	7 (28.0)	14 (56.0)	4 (16.0)	12 (48.0)	11 (44.0)	2 (8.0)	0.13
Pressure to perform	12 (48.0)	11 (44.0)	2 (8.0)	14 (56.0)	11 (44.0)	0 (0)	0.43
Sexual experience and behavior							
Sexual experience	2 (8.0)	14 (56.0)	9 (36.0)	2 (8.0)	15 (60.0)	8 (32.0)	0.80
Sexual satisfaction	15 (60.0)	4 (16.0)	6 (24.0)	13 (52.0)	6 (24.0)	6 (24.0)	0.68
Masturbation	7 (28.0)	12 (48.0)	6 (24.0)	14 (56.0)	8 (32.0)	3 (12.0)	0.05
Pornography	0 (0)	7 (28.0)	18 (72.0)	1 (4.0)	7 (28.0)	17 (68.0)	0.70
Contextual factors							
Psychological condition	23 (92.0)	2 (8.0)	0 (0)	9 (36.0)	13 (52.0)	3 (12.0)	<0.001
Family problems	17 (68.0)	8 (32.0)	0 (0)	9 (36.0)	14 (56.0)	2 (8.0)	0.02
Problems with neighbors	11 (44.0)	12 (48.0)	2 (8.0)	7 (28.0)	13 (52.0)	5 (20.0)	0.15
Problems at work	15 (60.0)	9 (36.0)	1 (4.0)	11 (44.0)	11 (44.0)	3 (12.0)	0.21
Housing problems	0 (0)	15 (60.0)	10 (40.0)	1 (4.0)	11 (44.0)	13 (52.0)	0.51
Money problems	6 (24.0)	16 (64.0)	3 (12.0)	4 (16.0)	10 (40.0)	11 (44.0)	0.04
Legal problems	0 (0)	12 (48.0)	13 (52.0)	1 (4.0)	7 (28.0)	17 (68.0)	0.32
Other psychosocial problems	6 (24.0)	13 (52.0)	6 (24.0)	2 (8.0)	15 (60.0)	8 (32.0)	0.22

*Mann–Whitney test: GPs vs. urologists.
Number of physicians asking about the psychosocial factor for the domain; figures in parentheses = %.
SHT = sexual history taking; GPs = general practitioners.

Part I [5]

Summary

The urologists reported a significantly higher frequency of actively asking male patients about sexual dysfunction (22.80% vs. 10.42%, $P = 0.01$). The GPs and urologists avoided actively asking certain patient groups about sexual dysfunction (e.g., "immigrants" and "macho men"). The GPs reported a significantly lower percentage of male patients who spontaneously address sexual problems (6.35% vs. 18.40%, $P < 0.001$). Both physician groups emphasized erectile dysfunction in SHT. Eight percent of GPs and 28% of urologists considered their competence in *discussing* sexual dysfunction as *very good*. No GP and 20% of urologists considered their competence in *treating* sexual dysfunction as *very good*. The urologists reported having a significantly greater competence in discussing ($P = 0.02$) and treating ($P < 0.001$) sexual dysfunction than the GPs. Competence in discussing correlated positively with competence in treating sexual dysfunction for the GPs ($P = 0.01$) and urologists ($P < 0.001$). The majority of GPs (92%) and urologists (76%) reported a need for continuing education in sexual issues [5].

Part II

Basics about Patient's Sexuality/Fears and Anxiety/Sexual Experience and Behavior/ Contextual Factors

Our first hypothesis, which assumed there was a difference between the two physician groups in their exploration of given psychosocial factors, was not confirmed. Table 2 shows the results for each psychosocial factor. The GPs and urologists differed significantly from each other in only 5 out of 22 psychosocial factors, namely in the exploration of the factors *concept of love*, *masturbation*, *psychological condition*, *family problems*, and *money problems*.

Table 3 shows the final scores representing the summarized scores of the psychosocial factors per domain. The GPs and urologists differed significantly from each other only in the domain *contextual factors*.

Approach and Classification Systems in SHT

Our assumption that the two physician groups would differ in terms of their exploration of psychosocial factors was also not supported by the results related to the physician's approach and classification system used in SHT. We assumed

Table 3 Mean final scores resulting from the cumulated scores of the psychosocial factors in each domain

	GPs (N = 25)		Urologists (N = 25)		
	M	SD	M	SD	*P**
Basics about patient's sexuality†	7.68	3.44	6.92	3.16	0.41
Fears and anxiety‡	2.52	1.05	2.96	1.06	0.16
Sexual experience and behavior§	3.40	1.83	3.84	1.70	0.45
Contextual factors¶	9.72	2.15	7.28	3.41	0.003

*Mann–Whitney test: GPs vs. urologists.
†Possible scores: 0–16.00.
‡Possible scores: 0–4.00.
§Possible scores: 0–8.00.
¶Possible scores: 0–16.00.
GPs = general practitioners; SD = standard deviation.

that a structured approach in SHT (e.g., use of questionnaires, structured interviews, and guidelines) would help remind a physician to explore psychosocial factors. Table 4 shows the frequencies with which the use of the various approaches in SHT was reported. The majority of GPs and urologists indicated an open conversation as their approach in SHT.

We also assumed that psychosocial factors would receive more consideration if the diagnosis is based on the ICD-10/DSM-IV criteria. Table 4 shows the frequencies with which a classification system was cited as a basis for diagnosing sexual dysfunction. All GPs and a majority of urologists diagnosed male sexual dysfunction based upon their own diagnostic criteria.

Therapeutic Approaches to Hypoactive Sexual Desire Disorder, Erectile Dysfunction, Premature Ejaculation, and Orgasmic Disorder

Our second hypothesis, which assumed there would be a difference between the two physician groups in terms of their therapeutic approaches to hypoactive sexual desire disorder, erectile dysfunction, premature ejaculation, and orgasmic disorder, was not confirmed. Table 5 shows the frequencies with which the given therapeutic approaches were applied to each of the sexual dysfunctions mentioned. The two physician groups differed from each other in only 4 out of 16 possible combinations of sexual dysfunction/therapeutic approach.

Table 6 shows the scores for each therapeutic approach cumulated for hypoactive sexual desire disorder, erectile dysfunction, premature ejaculation, and orgasmic disorder. The GPs and urologists differed significantly from each other only for *medication*.

Table 4 Approaches to SHT (multiple responses possible). Classification system used in diagnosis of sexual dysfunction

	GPs (N = 25)	Urologists (N = 25)	*P**
Approach			
Open conversation	25 (100.0)	20 (80.0)	0.02
Questionnaire	0 (0)	4 (16.0)	0.04
Structured interview/guidelines	0 (0)	6 (24.0)	0.01
Classification system			
Own diagnosis	25 (100.0)	17 (68.0)	
ICD-10	0 (0)	8 (32.0)	
DSM-IV	0 (0)	0 (0)	0.002

*Chi-square test: GPs vs. urologists.
Number of physicians reporting use of the approach/classification system indicated; figures in parentheses = %.
SHT = sexual history taking; GPs = general practitioners; ICD-10 = International Classification of Diseases (10th edition); DSM = Diagnostic and Statistical Manual of Mental Disorders.

Discussion

The results for part II are discussed here with respect to the content of the two hypotheses underlying part II of the study.

Exploration of Given Psychosocial Factors

Basics about Patient's Sexuality/Fears and Anxiety/Sexual Experience and Behavior/ Contextual Factors

Our findings do not support the hypothesis that a difference would be found in the exploration of given psychosocial factors in our sample. The GPs and urologists differed significantly from each other with respect to only 5 out of 22 psychosocial factors, namely in the exploration of the factors *concept of love*, *masturbation*, *psychological condition*, *family problems*, and *money problems*. No difference between the two groups was found for the remaining 17 factors. The two groups differed from one another in only one out of four domains, namely *contextual factors*, as indicated by the summarized scores. This information is an important addition to the results obtained in part I [5] of this study:

Table 5 Therapeutic approaches to treating sexual dysfunctions (multiple responses possible)

	Medication			Self-conducted counseling			Partner involvement			Referral		
	GPs (N = 25)	Urologists (N = 25)	*P**	GPs (N = 25)	Urologists (N = 25)	*P**	GPs (N = 25)	Urologists (N = 25)	*P**	GPs (N = 25)	Urologists (N = 25)	*P**
Hypoactive sexual desire disorder	7 (28.0)	9 (36.0)	0.54	18 (72.0)	12 (48.0)	0.08	15 (60.0)	7 (28.0)	0.02	19 (76.0)	20 (80.0)	0.73
Erectile dysfunction	23 (92.0)	24 (96.0)	0.55	15 (60.0)	13 (52.0)	0.57	10 (40.0)	8 (32.0)	0.56	16 (64.0)	9 (36.0)	0.05
Premature ejaculation	9 (36.0)	23 (92.0)	<0.001	16 (64.0)	20 (80.0)	0.21	8 (32.0)	4 (16.0)	0.19	17 (68.0)	12 (48.0)	0.15
Orgasmic disorder	1 (4.0)	7 (28.0)	0.02	10 (40.0)	10 (40.0)	1.00	2 (8.0)	4 (16.0)	0.38	17 (68.0)	16 (64.0)	0.77

*Chi-square test: GPs vs. urologists.
Number of physicians choosing the therapeutic approach indicated for treating various types of sexual dysfunction; figures in parentheses = %.
GPs = general practitioners.

Table 6 Mean final scores for frequency with which given therapeutic approaches were chosen by physicians as a therapeutic response to *hypoactive sexual desire disorder*, *erectile dysfunction*, *premature ejaculation*, and *orgasmic disorder*

	GPs (N = 25)		Urologists (N = 25)		
	M	SD	M	SD	*P**
Medication†	1.60	0.76	2.52	0.96	0.001
Self-conducted counseling†	2.36	1.44	2.20	1.38	0.66
Partner involvement†	1.40	1.12	0.92	1.26	0.08
Referral†	2.76	1.33	2.28	1.24	0.13

*Mann–Whitney test: GPs vs. urologists.
†Possible scores: 0–4.00.
GPs = general practitioners; SD = standard deviation.

besides not sufficiently exploring sexual dysfunction and not feeling competent enough to deal with male sexual dysfunction, GPs do not inquire more often about psychosocial factors as compared with urologists, which is often assumed, because GPs are considered to be better informed about the personal and family situation of their patients [24,25]. We were also interested in finding out how psychosocially oriented our physicans were. We assumed that the response *always*, as a measure of the frequency with which the physicians inquired about a psychosocial factor, was a suitable criterion for expressing an interviewee's strong psychosocial orientation. We observed that the GPs responded with *always* more frequently than the urologists did for four out of five psychosocial factors, for which a significant difference was found. However, generally, for both groups, we observed rather low response frequencies for *always*, which means that for most psychosocial factors, the responses *depends on patient* or *never* were very frequently indicated. Looking at the frequency with which interviewees reported *never* asking about a given psychosocial factor—presumably an indication of a weak psychosocial orientation—some remarkable outcomes for a number of psychosocial factors were observed: e.g., 36% of GPs and 32% of urologists *never* ask how sexually experienced a patient is. This question is therapeutically relevant for helping decide if the patient should work on developing new sexual skills or enhancing existing ones as part of the therapeutic process. Seventy-two percent of GPs and 68% of urologists *never* ask about the use of pornography. A patient's response here may reveal important aspects of avoidance and/or addictive behavior (e.g.,

Internet), which can be factors that perpetuate sexual dysfunction.

Approach and Classification Systems in SHT

The results for *approach and classification systems in SHT* also do not support our first hypothesis. The GPs and urologists focus on an open conversation as their approach to SHT. We postulated that if a structured approach (use of questionnaires, structured interviews, and guidelines) was taken to SHT, attention to psychosocial factors would be enhanced, and especially so if the diagnosis was based on the ICD-10/DSM-IV criteria. No GP and only a minority of urologists based their diagnosis of sexual dysfunction on the ICD-10 or DSM-IV criteria. We also observed that a majority of GPs and urologists were not familiar with the DSM-IV. Our results show that the GPs and urologists preferred to use their own diagnostic criteria. Clinical reality shows, however, that physicians' own diagnostic criteria are often not sufficiently reliable or valid, e.g., when an erectile dysfunction is diagnosed instead of a hypoactive sexual desire disorder.

Results from part I suggest that Swiss GPs and urologists need to explore male sexual dysfunction more—not only quantitatively but also qualitatively, e.g., by adopting an approach in SHT that goes beyond a strong focus on erectile dysfunction. Results from part II supplement the findings from part I of this study: the physicians' sense of competence may be improved by learning the importance of a psychosocial orientation in SHT so that they can appropriately address their male patients' sexual concerns. A psychosocial orientation takes the whole patient into consideration and will facilitate the therapeutic goal of enabling the patient to experience genuine sexual satisfaction.

Therapeutic Approaches to Hypoactive Sexual Desire Disorder, Erectile Dysfunction, Premature Ejaculation, and Orgasmic Disorder

Our findings do not support the hypothesis that in our sample, there was a significant difference in the therapeutic approaches taken by the two physician groups when treating hypoactive sexual desire disorder, erectile dysfunction, premature ejaculation, or orgasmic disorder. We found a significant difference between the two groups in only 4 out of 16 possible combinations related to therapeutic approach and sexual dysfunction. The GPs more frequently chose *partner involvement* when treating hypoactive sexual desire disorder. This may demonstrate a certain psychosocial orientation among the GPs. However, we must critically question why partners are not involved more frequently in the treatment of erectile dysfunction, premature ejaculation, and orgasmic disorder as well. Among the urologists, *partner involvement* was rarely chosen as a therapeutic option for any form of sexual dysfunction. The GPs also relied more frequently on *referral* when treating erectile dysfunction (normally to a urologist). This is in line with the results of part I, which showed that GPs in particular do not feel sufficiently competent to deal with male sexual dysfunction. This is also supported by high response rates for *referral* by the GPs for hypoactive sexual desire disorder, premature ejaculation, and orgasmic disorder. The urologists also frequently cited *referral* with respect to hypoactive sexual desire disorder, premature ejaculation, and orgasmic disorder. For both groups, this may reflect the therapeutic helplessness when dealing with male sexual dysfunction for which medication, such as PDE5 inhibitors, is not available. In fact, many patients with hypoactive sexual desire disorder, premature ejaculation, and orgasmic disorder are referred by GPs and urologists to a psychiatrist or psychologist. The urologists cited reliance on *medication* when treating premature ejaculation or orgasmic disorder more frequently than the GPs did. Especially for premature ejaculation, prescription of a selective serotonin reuptake inhibitor (SSRI) is increasingly regarded as a therapeutic option [26]. However, we must critically question if the physician is really working on the patient's long-term sexual satisfaction by focusing on medication such as SSRIs, which produce other well-known side effects. Finally, the values reported for *self-conducted counseling* must be critically questioned: is this counseling focusing on the exploration of symptoms rather than on etiological (including psychosocial) factors, and on the prescription of medication rather than on the improvement of therapeutic approaches? The individual scores for the different forms of sexual dysfunction are confirmed by the cumulated scores for all categories of sexual dysfunction: the urologists focus strongly on *medication*, the scores for *referral* are high for both groups, and there is a tendency observable among the GPs to more frequently involve the partner in treatment efforts.

Exploring male sexual dysfunction to a greater extent both in quantitative and qualitative terms, intensifying psychosocial orientation, and improving therapeutic responses are, of course, more

time-consuming approaches. The estimated mean time invested in SHT by our sample was approximately 20 minutes. The physicians' sense of competence will improve qualitatively through targeted education, and quantitatively through individual practice. A greater sense of competence by the physician when dealing with sexual issues will better facilitate the patient achieving genuine sexual satisfaction and will ultimately result in fewer health insurance costs.

In part I of this study, we noted some limitations in our research, which also apply to part II: our results can only partly be generalized because of the size of the sample and its limited representativeness. Our study is the first of its kind in Switzerland, so the study should be repeated to confirm our conclusions. Furthermore, the physicians reported subjectively on their own practice, the impact of social desirability was not systematically controlled for, and our sample consisted mainly of male physicians. There are some limitations that are specific to part II: the 22 psychosocial factors were assigned to the domains at the researchers' own discretion. Methodologically speaking, this is not a strict procedure. We tried to circumscribe the domains in a valid way by considering content and using our common sense. The results on the psychosocial orientation of the interviewees are based on the response *always*, which we defined as a strong indicator in this context. The response *depends on patient* was considered to be closer to *never* than *always* based on the impression gained during the interviews, which for social desirability reasons, the interviewees tended to answer *depends on patient* instead of *never*. We must assume that some *depends on patient* responses might more strongly reflect an *always* attitude. Multiple answers were possible in the area of therapeutic approaches. This is based on considerations that clinical reality is often characterized by the consecutive use of several therapeutic approaches. No final conclusion is possible from our results with respect to what the sequence of the therapeutic approaches is when several options are considered. Finally, relating the four types of sexual dysfunction taken together to the therapeutic approaches may not fully reflect the fact that the therapeutic approaches can vary for different types of sexual dysfunction. Nevertheless, we believe that this technique indicates what therapeutic approach the interviewees generally gravitated toward when treating sexual problems.

There is a clear need for improvement among Swiss GPs and urologists with respect to exploration, focus, sense of competence, psychosocial orientation, and therapeutic approaches in SHT when addressing male sexual problems. We believe that improvement can be achieved through the following three steps. First, training resources in SHT need to be developed for Swiss physicians. In Switzerland, there is only one university postgraduate curriculum related to sexual health, no full- or part-time professorship in the field of sex research, and only very limited options for sex therapy training. Second, a set of guidelines needs to be established so that physicians can refer to them in their daily practice. Third, interdisciplinary cooperation between physicians and psychiatrists/psychologists involved with male sexual problems, and between these professionals and national/international sex researchers must become the standard. The main goal is to enhance the general competence of those dealing with male sexual issues so that ultimately they can focus their therapeutic efforts on helping the patient achieve long-term genuine sexual satisfaction.

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References

1 DeRogatis LR, Burnett AL. The epidemiology of sexual dysfunctions. J Sex Med 2008;5:289–300.
2 Laumann EO, Nicolosi A, Glasser DB, Paik A, Gingell C, Moreira E, Wang T. Sexual problems among women and men aged 40–80 y: Prevalence and correlates identified in the global study of sexual attitudes and behaviours. Int J Impot Res 2005; 17:39–57.
3 Lewis RW, Fugl-Meyer KS, Bosch R, Fugl-Meyer AR, Laumann OE, Lizza E, Martin-Morales A. Epidemiology/risk factors of sexual dysfunctions. J Sex Med 2004;1:35–9.
4 Simons JS, Carey MP. Prevalence of sexual dysfunctions: Results from a decade of research. Arch Sex Behav 2001;30:177–219.
5 Platano G, Margraf J, Alder J, Bitzer J. Frequency and focus of sexual history taking in male patients—a pilot study conducted among Swiss general practitioners and urologists. J Sex Med 2008;5:47–59.
6 Meuleman EJ, van Lankveld JJ. Hypoactive sexual desire disorder: An underestimated condition in men. BJU Int 2005;95:291–6.
7 McMahon C, Abdo C, Incrocci L, Perelman M, Rowland D, Waldinger M, Cheng Xin Z. Disorders of orgasm and ejaculation in men. J Sex Med 2004;1:58–65.
8 Althof S. The psychology of premature ejaculation: Therapies and consequences. J Sex Med 2006;3(4 suppl):324–31.
9 Richardson D, Nalabanda A, Goldmeier D. Retarded ejaculation—a review. Int J STD AIDS 2006;17:143–50.
10 Waldinger MD, Schweitzer DH. Retarded ejaculation in men: An overview of psychological and neurobiological insights. World J Urol 2005;23:76–81.
11 Sadovsky R, Nusbaum M. Sexual health inquiry and support is a primary care priority. J Sex Med 2006;3:3–11.
12 Tsimtsiou Z, Hatzimouratidis K, Nakopoulou E, Kyrana E, Salpigidis G, Hatzichristou D. Predictors of physicians' involvement in addressing sexual health issues. J Sex Med 2006;3:583–8.
13 Nazareth I, Boynton P, King M. Problems with sexual function in people attending London general practitioners: Cross sectional study. BMJ 2003; 327:423–8.
14 Aschka C, Himmel W, Ittner E, Kochen MM. Sexual problems of male patients in family practice. J Fam Pract 2001;50:773–8.
15 Bitzer J, Platano G, Tschudin S, Alder J. Sexual counselling in the elderly couple. J Sex Med 2008; 5:2027–43.
16 Bitzer J, Platano G, Tschudin S, Alder J. Sexual counselling for women in the context of physical diseases—a teaching model for physicians. J Sex Med 2007;4:29–37.
17 Van Lusen RH. The role of the sexologists in urology. Eur Urol 1998;34(1 suppl):43–4.
18 Parish SJ, Clayton AH. Sexual medicine education: Review and commentary. J Sex Med 2007;4:259–67; quiz 268.
19 Althof S, Leiblum S, Chevret-Measson M, Hartmann U, Levine S, McCabe M, Plaut M, Rodrigues O, Wylie K. Psychological and interpersonal dimensions of sexual function and dysfunction. J Sex Med 2005;2:793–800.
20 Latini DM, Penson DF, Wallace KL, Lubeck DP, Lue TF. Clinical and psychosocial characteristics of men with erectile dysfunction: Baseline data from ExCEED™. J Sex Med 2006;3:1059–67.
21 Latini DM, Penson DF, Wallace KL, Lubeck DP, Lue TF. Longitudinal differences in psychological outcomes for men with erectile dysfunction: Results from ExCEED™. J Sex Med 2006;3:1068–76.
22 Lue TF, Giuliano F, Montorsi F, Rosen RC, Andersson KE, Althof S, Christ G, Hatzichristou D, Hirsch M, Kimoto Y, Lewis R, McKenna K, MacMahon C, Morales A, Mulcahy J, Padma-Nathan H, Pryor J, Saenz de Tejada I, Shabsigh R, Wagner G. Summary of the recommendations on sexual dysfunctions in men. J Sex Med 2004;1:6–23.
23 Beier KM, Bosinski HA, Fröhlich G, Hartmann U, Loewit K, Peglau M, Rauchfuss M, Völkel H, Vogt HJ. Praxisleitlinien der Akademie für Sexualmedizin zur Diagnostik und Therapie von sexuellen Störungen. Sexuologie 2000;7:170–81.
24 Hartmann U, Burkhart M. Erectile dysfunctions in patient–physician communication: Optimized strategies for addressing sexual issues and the benefit of using a patient questionnaire. J Sex Med 2007;4:38–46.
25 Read S, King M, Watson J. Sexual dysfunction in primary medical care: Prevalence, characteristics and detection by the general practitioner. J Public Health Med 1997;19:387–91.
26 Waldinger MD. Premature ejaculation: State of the art. Urol Clin North Am 2007;34:591–99, vii–viii.

Appendix I

Overview

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SEMI-STRUCTURED INTERVIEW FOR GPs AND UROLOGISTS

Date of interview _____

DEMOGRAPHIC DATA

CODE (anonymization)

3rd letter of family name _____
1st letter of first name _____
1st digit of street number of practice _____
Last letter of first name of mother _____

Sex ☐ male ☐ female
Age _____ years
Marital status ☐ unmarried ☐ married ☐ divorced ☐ widowed
Number of children _____

Board-certified in ☐ general or internal medicine / ☐ urology
In practice since _____
Practice located in _____ ☐ city ☐ suburban area or countryside
Type of physician
☐ GP
☐ Urologist

- **IN THE FOLLOWING INTERVIEW THE TERM "PATIENT" REFERS TO THE MALES YOU SEE IN YOUR MEDICAL PRACTICE WHO ARE SEEKING ANY TYPE OF MEDICAL TREATMENT**

Active exploration of sexual problems

1. Please estimate:
   What percentage of your patients do you *actively* ask about sexual problems?
   Estimate in %: _____

---

2. In which cases do you think you should *actively* ask patients about sexual problems?
   _____
   _____
   _____
   _____

---

3. Do you ask your patients about how important sexuality is for them?
   ☐ Yes ☐ No

---

4. When you *actively* ask about sexual problems, do you take any special approach?
   _____
   _____
   _____
   _____

---

5. Do you rely on any typical initial questions?
   _____
   _____
   _____
   _____

---

6. Are there any cases in which you avoid *actively* asking your patients about sexual problems?
   _____
   _____
   _____
   _____

---

7. Does your *actively* asking about sexual problems depend on the age of the patient?
   ☐ Yes ☐ No

   If yes—with which age group do you actively ask about sexual problems, and with which age group do you not?

   _____
   _____

---

8. How easy is it for you to *actively* ask your patients about sexual problems?
   Please rate yourself somewhere between 0 (absolutely no problem for me) and 100 (this is a big problem for me)
   Rating: _____

ORGANIC DISEASE → SEXUAL DYSFUNCTION?

9. Which organic diseases prompt you to *actively* ask about sexual problems?

   _____
   _____
   _____
   _____

   → *specify for each disease*
   Organic disease 1: _____

   How often do you ask about sexual problems in connection with organic disease 1?
   ☐ always
   ☐ mostly
   ☐ sometimes
   ☐ rarely

   Which sexual problems do you ask about in connection with organic disease 1?
   ☐ Hypoactive sexual desire disorder
   ☐ Hypersexual desire disorder
   ☐ Sexual aversion disorder
   ☐ Erectile dysfunction
   ☐ Male orgasmic disorder (delayed/absent ejaculation)
   ☐ Premature ejaculation
   ☐ Dyspareunia
   ☐ Sexual dysfunction due to a general medical condition
   ☐ Substance-induced sexual dysfunction
   Organic disease 2: _____

   How often do you ask about sexual problems in connection with organic disease 2?
   ☐ always
   ☐ mostly
   ☐ sometimes
   ☐ rarely

   Which sexual problems do you ask about in connection with organic disease 2?
   ☐ Hypoactive sexual desire disorder
   ☐ Hypersexual desire disorder
   ☐ Sexual aversion disorder
   ☐ Erectile dysfunction
   ☐ Male orgasmic disorder (delayed/absent ejaculation)
   ☐ Premature ejaculation
   ☐ Dyspareunia

☐ Sexual dysfunction due to a general medical condition
☐ Substance-induced sexual dysfunction
Organic disease 3: _____

How often do you ask about sexual problems in connection with organic disease 3?
☐ always
☐ mostly
☐ sometimes
☐ rarely

Which sexual problems do you ask about in connection with organic disease 3?
☐ Hypoactive sexual desire disorder
☐ Hypersexual desire disorder
☐ Sexual aversion disorder
☐ Erectile dysfunction
☐ Male orgasmic disorder (delayed/absent ejaculation)
☐ Premature ejaculation
☐ Dyspareunia
☐ Sexual dysfunction due to a general medical condition
☐ Substance-induced sexual dysfunction
Organic disease 4: _____

How often do you ask about sexual problems in connection with organic disease 4?
☐ always
☐ mostly
☐ sometimes
☐ rarely

Which sexual problems do you ask about in connection with organic disease 4?
☐ Hypoactive sexual desire disorder
☐ Hypersexual desire disorder
☐ Sexual aversion disorder
☐ Erectile dysfunction
☐ Male orgasmic disorder (delayed/absent ejaculation)
☐ Premature ejaculation
☐ Dyspareunia
☐ Sexual dysfunction due to a general medical condition
☐ Substance-induced sexual dysfunction

ENDOCRINE DISEASE → SEXUAL DYSFUNCTION?

10. Which endocrine diseases prompt you to *actively* ask about sexual problems?

_____
_____
_____
_____

→ *specify for each disease*
Endocrine disease 1: _____

How often do you ask about sexual problems in connection with endocrine disease 1?
☐ always
☐ mostly
☐ sometimes
☐ rarely

Which sexual problems do you ask about in connection with endocrine disease 1?
☐ Hypoactive sexual desire disorder
☐ Hypersexual desire disorder
☐ Sexual aversion disorder
☐ Erectile dysfunction
☐ Male orgasmic disorder (delayed/absent ejaculation)
☐ Premature ejaculation
☐ Dyspareunia
☐ Sexual dysfunction due to a general medical condition
☐ Substance-induced sexual dysfunction
Endocrine disease 2: _____

How often do you ask about sexual problems in connection with endocrine disease 2?
☐ always
☐ mostly
☐ sometimes
☐ rarely

Which sexual problems do you ask about in connection with endocrine disease 2?
☐ Hypoactive sexual desire disorder
☐ Hypersexual desire disorder
☐ Sexual aversion disorder
☐ Erectile dysfunction
☐ Male orgasmic disorder (delayed/absent ejaculation)
☐ Premature ejaculation
☐ Dyspareunia
☐ Sexual dysfunction due to a general medical condition
☐ Substance-induced sexual dysfunction
Endocrine disease 3: _____

How often do you ask about sexual problems in connection with endocrine disease 3?
☐ always
☐ mostly
☐ sometimes
☐ rarely

Which sexual problems do you ask about in connection with endocrine disease 3?
☐ Hypoactive sexual desire disorder
☐ Hypersexual desire disorder
☐ Sexual aversion disorder
☐ Erectile dysfunction
☐ Male orgasmic disorder (delayed/absent ejaculation)
☐ Premature ejaculation
☐ Dyspareunia
☐ Sexual dysfunction due to a general medical condition
☐ Substance-induced sexual dysfunction
Endocrine disease 4: _____

How often do you ask about sexual problems in connection with endocrine disease 4?
☐ always
☐ mostly
☐ sometimes
☐ rarely

Which sexual problems do you ask about in connection with endocrine disease 4?
☐ Hypoactive sexual desire disorder
☐ Hypersexual desire disorder
☐ Sexual aversion disorder
☐ Erectile dysfunction
☐ Male orgasmic disorder (delayed/absent ejaculation)
☐ Premature ejaculation
☐ Dyspareunia
☐ Sexual dysfunction due to a general medical condition
☐ Substance-induced sexual dysfunction

MENTAL HEALTH PROBLEMS → SEXUAL DYSFUNCTION?

11. Which mental health problems prompt you to *actively* ask about sexual problems?

_____
_____
_____
_____

→ *specify for each disease*
Mental health problem 1: _____

How often do you ask about sexual problems in connection with mental health problem 1?
☐ always
☐ mostly
☐ sometimes
☐ rarely

Which sexual problems do you ask about in connection with mental health problem 1?
☐ Hypoactive sexual desire disorder
☐ Hypersexual desire disorder
☐ Sexual aversion disorder
☐ Erectile dysfunction
☐ Male orgasmic disorder (delayed/absent ejaculation)
☐ Premature ejaculation
☐ Dyspareunia
☐ Sexual dysfunction due to a general medical condition
☐ Substance-induced sexual dysfunction
Mental health problem 2: _____

How often do you ask about sexual problems in connection with mental health problem 2?
☐ always
☐ mostly
☐ sometimes
☐ rarely

Which sexual problems do you ask about in connection with mental health problem 2?
☐ Hypoactive sexual desire disorder
☐ Hypersexual desire disorder
☐ Sexual aversion disorder
☐ Erectile dysfunction
☐ Male orgasmic disorder (delayed/absent ejaculation)
☐ Premature ejaculation
☐ Dyspareunia
☐ Sexual dysfunction due to a general medical condition
☐ Substance-induced sexual dysfunction
Mental health problem 3: _____

How often do you ask about sexual problems in connection with mental health problem 3?
☐ always
☐ mostly
☐ sometimes
☐ rarely

Which sexual problems do you ask about in connection with mental health problem 3?
☐ Hypoactive sexual desire disorder
☐ Hypersexual desire disorder
☐ Sexual aversion disorder
☐ Erectile dysfunction
☐ Male orgasmic disorder (delayed/absent ejaculation)
☐ Premature ejaculation
☐ Dyspareunia
☐ Sexual dysfunction due to a general medical condition
☐ Substance-induced sexual dysfunction

Mental health problem 4: _____

How often do you ask about sexual problems in connection with mental health problem 4?
☐ always
☐ mostly
☐ sometimes
☐ rarely

Which sexual problems do you ask about in connection with mental health problem 4?
☐ Hypoactive sexual desire disorder
☐ Hypersexual desire disorder
☐ Sexual aversion disorder
☐ Erectile dysfunction
☐ Male orgasmic disorder (delayed/absent ejaculation)
☐ Premature ejaculation
☐ Dyspareunia
☐ Sexual dysfunction due to a general medical condition
☐ Substance-induced sexual dysfunction

PHARMACEUTICALS, ALCOHOL, DRUGS → SEXUAL DYSFUNCTION?

12. Which pharmaceuticals do you think have side-effects on sexuality?

Antihypertensives/diuretics	☐
Antiarrhythmics	☐
Psychotropics	☐
Anticholesterics	☐
Cortisone	☐
Antidiabetics	☐
Agents against prostate diseases	☐
Antiandrogens	☐
Steroids	☐
I don't know of any	☐

---

13. If you prescribe pharmaceuticals to your patient, do you *actively* ask about possible side-effects on sexuality?
☐ always
☐ mostly
☐ never

---

14. If you know or assume your patient has an alcohol addiction, do you ask about sexual problems?
    - ☐ always
    - ☐ mostly
    - ☐ never

---

15. If you know or assume your patient has a drug addiction, do you ask about sexual problems?
    - ☐ always
    - ☐ mostly
    - ☐ never

ACTIVE ADDRESSING OF SEXUAL PROBLEM BY PATIENT

16. Please estimate:
    What percentage of your patients *actively* address a sexual problem during consultation?
    Estimate in %: _____

---

17. Which sexual problems do your patients *actively* address?
    - ☐ Hypoactive sexual desire disorder
    - ☐ Hypersexual desire disorder
    - ☐ Sexual aversion disorder
    - ☐ Erectile dysfunction
    - ☐ Male orgasmic disorder (delayed/absent ejaculation)
    - ☐ Premature ejaculation
    - ☐ Dyspareunia
    - ☐ Sexual dysfunction due to a general medical condition
    - ☐ Substance-induced sexual dysfunction

---

18. How easy is it for you to discuss sexual problems if your patient addresses this issue?
    Please rate yourself somewhere between 0 (absolutely no problem for me) and 100 (this is a big problem for me)
    Rating: _____

SEXUAL HISTORY TAKING

The following questions apply in cases in which a sexual problem has been identified and more accurate sexual history taking is therefore done.

PHYSICIAN'S APPROACH

19. How do you conduct sexual history taking?
    - ☐ open conversation
    - ☐ questionnaire
    - ☐ structured interview

    _____
    _____
    _____

    Which of the above-mentioned approaches do you apply most frequently?

    _____
    _____
    _____

ICD-10/DSM-IV SPECIFICATION

20. When taking a patient's sexual history, do you explore whether the problem in question has been a lifelong or an acquired sexual problem?
    - ☐ always
    - ☐ depends on patient, e.g. _____
    - ☐ never

---

21. When taking a patient's sexual history, do you explore whether the problem in question is a generalized or situation-specific sexual problem?
    - ☐ always
    - ☐ depends on patient, e.g. _____
    - ☐ never

SPECIFIC BEHAVIOURAL PATTERN

22. When taking a patient's sexual history, how accurately do you explore the sexual interaction itself, e.g. by letting the patient describe a typical episode of sexual interaction?
    - ☐ always
    - ☐ depends on patient, e.g. _____
    - ☐ never

CONCEPT OF LOVE, SEXUALITY, FIDELITY

23. When taking a patient's sexual history, do you explore what the patient's concept of love is?
    - ☐ always
    - ☐ depends on patient, e.g. _____
    - ☐ never

---

24. When taking a patient's sexual history, do you explore what the patient's concept of sexuality is (lust, relationship, procreation)?
    - ☐ always
    - ☐ depends on patient, e.g. _____
    - ☐ never

---

25. When taking a patient's sexual history, do you explore the patient's attitudes towards fidelity/infidelity?
    - ☐ always
    - ☐ depends on patient, e.g. _____
    - ☐ never

TARGET STATE WITHOUT SEXUAL PROBLEM

26. When taking a patient's sexual history, do you explore the patient's idea of a sexual life without sexual problems (target state)?
    - ☐ always
    - ☐ depends on patient, e.g. _____
    - ☐ never

SEXUAL ORIENTATION

27. When taking a patient's sexual history, do you explore the patient's sexual orientation?
    - ☐ always
    - ☐ depends on patient, e.g. _____
    - ☐ never

CONTRACEPTION

28. When taking a patient's sexual history, do you explore whether the patient (or his partner) uses contraception?
    - ☐ always
    - ☐ depends on patient, e.g. _____
    - ☐ never

PARTNER WITH SEXUAL PROBLEMS DESIRE FOR CHILDREN

29. When taking a patient's sexual history, do you explore the possibility that the patient's sexual partner has a sexual problem?
    - ☐ always
    - ☐ depends on patient, e.g. _____
    - ☐ never

---

30. When taking a patient's sexual history, do you explore whether the patient (or his partner) has an unfulfilled desire for children?
    - ☐ always
    - ☐ depends on patient, e.g. _____
    - ☐ never

SEXUAL ANXIETY AND PRESSURE TO PERFORM

31. When taking a patient's sexual history, do you explore whether the patient suffers from any form of sexual anxiety (e.g. fear of not coping, fear of pregnancy, fear resulting from sexual trauma)?
    - ☐ always
    - ☐ depends on patient, e.g. _____
    - ☐ never

---

32. When taking a patient's sexual history, do you explore whether the patient feels under pressure to perform during sexual interaction?
    - ☐ always
    - ☐ depends on patient, e.g. _____
    - ☐ never

SEXUAL BIOGRAPHY OF PATIENT

33. When taking a patient's sexual history, do you explore how experienced the patient is sexually (number of sexual partners, techniques etc.)?
    - ☐ always
    - ☐ depends on patient, e.g. _____
    - ☐ never

---

34. When taking a patient's sexual history, do you explore how satisfied the patient is sexually?
    ☐ always
    ☐ depends on patient, e.g. _____
    ☐ never

---

35. When taking a patient's sexual history, do you explore whether the patient masturbates when alone?
    ☐ always
    ☐ depends on patient, e.g. _____
    ☐ never

---

36. When taking a patient's sexual history, do you explore whether the patient consumes pornography (DVD, Internet, magazines)?
    ☐ always
    ☐ depends on patient, e.g. _____
    ☐ never

AETIOPATHOGENESIS OF SEXUAL DYSFUNCTIONS

SEXUAL DYSFUNCTION → ORGANIC DISEASES?

37. When taking a patient's sexual history, do you explore whether the patient suffers from any organic diseases?
    ☐ Yes ☐ No
    If yes—which one(s)?
    _____
    _____
    _____
    _____

SEXUAL DYSFUNCTION → ENDOCRINE DISEASES?

38. When taking a patient's sexual history, do you explore whether the patient suffers from any endocrine diseases?
    ☐ Yes ☐ No
    If yes—which one(s)?
    _____
    _____
    _____
    _____

SEXUAL DYSFUNCTION → MENTAL HEALTH PROBLEMS?

39. When taking a patient's sexual history, do you explore whether the patient suffers from any mental health problems?
    ☐ Yes ☐ No
    If yes—which one(s)?
    _____
    _____
    _____
    _____

SEXUAL DYSFUNCTION → PHARMACEUTICALS, ALCOHOL, DRUGS?

40. When taking a patient's sexual history, do you explore whether the patient consumes any substances which might potentially cause the sexual dysfunction in question?
☐ Yes ☐ No
If yes—which one(s)?
_____
_____
_____
_____

SEXUAL DYSFUNCTION → PSYCHOSOCIAL FACTORS?

41. When taking a patient's sexual history, do you explore the following issues?

Psychological condition
☐ always
☐ depends on patient, e.g. _____
☐ never

Problems with parents, children, relatives
☐ always
☐ depends on patient, e.g. _____
☐ never

Problems with surroundings (e.g. neighbours)
☐ always
☐ depends on patient, e.g. _____
☐ never

Problems at work or school/university
☐ always
☐ depends on patient, e.g. _____
☐ never

Housing problem
☐ always
☐ depends on patient, e.g. _____
☐ never

Money problems
☐ always
☐ depends on patient, e.g. _____
☐ never

Legal problems
☐ always
☐ depends on patient, e.g. _____
☐ never

Other psychosocial problems such as social or cultural background (e.g. immigrants)
☐ always
☐ depends on patient, e.g. _____
☐ never

DIAGNOSIS

42. I base the diagnosis of sexual dysfunctions on. . . .
    - ☐ ICD-10
    - ☐ DSM-IV
    - ☐ own diagnostic criteria

AMOUNT OF TIME/DIFFERENT PROCEDURES

43. How much time do you invest in taking the sexual histories of patients (in minutes per consultation)?

---

44. Do you use different procedures in your sexual history taking (e.g. short vs. extended version)?

CLARIFICATION

45. Which of the following measures do you employ to clarify the patient's sexual problem?
    - ☐ physical examination
    - ☐ laboratory tests
    - ☐ check-up by another specialist
    - ☐ other (please specify)

THERAPY

46. What does your therapy of ***hypoactive sexual desire disorder*** consist of?
    - ☐ I prescribe pharmaceuticals
    - ☐ I try to find a solution with him by talking about the sexual problem
    - ☐ I involve his partner
    - ☐ I refer him to another specialist

---

47. What does your therapy of ***erectile dysfunction*** consist of?
☐ I prescribe pharmaceuticals
_____
_____
☐ I try to find a solution with him by talking about the sexual problem
_____
_____
☐ I involve his partner
_____
_____
☐ I refer him to another specialist
_____
_____

48. What does your therapy of ***premature ejaculation*** consist of?
☐ I prescribe pharmaceuticals
_____
_____
☐ I try to find a solution with him by talking about the sexual problem
_____
_____
☐ I involve his partner
_____
_____
☐ I refer him to another specialist
_____
_____

49. What does your therapy of ***male orgasmic disorder*** (delayed/absent ejaculation) consist of?
☐ I prescribe pharmaceuticals
_____
_____
☐ I try to find a solution with him by talking about the sexual problem
_____
_____
☐ I involve his partner
_____
_____
☐ I refer him to another specialist
_____
_____

INEFFECTIVE THERAPY

50. How do you handle a patient whose sexual problem could not be resolved or could only be partially resolved?
_____
_____
_____

COMPETENCE

51. How do you rate your competence in ***discussing*** sexual problems with your male patients?
    - ☐ very good
    - ☐ good
    - ☐ moderate
    - ☐ sufficient
    - ☐ insufficient

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52. How do you rate your competence in *treating* male sexual problems?
    - ☐ very good
    - ☐ good
    - ☐ moderate
    - ☐ sufficient
    - ☐ insufficient

FURTHER EDUCATION

53. Do you have a need for continuing education regarding sexuality issues?
    ☐ Yes ☐ No

    If yes—what should this education consist of?

    _____
    _____
    _____

    If no—by whom and how is this education already covered?

    _____
    _____
    _____

THANK YOU VERY MUCH FOR YOUR PARTICIPATION