

## DEALING WITH SEXUAL ISSUES IN WOMEN

**Introduction:** Physicians who deal with women, whether family practitioners or Ob-Gyns, often hesitate to bring up sexual issues with patients. However, studies in specific groups of patients such as diabetics and cancer patients have shown that patients not only want to talk about sexual issues, but also expect physicians to bring up the subject. Physicians are often uncomfortable with these issues for various reasons that will be discussed below. Physicians who do talk about sexual issues with patients tend to discuss these issues more frequently with men than with women, and with younger than with older patients. Studies have indicated, however, that there is no age group above which sexual concerns are not important.

Taking a sexual history benefits not only the patient but also the physician. In one study involving general internists, taking a sexual history yielded information of medical importance in 26% of cases, and affected treatment and follow-up plans in 16%. Similar studies have not been undertaken in the gynecological population but one might speculate that based on the nature of gynecological practice, these figures would be even higher in the gynecological population. For that reason alone, taking a sexual history should be viewed as an essential component of female medical care.

### **Obstacles to routine sexual history-taking:**

- 1) Physician discomfort with the subject. There are several reasons for this. Physicians sometimes worry that patients will misconstrue the questioning. However, studies have shown that patients expect and want their doctor to ask. It is important, of course, to ask at the appropriate time i.e. during the history-taking and not in the course of the pelvic examination.  
One study involving gynecology nurses found that virtually all the nurses were comfortable discussing sexuality if the patient brought up the issue, but only half were comfortable bringing up the topic themselves. While similar studies have yet to be conducted with physicians, there is no reason to suspect that the proportions would be different. Unfortunately, there is only one way to become comfortable discussing sexual issues and that is to do it regularly.
- 2) Perceived lack of time. With some studies showing that half the population has sexual issues at any given time, physicians worry that asking everyone about sexual issues will slow down their office pace considerably. However, asking about sexual issues saves time in the long run since the underlying issues are dealt with. Each physician can decide for him/herself to what depth he or she wants to deal with sexual concerns and can develop a list of resources (see below).
- 3) Perceived lack of expertise. However, one doesn't have to be a psychologist to deal with sexual dysfunction. As a physician, one should be able to rule out and treat physiological causes. In addition, one should be able to assess psychological factors at least to the extent of being able to refer appropriately.
- 4) The fact that there is usually "no quick fix". Male sexual dysfunction is **perceived** to be simpler to diagnose and treat. (This is not necessarily true.) Female sexual dysfunction is often multi-determined. The good news is that you usually don't have to resolve all the components in order to effect improvement; a change in one area may lead to a situation that is, not perfect, but at least "good enough".

**Classification of female sexual dysfunction:**

There is still a lot we don't know about female sexual function. While there has been a marked resurgence in research interest in the past few years, we are still at the stage of studying rats and rabbits. One might argue that we really shouldn't even have been classifying female sexual dysfunction into distinct categories. The old Masters and Johnson model is in the process of being replaced by a new model that emphasizes the responsive nature of female sexuality. (see Rosemary Basson's article in the May 2000 SOGC Journal). However Masters and Johnson's model, as modified by Helen Kaplan, is still helpful in categorizing and ruling out physiological causes of sexual dysfunction. This model divides sexual response into 3 phases: desire, arousal and orgasm.

Dysfunctions of the desire phase (as defined in the DSM-IV) include hypoactive sexual desire, and sexual aversion disorder. Dysfunctions of the arousal phase include female sexual arousal disorder as well as dyspareunia and vaginismus. Orgasm phase disorders include female orgasmic disorder. In addition, there are the dysfunctions due to general medical conditions and substance-induced dysfunctions.

**Screening for sexual dysfunction:**

Screening for sexual dysfunction should be considered part of the routine history and physical. This can be done during the review of systems (when discussing contraception, STD's, etc.) and the patient told that this is something you ask everyone. The exact words used will vary from practitioner to practitioner; most people eventually find a phrase that they are comfortable with. Examples include: "Do you have any sexual concerns that you would like to discuss?" "Do you ever have pain with intercourse? Do you have any difficulties getting aroused or having an orgasm?"

In specific situations, more detailed questions can be asked. For example:

"One of the possible effects of multiple sclerosis is that it can be harder to have an orgasm? Has this been the case for you?"

"Sometimes, but by no means always, people on drug x note changes in their sexual functioning. Has this happened to you?"

"Women in perimenopause sometimes notice that their sex drive changes; have you noticed anything along those lines?"

"Sometimes after menopause women notice that vaginal dryness makes intercourse uncomfortable. Has this been a problem for you?"

In a new patient, one would also want to ask about a history of sexual trauma. Again, one can explain that this is a routine question so that the patient doesn't think that the fact she has been abused is written on her forehead for all the world to see. "This is a question I ask all my patients. Have you ever had any unpleasant sexual experiences? For example, have you ever been molested or fondled as a child? Have you ever experienced date rape or otherwise been forced to have sex against your wishes?" The exact words used matter less than the tone used which should convey that this is a topic she can talk about with

her doctor. If a history of abuse is disclosed, then ascertain whether or not the patient has dealt with the situation or should be referred for counselling.

A screening sexual history is also a good opportunity to practice preventive medicine. For example, asking post-partum patients at their six-week visit about dyspareunia and explaining what is normal and what isn't can prevent long-term vaginismus. Sexual dysfunctions are much more easily treated, either by oneself or by a therapist, when they are of short duration than after years of problems where physical causes and psychological overlay are so entwined that it is difficult to disentangle the various threads of the situation.

### **History-taking when the presenting complaint is sexual dysfunction:**

It helps to remember that in many ways a sexual problem is no different from any other medical problem and that the line of questioning follows the same principles:

- 1) Clarification of the problem. Can you tell me more about that?
- 2) How long has the problem been present? Is it primary (lifelong) or secondary (following a period of "normal" sexual functioning)? If secondary, what else was going on in her life at the time?
- 3) Is it present in all situations (global) or only in certain situations (situational)?
- 4) How has it changed over time? Has it gotten better, worse, or stayed the same?
- 5) If the problem is dyspareunia, then the same line of questioning should be followed as one does for any pain, including exact location, when it comes on and when it leaves, radiation, aggravating and alleviating factors, etc.
- 6) Is there anything that makes the situation better? For example, does her libido improve when on holidays? Anything make it worse? For example, is there any relationship to timing in the menstrual cycle, or to a specific life event such as a new job or the death of a parent?
- 7) How is this affecting her relationship? Are they still sexually active, perhaps in noncoital ways, or have they ceased sexual activity altogether? Do they still show physical affection or does she avoid this for fear it may lead to sex? What is her partner's reaction to the situation?
- 8) If the problem has been going on for a long time, it is important to ask what made her decide that now is the time to do something about it. (Has her partner threatened to leave? Is she very uncomfortable discussing sexual matters and has only come because the situation has finally reached a point where she and/or the partner find it intolerable?)
- 9) A general medical history and review of systems is important, particularly in a new patient.
- 10) Does the partner have any sexual difficulties?
- 11) What are her and her partner's thoughts on possible causes for the problem? What have they tried?
- 12) Has she seen anyone else about this and if so, what was suggested and what was the outcome?

It is not unusual for a woman to present with problems in more than one component of the sexual response cycle. In that case, it is crucial to determine what came first. For example, is she not interested in sex because it hurts or does it hurt because she is not interested and so does not lubricate?

## **Management of Female Sexual Dysfunction – Dyspareunia**

The management of dyspareunia is to treat the underlying cause. Table 1 outlines some of the more common causes of dyspareunia. The management of vaginismus involves having the woman learn to control her pelvic floor muscles. It is important to remember, and to stress to the patient, that she is not “too small” and does not need to “stretch” anything. She needs to learn to control the involuntary muscle spasm that occurs when she attempts to insert an object (tampon, speculum, penis) in her vagina. There are several variations on the way to do this. Basically, the woman does Kegel exercises to learn which muscles she need to work on, then practices these exercises using either her fingers or other objects of increasing diameter in her vagina. Some patients, particularly those who also have low back problems, do well with pelvic floor physiotherapy. The details of the treatment of vaginismus are beyond the scope of this article; see the references at the end. The SOGC public education committee has developed a pamphlet on vaginismus for patients that describes a set of suggested exercises in detail.

## **Management of Anorgasmia**

In primary anorgasmia, the woman usually has not learned the type and duration of stimulation that she requires. There are several good books (see Resources) that can help her do this. Almost all such books start with the premise that it is easier for her to learn to do this initially on her own. She can then teach her partner what she has learned. Women of certain religious faiths may feel that masturbation is wrong. Some may believe it is acceptable as a temporary measure if the long-term goal is improving their marriage, but others may find it unacceptable under any circumstances. In these cases, books written specifically for that particular group or referral to a sympathetic therapist who will work with the couple may help.

The treatment of secondary anorgasmia depends on the underlying cause. If the problem is SSRIs, possible things to try include changing the medication, giving something that will temporarily reverse the effect (drugs that have been tried include amantadine, cyproheptadine, and sildenafil with varying results). If the secondary anorgasmia is due to nerve damage from, for example, multiple sclerosis or surgery, orgasms are usually possible but more difficult to attain. One way to get around this is to provide stronger stimulation i.e. by using a vibrator.

## **Management of low libido**

The first step in the management of low libido is to determine whether the woman truly has low libido or simply a different appetite than her partner. If she is interested at least every couple of weeks, then the problem is one of appetite differences and the partner may need to be brought in for a discussion. It makes no more sense to say in that case that she has a low libido problem than it would be to say that the partner’s libido is “too high”.

The second step is to rule out medical causes. These include hypo- or hyper-thyroidism, hyperprolactinemia, testosterone deficiency in menopausal women (recent research suggests that some pre-menopausal women may also suffer from testosterone deficiency, but this is not common in spite of what popular talk-shows suggest), depression, and fatigue from medical causes.

The most common reasons for low libido in women are tension-fatigue states and relationship difficulties. Women ARE different from men: men use sex to relax, while most women need to be relaxed in order to have sex. Men can have an argument with their partner and still feel like having sex afterwards; many women need time before they want to be close again. If the patient says that the relationship is fine, ask her how she and her partner work out disagreements; if they don't, resentment may be expressed in the bedroom. Ask her also if she knows what she likes sexually and if she is comfortable expressing her preferences to her partner. Some women assume that their partners should know what turns them; these women need to be encouraged to take responsibility for their own sexual pleasure.

Ask the woman to describe a typical day. If she doesn't stop from the moment she rises until she drops into bed exhausted at night, sex is probably just one more thing on her to-do list. Explain that she may need to plan for sex. Many people resist this idea, feeling that sex should be spontaneous. Unfortunately, in today's hectic world, if we don't plan for something, we often don't get around to it. The sexual component of a relationship is important enough that it deserves the same attention and care that we devote to other aspects of our lives.

If everything in the patient's life and relationship is such that there are no obstacles to libido, there may be underlying intra- or inter-personal issues. These include unresolved family of origin issues, a history of sexual trauma, body image, sexual self-image, sex education or lack of, religious influences, and the partner's sexual issues. Some family physicians do counselling and are comfortable dealing with these issues; others, and the vast majority of gynecologists, would rather refer. It is helpful to have a list of people one can refer to (see resources). In many cases, discussion of the new sexual response cycle for women (SOGC Journal May 2000) and trying to identify with the patient "where the break in the cycle is" is very helpful.

**Things to avoid:**

1. Getting into a discussion of what's "normal" and what isn't, particularly regarding such issues as "normal" frequency of intercourse. What matters is what the two partners would like or are comfortable with.
2. Taking one's personal experience as the gold standard.
3. Dismissing sexual concerns as unimportant, or saying that time will take care of it.
4. Seeing every sexual problem as having a psychological cause or, inversely, seeing everything as physical. The usual error is that we tend to see (and society in general tends to see) women's sexual problems as psychological or relationship related, while conceptualizing men's sexual problems as having a physical basis.
5. Not getting the partner's perspective.

**Human Resources:**

Human resources vary in different areas of the country. It is very helpful to develop a list of people you can refer to. In some cases, it may be necessary to discuss costs with patients; for example, many insurance plans cover therapy, but the therapist must be a Ph.D. psychologist. Some patients have physiotherapy coverage; others don't. The following people are worth making an effort to locate and to cultivate a referral relationship with:

- 1) Physiotherapist with training and expertise in treating vaginismus and other sexual dysfunctions related to the pelvic floor.
- 2) Gynecologist with a special interest in vulvar disorders
- 3) Neurologist with an interest in neurological disorders of the vulva
- 4) Mental health professional (psychiatrist, psychologist or MSW) with a special interest in dealing with victims of sexual abuse
- 5) Marriage/relationship therapist
- 6) Sex therapist. (Quebec is fortunate in having sexologists who have gone through a Master's degree in sexology; in Ontario, BESTCO members have gone through an assessment process.)
- 7) Local clinics that offer free or sliding-scale fees for relationship or personal therapy

**Patient Literature:**

For dyspareunia:

- 1) "A Woman's Guide to Overcoming Sexual Fear and Pain" by Goodwin and Agronin. New Harbinger Publications, Inc. (1997)
- 2) SOGC pamphlet: Vaginismus

For anorgasmia:

- 1) For Yourself: The Fulfillment of Female Sexuality\_by Lonnie Barbach
- 2) Becoming Orgasmic\_by Julia Heiman and J. LoPiccolo
- 3) SOGC pamphlet for patients: Anorgasmia

For low libido and sexual issues in general:

- 1) "For Each Other" by Lonnie Barbach
- 2) "For Women Only: A Revolutionary Guide to Overcoming Sexual dysfunction and Reclaiming your Life" by Jennifer Berman and Laura Berman
- 3) Woman's Experience of Sex by Sheila Kitzinger

For religious patients who hesitate to read a "secular" book that may offend their values:  
"The Gift of Sex" by Cliff and Joyce Penner.

These books are all very readable, and a physician would also learn a lot from them.

### **Literature Resources for Physicians:**

1. Sexual Pharmacology: Drugs that affect sexual function by Crenshaw and Goldberg. Norton and Co. 1996
2. Principles and Practice of Sex Therapy. Sandra Leiblum and Raymond Rosen, editors
3. Medical Aspects of Human Sexuality (journal for primary care physicians started November 2000) see [www.medicalsexuality.org](http://www.medicalsexuality.org) Recent(ongoing) series of articles on taking a sexual history.
4. Basson, R.: The Female Sexual Response Revisited. Journal SOGC May 2000; 22: 378-382.
5. Bourgeois-Law, G. Vaginismus: Eliminating the Pain. Canadian Journal of Diagnosis 16 (5) May, 1999. 129-134
6. The Canadian Journal of Human Sexuality, published quarterly by SIECAN
7. Barbach, Lonnie. Series of workbooks for anorgasmia, low libido, premature ejaculation and erectile dysfunction. 12 weeks of "exercises" based on sensate focus and cognitive-behavioral therapy.
8. Sex is Not a Natural Act and Other Essays. Lenore Tiefer Westview Press. 1995.
9. William Maurice's Sexual Medicine in Primary Care, Mosby, 1999,

TABLE 1

Possible Causes of Dyspareunia

- Vulvar: Imperforate hymen  
Chronic yeast vulvitis  
Vulvar vestibulitis  
Any vulvar skin condition (eczema, psoriasis, etc.)  
Poorly repaired episiotomy
- Vaginal: Lack of lubrication  
Infections such as chronic yeast vaginitis  
Vaginismus
- Pelvic: Bowel (constipation; proctitis)  
Bladder (interstitial cystitis)  
Pelvic varicosities  
Endometriosis  
Ovary in cul-de-sac  
Anything that causes tethering or fixation of the peritoneum
- Fear: History of sexual trauma  
Previous painful intercourse for whatever reason