Clinical Case Applicability
How to counsel your female patients about issues pertaining to sexuality and sexual health and incorporate it into every well-woman visit across the lifespan.

Learning Objectives
• How to start, continue, and follow up on conversations about sexual health and sexual history
• How to explain the physiology of the female sexual response
• Understand factors impacting sexual health
• How to define sexual dysfunction and changes from DSM IV to V

Importance of Sexual Health
• Sexual health is important to a woman’s overall health and well-being
• American College of Obstetricians and Gynecologists (ACOG) recommends that sexual health be incorporated into every well-woman visit across the lifespan
  – Sexual problems are common, and most women want providers to bring up the topic of sexuality during healthcare visits
• Discussion of sexual health can prevent unnecessary sexual health-related outcomes such as HIV and other STIs, unintended pregnancies, and sexual assaults and can uncover sexual problems, gynecologic and medical conditions, and sexual dysfunctions

Challenge Your Assumptions
• Your patient may be heterosexual, lesbian, bisexual, or sexually fluid
• Your patient may not be sexually active, or active with one or many partners
• Do not assume that all women are in stable, loving relationships, monogamous, using contraception if they are of reproductive age and sexually active, and are not being abused or coerced into sexual activity by their partner

Barriers to HCP/Patient Discussions
• HCP discomfort
  – Identify your comfort level and personal biases
  – Increase confidence through practice
• Fear that screening will take too long
  – Schedule visits specifically to discuss sexual health issues when a patient expresses a concern
  – Provide resources
• Misconceptions about treatment options
• Reluctance to refer

Communication Techniques
• Ask open-ended questions, e.g. “What sexual concerns would you like to talk about?”
  – Follow up with pointed, detailed questions if necessary
  – Follow a pattern of asking an open-ended question, educating, and then asking another question
Communication Techniques, cont’d.

- Speak in neutral and inclusive terms (non-judgmental)
  - E.g. use the term “partner” rather than “husband” or “boyfriend.”
- Non-reactive
- Body language and posture
- Effective use of silence
- Use patient’s vernacular
- Educate
- Confirm understanding

Physiology of the Female Sexual Response

1. William Masters and Virginia Johnson
   - Arousal and sexual desire proceed in a linear manner to plateau, orgasm, and resolution
   - Women can experience resolution without orgasm
   - Kaplan added concept of desire

2. Dr. Rosemary Basson, Centre for Sexual Medicine at Vancouver General Hospital
   - Circular model, incorporating emotional components
   - Female sexuality is multifactorial and heterogenous
   - Desire for sexual activity may be motivated by desire for emotional intimacy rather than sexual release
   - Reactive libido; arousal before desire

3. Multiple models and theories; there is no one accepted model

Factors Impacting Sexual Health (see table)

Definitions of Sexual Dysfunction (see table)

- Whether or not it causes “clinically significant distress in the individual”
  - Without distress, treatment may not be necessary
- Problem should be present ≥ 6 months to be diagnosed as a sexual dysfunction
  - Problem may be transient, though distressing

References (see listing)
### Factors Impacting Sexual Health

<table>
<thead>
<tr>
<th>Category</th>
<th>Examples</th>
</tr>
</thead>
<tbody>
<tr>
<td>Changes in anatomical/hormonal and neurobiological sexual function throughout the life cycle</td>
<td>Pregnancy, chronic disease, surgery, cancer, or menopause</td>
</tr>
<tr>
<td>Life transitions</td>
<td>Affairs, divorce, death of a partner, birth of children or infertility, remarriage, child-rearing</td>
</tr>
<tr>
<td>Chronic or acute illness and long-term disability</td>
<td>Dysmenorrhea, fibroids, endometriosis, vulvodynia, dyspareunia, hypoestrogenism (surgical or medical), polycystic ovary syndrome, vaginitis, incontinence, diabetes and metabolic syndrome, depression, cancer, multiple sclerosis, spinal cord injury</td>
</tr>
<tr>
<td>Medications</td>
<td>Antidepressants, hormonal agents (aromatase inhibitors, tamoxifen, oral contraceptives, GnRh agonists), anticholinergics, antifungals, antihistamines, opioids, sedatives, others</td>
</tr>
<tr>
<td>Sexually transmitted infections (STIs)</td>
<td>Chlamydia, gonorrhea, herpes, HPV, HIV, syphilis</td>
</tr>
<tr>
<td>Violence and trauma</td>
<td>Emotional, sexual, physical, intimate patient violence/abuse, trauma resulting in scarring or pelvic fracture, post-traumatic stress disorder (PTSD)</td>
</tr>
<tr>
<td>Stigmas and religious beliefs</td>
<td>Societal, cultural, gender, sexual orientation stigmas, religious beliefs prohibiting sex outside of marriage and same-sex marriage</td>
</tr>
<tr>
<td>Use of tobacco, drugs, and alcohol</td>
<td>Work, life/family, financial</td>
</tr>
<tr>
<td>Stress</td>
<td></td>
</tr>
<tr>
<td>Changes in sexual self-esteem: Poor body image/perception of self as a sexual being</td>
<td>Due to cancer or other disfiguring diseases/conditions</td>
</tr>
</tbody>
</table>
**DSM 5 Patterns of Female Sexual Dysfunction**

<table>
<thead>
<tr>
<th>Disorder</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Female Sexual Interest/Arousal Disorder (FSIAD)</td>
<td>Changes in anatomical/hormonal and neurobiological sexual function throughout the life cycle. Lack of, or significantly reduced, sexual interest/arousal as manifested by 3 of the following: • Absent/reduced interest in sexual activity • Absent/reduced sexual/erotic thoughts or fantasies • No/reduced initiation of sexual activity and unreceptive to partner’s attempts to initiate • Absent/reduce sexual excitement/pleasure during sexual activity in almost all or all (75%-100%) sexual encounters • Absent/reduced sexual interest/arousal in response to any internal or external sexual/erotic cues (written, verbal, visual) • Absent/reduced genital or nongenital sensations during sexual activity in almost all or all (75%-100%) sexual encounters</td>
</tr>
<tr>
<td>Female Orgasmic Disorder</td>
<td>Presence of either of the following on all or almost all (75%-100%) occasions of sexual activity: • Marked delay in, marked infrequency of, or absence of orgasm • Markedly reduced intensity of orgasmic sensations</td>
</tr>
<tr>
<td>Genito-Pelvic Pain/Penetration Disorder (GPPPD)</td>
<td>Persistent or recurrent difficulties with 1 or more of the following: • Vaginal penetration during intercourse • Marked vulvovaginal or pelvic pain during intercourse or penetration attempts • Marked fear or anxiety about vulvovaginal or pelvic pain in anticipation of, during, or as a result of vaginal penetration • Marked tensing or tightening of the pelvic floor muscles during attempted vaginal penetration</td>
</tr>
</tbody>
</table>

**DSM IV-TR Patterns of Female Sexual Dysfunction**

<table>
<thead>
<tr>
<th>Disorder</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sexual Desire Disorders</td>
<td>• Hypoactive sexual desire disorder (HSDD)</td>
</tr>
<tr>
<td>Sexual Arousal Disorders</td>
<td>• Female sexual arousal disorder</td>
</tr>
<tr>
<td>Orgasm Disorders</td>
<td>• Female orgasmic disorder</td>
</tr>
<tr>
<td>Pain Disorders</td>
<td>• Dyspareunia, vaginismus</td>
</tr>
</tbody>
</table>
References