Female Sexual Dysfunction in Primary Care:

When Is Referral to a Sex Therapist Indicated?

Carole Pasahow, DSW

Until recently, most women who had sexual concerns suffered in silence. As women's roles have evolved, however, so too have perceptions about the importance of a fulfilling sexual life. Furthermore, female sexual dysfunction (FSD) was neglected due to the lack of appropriate, available treatment compared with male sexual dysfunction. Today, FSD is recognized as a valid, treatable group of disorders. As multiple effective therapies for FSD have been developed, coupled with the pharmaceutical industry's ongoing race to produce agents to enhance female genital circulation, sexual health has become an essential component of women's medical care.

WOMEN'S SEXUAL CONCERNS AND THE EXAM ROOM

More women are now looking to their physicians for advice and guidance about improving their sexual experiences. However, many physicians are reluctant to engage in such discussions due to lack of knowledge, embarrassment, and/or time limitations. As a result, physicians may fail to address sexual function, and this important element of the patient's history is left undocumented.[1]

In such cases, there is the possibility of missing both the physical and the psychological aspects of sexual complaints. Thus, it is crucial for physicians to acquire the tools to diagnose and treat such problems—and to discern when referral to a sex therapist is indicated.

This article describes brief diagnostic and treatment interventions that physicians can utilize for FSD. In addition, the basic treatment approaches used by sex therapists will be discussed, with emphasis on indications for therapist referral.

DEFINITIONS

Female sexual dysfunction includes disorders of desire, arousal, and orgasm, as well as dyspareunia and vaginismus. Hypoactive sexual desire is defined as a persistent lack of desire for sexual activity and sexual fantasies. Female arousal disorder is a chronic inability to develop and maintain sexual excitement and genital lubrication. Orgasm disorder is a persistent delay or absence of orgasm following normal sexual excitement and stimulation. Finally, sexual pain disorders include dyspareunia, which is defined as recurrent complaints of genital pain associated with sexual intercourse. Vaginismus, a subset of pain disorder, is an involuntary contraction of the perineal muscles when vaginal penetration is attempted. In order to satisfy the *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition* criteria for FSD, the sexual problem must cause marked distress or interpersonal difficulty.[2]

SEXUAL HISTORY

Physicians can assume a proactive role in evaluating and sometimes treating these disorders. It is imperative that physicians become comfortable talking with their patients about these concerns. If physicians approach this information as a routine aspect of patient history, patients will be more likely to share their difficulties.[3]

The sexual history must be incorporated into the busy schedule of the modern office practice. Certain key questions can help to target common female sexual complaints, and can be integrated easily into the medical history (Table). This will provide the essential information for an initial assessment of the

Carole Pasahow, DSW, is a private practitioner in Fair Lawn, NJ. She may be contacted at cpasahow@yahoo.com.

TABLE. Brief Assessment of Female Sexual Function

- Have you experienced any difficulties in your sexual relationship with your partner?
- Are sexual difficulties creating any stress in your relationship?
- Do you desire more or less sexual activity than your partner?
- Have there been any changes in your sexual desire?
- When you have sex, does everything work properly? Are you lubricating? Are you aroused?
- Do you have orgasms with regularity?
- Are you experiencing any pain during intercourse?

patient's level of functioning in all phases of the sexual response cycle.

In addressing these issues, patients with FSD can be identified for further assessment. The physician should then try to establish onset (ie, lifelong versus acquired) and, for an acquired complaint, to ascertain a possible trigger or cause. It is also important to consider context (ie, generalized versus situational) to evaluate whether the FSD is limited to certain types of stimulation, situations, or partners, or is present in all circumstances. Finally, it is necessary to determine whether the etiology is medical, psychological, or both. It is particularly important to assess patients with FSD for depression and anxiety, as these emotional disorders frequently underline or accompany sexual dysfunction.

BRIEF INTERVENTIONS

All techniques for treating FSD involve patient encouragement and education about the physical and psychological components of sexual activity. It is important to recognize that FSD is almost always inextricably intertwined with "real life" psychosocial issues. Both patients and partners should be provided with information about anatomy, sexual function, and the body changes that normally accompany pregnancy and menopause. The physician should emphasize how stresses such as work and child care can adversely affect sexual activity, and explain the importance of relaxation and accommodation in creating a favorable environment for sexual encounters.

Desire Dysfunction

Patients should be encouraged to make "dates" for sexual activities. Such planning can help to create sexual anticipation, which in turn promotes sexual desire.

Arousal Dysfunction

Patients should be advised to try noncoital massage. Sensual massage without genital stimulation—where one partner provides stimulation while the other partner receives pleasure and gives feedback as to what feels good—can give couples a "model" for sexual activity. These exercises are aimed at promoting relaxation, enhancing communication, and heightening physical and sexual feelings. Couples can also use erotic materials such as videos and books to enhance stimulation and provide distraction from life stresses.[3]

Orgasmic Dysfunction

Many women complain not necessarily of anorgasmia, but rather that it takes them too long to reach orgasm—that it seems like too much work for them and their partners. The physician should explain the importance of direct clitoral stimulation by the patient or her partner. This can be provided orally, manually, and/or with a vibrator, with additional mental stimulation through the use of fantasy and sexual communication. The patient can also be instructed in the correct way to perform Kegel exercises, which can be used during intercourse to enhance orgasm.

Sexual Pain Disorders

Patients with dyspareunia and vaginismus must be evaluated carefully to eliminate any possible physical causes. After ruling out physical etiologies, the physician can recommend the use of vaginal lubricants (eg, Astroglide, Replens) and specific intercourse positions to decrease friction and minimize deep thrusting. Other helpful suggestions include using graduated vaginal dilators to desensitize the fear response to penetration and promote better muscle tone and accommodation; taking a warm bath before sexual activity; and using topical lidocaine or nonsteroidal anti-inflammatory drugs before intercourse.[4]

SEX THERAPY

If patients' sexual problems do not respond to these interventions and they are motivated to continue working on FSD, referral to a sex therapist can be helpful. In such cases, the physician and sex therapist should work together to provide the most effective treatment.

To make an appropriate referral, it is important for physicians to understand what sex therapy entails. All sex therapies have a common aim, which is to change self-defeating beliefs and attitudes. This may involve resolving underlying pathologies, as well as addressing psychological problems and

marital discord.[5] The therapist also provides education, corrects misconceptions, and teaches specific skills to reduce performance anxiety and enhance pleasure.

Indications for Referral to a Sex Therapist

Longstanding Dysfunction.—Regardless of the etiology, sexual problems that remain uncorrected for a long period of time often lead to anger, chronic performance anxiety, feelings of rejection, and sex-avoidance behaviors in both the patient and her partner.

Multiple Dysfunctions.—Patients often present with multiple sexual dysfunctions and difficulties in several areas of the sexual response cycle. This may begin with one type of sexual disorder that gradually "poisons" all sexual activity over time, so that it may be difficult to identify the initial cause.

Sexually Aversive Behavior.—The patient finds sexual contact repugnant, and actively avoids genital contact with a partner, constituting a phobic disorder.

Psychological Disorder/Marital Conflict.—Often there are complicating factors that make FSD more difficult to treat, such as unresolved childhood conflicts resulting in guilt and fear of losing control during a sexual encounter. Religious prohibitions about engaging in sexual activity may also interfere with sexual pleasure. Stress and conflict in the couple's relationship, as well as depression and anxiety (which may be primary or secondary causes of FSD), generally require the intervention of a sex therapist.

Current/Past Physical or Sexual Abuse.—In these cases, there may be mandatory reporting requirements, with intervention by social services and law enforcement. A sex therapist can help to provide psychological support, as well as work with the patient over the long term to resolve fears arising from sexual violence.[4]

Desire Dysfunctions.—These problems may be difficult to treat in the context of a busy office practice, and can represent a wide range of difficulties. When the etiology is physical—eg, lack of desire can be traced to the use of birth control medications, hormonal changes, antidepressants, antihypertensives, or heart medications—the disorder is readily amenable to treatment by a physician. Frequently, however, desire disorders have an underlying

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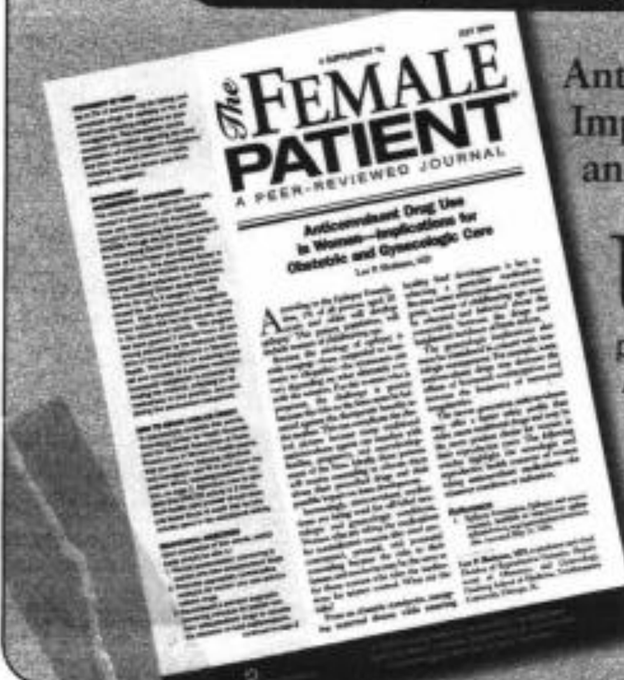
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Anticonvulsant Drug Use in Women: Implications for Obstetric and Gynecologic Care

Up to 5% of your patients may be taking anticonvulsant drugs for epilepsy or for off-label uses including migraine or pain management. As the record of a recent ACOG symposium, this newsletter covers the essential information regarding the next generation of anticonvulsant medications and their impact on women's health.

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psychological and/or marital component that requires considerable time to evaluate and treat. Discrepancies in sexual desire and frequency of sexual activity between partners can also benefit from intervention by a sex therapist.

Lack of Response to Physician Intervention.[4]—Patients who report no improvement in FSD after three or four physician visits should be referred to a sex therapist for more comprehensive evaluation and treatment.

If the physician determines that a sex therapist is required to treat a patient's sexual difficulties, the next step is to find a qualified professional. If the physician's health network does not include a therapist, the American Association of Sex Educators, Counselors, and Therapists can provide names of professionals in a given geographic area. This organization certifies sex therapists, and can be contacted by telephone at 804-644-3288 or via the Internet at http:// www.aasect.org.

CONCLUSION

In light of the changes in the US health care system, OB/GYNs and primary care physicians must be prepared to evaluate and treat FSD. This involves implementing strategies to obtain an adequate sexual history as part of the overall medical history, to assess for physical and psychological etiologies, to provide basic interventions, and to make referrals to a sex therapist when required. In many instances, patients' sexual complaints comprise both physical and psychological components. For these cases, the physician and sex therapist can work in tandem to ensure the best possible outcome.

Patient Information

Pasahow, C. *Sexy Encounters: 21 Days of Provocative Passion Fixes.* Avon, Mass: Adams Media Corporation, 2003. Web site: www.passion-fix.com.

REFERENCES

1. Krychman M, Shulman L. Sexual dysfunction: current issues. *The Female Patient.* 2001;26(11):4-7.
2. Diagnostic and Statistical Manual of Mental Disorders, ed IV. Washington, DC: The American Psychiatric Association; 1994:493 -518.
3. Pasahow, C. *Sexy Encounters: 21 Days of Provocative Passion Fixes.* Avon, Mass: Adams Media Corporation, 2003.
4. Phillips N. Female sexual dysfunction: evaluation and treatment. *Am Fam Physician.* 2000;62(1):127-136.
5. Foley S, Kope S, Sugrue D. *Sex Matters for Women.* New York: The Guilford Press; 2002:318.

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