

Just ask!

Talking to patients about sexual function

There's a simple way to overcome the obstacles to discussing sexual concerns with your patients: Simply ask. This helpful review of female sexual dysfunction focuses on lack of sexual desire after menopause, and tells how to make an accurate diagnosis and offer effective treatment and counseling.

Whether you are a parent or teenager, a patient or physician, talking about sex is usually associated with some level of discomfort. Most people simply are not aware that it is appropriate to discuss sexual concerns with their physician. At the same time, many physicians are reluctant to initiate these discussions with their patients. In a recent survey, only 14% of Americans aged 40 to 80 said they'd been asked by their physician about sexual difficulties within the past three years.¹

Why doctors don't talk about sex

A number of practical barriers get in the way of effective dialogue:

- **Lack of training.** Physicians who specialize in reproductive health "should have more in-depth training in human sexuality than the general practitioner," notes the World Health Organization.² Yet there are few standardized curriculum guides on sexuality, and precious little classroom time is spent on the topic: In a survey of North American medical schools, more than half dedicated fewer than 10 hours to training on human sexuality.³
- **Lack of comfort and confidence.** Most women who do seek help for sexual problems turn to an ob/gyn.⁴ Yet without specific training, physicians often do not feel they have the expertise to address patients' sexual concerns. One study found that health professionals who treat patients with ovarian cancer rarely discuss sexual issues, even though they are aware that these patients

are at increased risk for sexual problems.⁵ They cited their own embarrassment and lack of knowledge. Physicians may think, "Why bring up the subject if I am not confident that I'll be able to help?"

- **Perceived lack of time.** Busy office schedules can get in the way of frank, open-ended conversations about sexual function. Practitioners may not realize how much can be learned and accomplished with a few pertinent questions.

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KEY POINTS

- Only 14% of Americans aged 40–80 have been asked by their doctor about sexual difficulties within the past three years.
- In one survey, 68% of patients feared that raising concerns about sexual problems would embarrass their physician—71% believed the doctor would dismiss their concern.
- The most important step in starting a dialogue: Simply ask patients about their sexual activity and associated concerns.
- Women are more likely to bring up sexual matters if they have seen the physician before and if the physician seems concerned and comfortable or has a professional demeanor.
- Low sexual desire is the most prevalent female sexual dysfunction and is frequently associated with menopause. Persistent or recurrent low desire that causes personal distress is classified as hypoactive sexual desire disorder.
- If you suspect hormonal imbalance in a patient with hypoactive sexual desire disorder, consider estrogen and/or testosterone therapy.
- Offering brochures or books that address sex and marital problems helps to normalize a patient's concerns and provide education.

TABLE 1

Opportunities to screen for sexual dysfunction¹⁰

| | | | |
|---|--|--|---|
| Prior to surgery Uterine prolapse Hysterectomy Oophorectomy | Menopause-related visits Prior to discussing hormone therapy | Antenatal visits Postnatal visits Annual visits | Infertility Chronic illnesses Depression |
|---|--|--|---|

- **Lack of treatment options.** There are no FDA-approved pharmacologic therapies for female sexual dysfunction, and most physicians' comfort level with current treatment strategies is low.

In a survey of North American medical schools, more than half dedicated fewer than 10 hours to training on human sexuality.

Why patients don't talk about sex

Patients are not likely to bring up the subject of their sexuality, and very few women seek help or treatment for sexual concerns. In the American Association of Retired Persons/*Modern Maturity* Sexuality Study of 1,384 Americans aged 45 and older, only 14% of women reported ever seeking assistance from a health care professional for problems relat-

ed to sexual function.⁶ On the other hand, if a physician takes the lead in discussing sexuality, patients are more likely to report problems. In a study of patients receiving selective serotonin reuptake inhibitors, the incidence of sexual dysfunction was only 14% when based on spontaneous patient reports, compared with 55% when physicians posed direct questions.⁷

Patients' reluctance to discuss sex has much to do with the reaction they anticipate from their doctor. In a survey of Americans 25 and older, 68% of men and women said they feared that raising concerns about sexual problems would embarrass their physician—and 71% believed that the doctor would dismiss their concern.⁸ Women are more likely to bring up sexual concerns if they have seen the physician before and if the physician seems concerned and comfortable or has a professional demeanor.⁹ Patients thus seem to be looking to their physician for "permission" to bring up sexuality issues.

Getting the conversation started

Healthcare professionals should approach female sexual dysfunction much like any other disorder: First accurately assess whether or not a problem exists, then treat and/or refer.

Although women are at risk for sexual dysfunction throughout their life span, there are several key periods, including the menopause transition and beyond, that are associated with increased risk.¹⁰⁻¹¹ Office visits at these times provide an opportunity to screen for sexual concerns (Table 1).

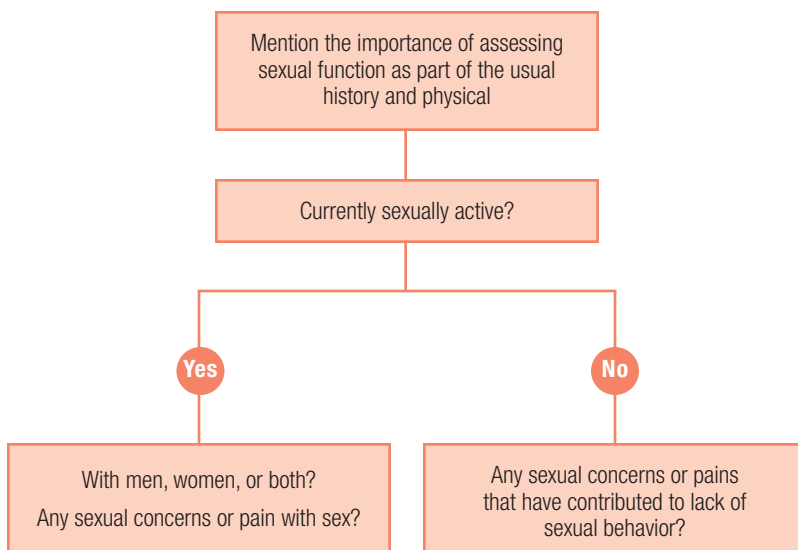
What is the best way to approach patients about sexuality and related concerns? Simply put, just ask them. Whether or not the patient offers information, physician-initiated questioning conveys concern and comfort and lets the patient know that it is appropriate to discuss these matters in an office setting.

An algorithm for screening sexual dysfunction is available (Figure 1), or the following questions can be used.^{10,12-13}

- Are you currently involved in a sexual relationship? With men, women, or both?
- How often do you engage in sexual activity?
- Do you have difficulty with desire, genital or subjective arousal, or orgasm?
- Are you satisfied with your current sexual relations?
- Do you have any sexual concerns you would like to discuss?

Physicians interested in conducting a

Figure 1. Screening for sexual dysfunction



more in-depth assessment may want to use the algorithm developed by Basson to help establish a diagnosis (Figure 2).¹⁰

Menopause, sexual issues, and loss of desire

Women who are menopausal, whether naturally or surgically, may have specific sexual concerns. Estrogen depletion causes physiologic changes, such as vaginal atrophy and dryness, that affect sexual function. A decrease in testosterone, which may lead to decreased sexual desire in women, occurs with aging and is further pronounced in women who undergo oophorectomy (See also “Women’s sexuality after menopause: What

role for androgens?” on page 204 of this issue.)

The following questions will help start a conversation with menopausal patients:

- Menopausal women often experience vaginal dryness that can make intercourse uncomfortable. Has this been a problem for you?
- Menopausal women sometimes experience changes in sexual desire. Have you noticed any changes in sexual desire?
- Since your ovaries were removed, have you experienced a meaningful loss in your desire for sex? Or a decrease in the frequency of your sexual activity?
- Are you concerned about or bothered by your current level of desire for sex?

Figure 2. Establishing a diagnosis of sexual dysfunction

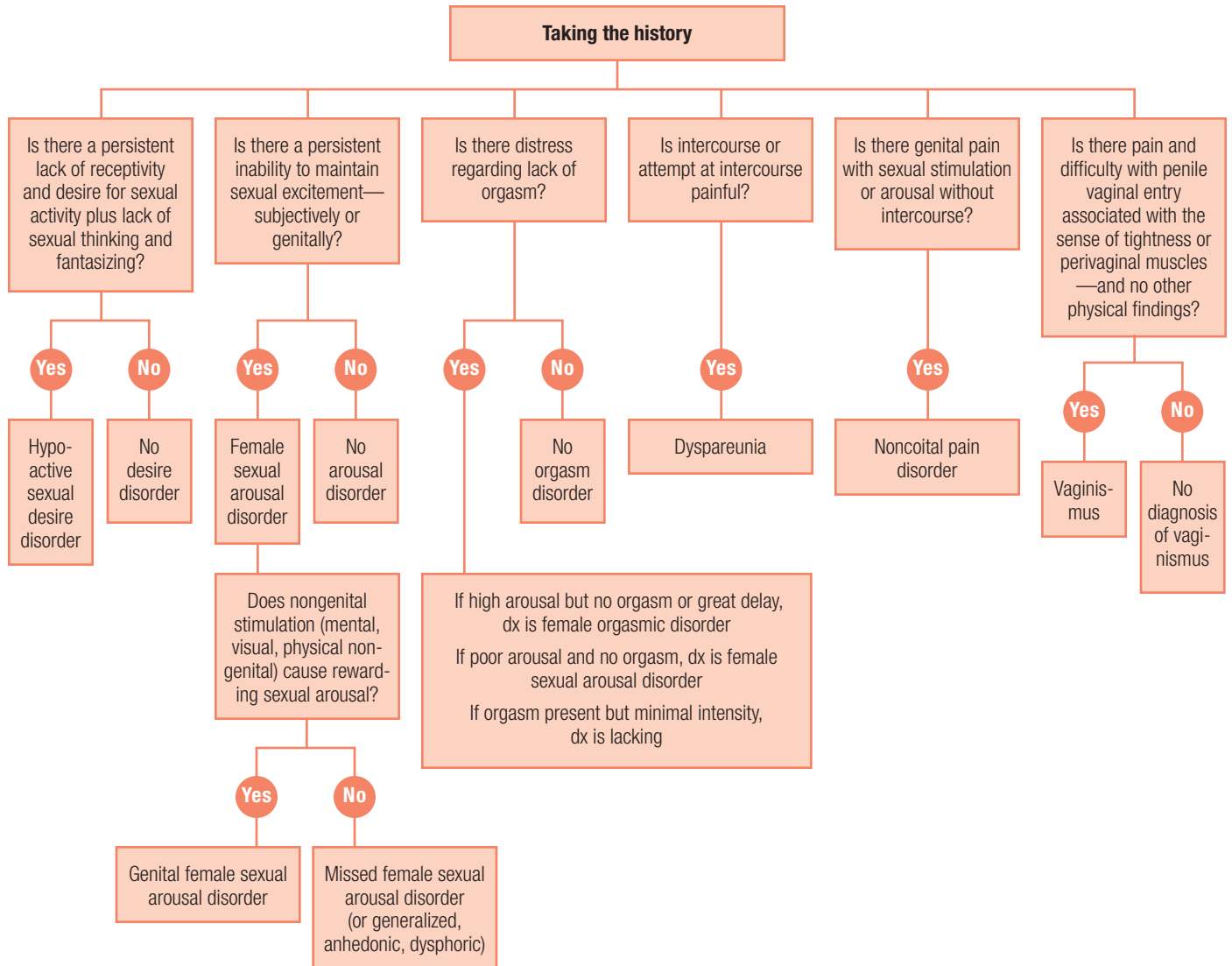


TABLE 2

Specialists for referral of patients with sexual dysfunctions¹⁰

- Sex therapist
- Mental health professional (psychologist, psychiatrist, marriage/relationship counselor)
- Neurologist
- Gynecologist/urologist specializing in sexual disorders

Persistent or recurrent low desire that causes personal distress is classified as hypoactive sexual desire disorder (HSDD). Low sexual desire is the most prevalent female sexual dysfunction and is frequently associated with menopause. The disorder is complex, involving biologic and psychosocial factors, and may overlap with other types of sexual dysfunction.

A careful evaluation of all potential factors is required to diagnose and treat HSDD. The following questions may help assess the impact of low desire:

- Describe your loss of desire in your own words.
- How long have you had concerns with respect to your desire?

Try to identify any medical conditions that could negatively affect sexual function.

These may include hyperprolactinemia, thyroid conditions, or depression.

- Is it always a problem, or only at certain times or in certain situations?
- Do you have sexual thoughts, daydreams, or fantasies?
- Has the problem changed over time? If so, how?
- Does anything appear to improve your desire (such as a romantic vacation or different partner)? Does anything make it worse?
- How is your emotional intimacy with your partner?

Complete medical and sexual histories should be taken when making a diagnosis of HSDD:

- Identify any medical conditions that could negatively affect sexual function. These may include hyperprolactinemia, thyroid condi-

tions, or depression. Although reproductive hormones may be involved, hormone assessments often are not indicative.

- Ask about any medications that could impair sexual function, such as selective serotonin reuptake inhibitors, estrogen therapies, and corticosteroids.
- Include in the sexual history first sexual experiences, number of lifetime partners, any sexually transmitted diseases, past history of sexual problems, reproductive history, and past sexual abuse or trauma.
- Consider interviewing the patient's partner to obtain important information on the quality of the relationship and any related issues that need to be addressed.¹⁴

Most screening tools for sexual dysfunction are lengthy and reserved for clinical research.¹⁵ Questionnaires such as the Female Sexual Function Index¹⁶ and the Arizona Sexual Experiences Scale for Women¹⁷ are available, and additional diagnostic tools for office-based screening are in development.

**Treatment options:
Estrogen and testosterone**

If you suspect hormonal imbalance in a patient with HSDD, consider estrogen and/or testosterone therapy. Systemic or local estrogen therapy can be used to treat problems associated with vaginal dryness but often does not affect a woman's loss of desire.¹⁸ The addition of testosterone to estrogen may increase sexual desire and activity and is well-tolerated, but currently there are no FDA-approved testosterone therapies for HSDD.¹⁹

Testosterone formulations, such as patches and lotions, are now in development for the treatment of female HSDD.²⁰⁻²¹ Meanwhile, testosterone products developed for men are sometimes used in women.

Remember the psychosocial aspects

Since many factors contribute to HSDD, psychosocial aspects must be addressed along with any medical interventions. Distinguishing biologic from relationship factors is essential for any physician assessing or treating sexual problems.

Treatments may be very different based on which components of desire are compromised. For example, a woman might have a very strong biologic drive to be sexual, but if she is not happy with her partner and has no motivation to be emotionally intimate, she

If a woman has lost some of her drive but is motivated to be close and intimate with her partner, this can compensate for the decreased biologic component of desire.

may not experience any perceived desire. On the other hand, if a woman has lost some of her drive but remains motivated to be close and intimate with her partner, this can compensate for the decreased biologic component of desire. These are important distinctions to make, because physicians can then normalize this reality for their patients who have come to believe that because their initial drive has diminished, they are no longer sexual beings.

In addition to openly discussing sexual health issues, offering brochures or books that address sex and marital problems helps to normalize concerns and provide education.²² Placing brochures in waiting rooms or exam rooms along with a “top 10” list of self-help sexuality books provides easy access for patients and makes their waiting time seem shorter.

Referrals: When and where?

The decision of when to refer a patient with sexual dysfunction depends on the physician's level of expertise and the complexity of the patient's dysfunction. Other considerations include the patient's own interest in receiving additional evaluation and the presence of sexual dysfunction in the partner.¹⁰

If available, a specialist can provide additional evaluation and management (Table 2).¹⁰ However, it is important for patients to recognize that treatment is a true collaboration among professionals. You don't want a patient to feel rejected or conclude that the problem “is all in my head.”

Psychosocial counseling often is useful even if the primary treatment is a medical intervention. Approaches include couples therapy, communication training, anxiety reduction, cognitive-behavioral interventions, or sex therapy (e.g., sensate focus).²³

But is there time?

The fear that treatment and counseling for sexual function disorders will take too much office time is not well founded, nor is it a valid reason to avoid the responsibility of managing patients' sexual health. A few brief questions allow the physician to quickly assess the gen-

eral nature of a sexual concern and determine:

- Can the concern be properly addressed within the office visit?
- Should the patient return for a separate appointment? or,
- Should the patient be referred to a specialist in treating sexual dysfunction? □

REFERENCES

1. The Pfizer Global Study of Sexual Attitudes and Behaviors. Available at: <http://www.pfizerglobalstudy.com/study/study-results.asp>.
2. World Health Organization. *The International Statistical Classification of Disease and Related Health Problems*. 10th rev. Geneva, Switzerland: World Health Organization, 1992.
3. Solursh DS, Ernst JL, Lewis RW, et al. The human sexuality education of physicians in North American medical schools. *Int J Impot Res* 2003;15 suppl 5:S41-S45.
4. Berman L, Berman J, Felder S, et al. Seeking help for sexual function complaints: what gynecologists need to know about the female patient's experience. *Fertil Steril* 2003;79:572-76.
5. Stead ML, Brown JM, Fallowfield L, Selby P. Lack of communication between healthcare professionals and women with ovarian cancer about sexual issues. *Br J Cancer* 2003;88:666-71.
6. American Association of Retired Persons. *Modern Maturity Sexuality Study*. Available at: <http://research.aarp.org/health/mmsexsurvey.pdf>.
7. Montejo AI, Llorca G, Izquierdo JA, et al. (Sexual dysfunction secondary to SSRIs: a comparative analysis in 308 patients). *Actas Luso Esp Neurol Psiquiatr Cienc Afines* 1996;24:311-21.
8. Marwick C. Survey says patients expect little physician help on sex. *JAMA* 1999;281:2173-74.
9. Nusbaum MR, Singh AR, Pyles AA. Sexual healthcare needs of women aged 65 and older. *J Am Geriatr Soc* 2004;52:117-22.
10. Basson R. Sexuality and sexual disorders. *Clinical Updates in Women's Health Care* 2003;11:1-94.
11. Dennerstein L, Randolph J, Taffe J, et al. Hormones, mood, sexuality, and the menopausal transition. *Fertil Steril* 2002;77 Suppl 4:S42-S48.
12. Nusbaum MR, Hamilton CD. The proactive sexual health history. *Am Fam Physician* 2002;66:1705-12.
13. Maurice WL, Bowman MA. *Sexual Medicine in Primary Care*. St. Louis, MO: Mosby, 1999.
14. Tiefer L, Schuetz-Mueller D. Psychological issues in diagnosis and treatment of erectile disorders. *Urol Clin North Am* 1995;22:767-73.
15. Derogatis L, Rust J, Colombok S, et al. Validation of the profile of female sexual function (PFSF) in surgically and naturally menopausal women. *J Sex Marital Ther* 2004;30:25-36.
16. Rosen R, Brown C, Heiman J, et al. The Female Sexual Function Index (FSFI): a multidimensional self-report instrument for the assessment of female sexual function. *J Sex Marital Ther* 2000;26:191-208.
17. McGahuey CA, Gelenberg AJ, Laukes CA, et al. The Arizona Sexual Experience Scale (ASEX): reliability and validity. *J Sex Marital Ther* 2000;26:25-40.
18. Simon J, Klaiber E, Wiita B, et al. Differential effects of estrogen-androgen and estrogen-only therapy on vasomotor symptoms, gonadotropin secretion, and endogenous androgen bioavailability in postmenopausal women. *Menopause* 1999;6:138-46.
19. Lobo RA, Rosen RC, Yang HM, et al. Comparative effects of oral esterified estrogens with and without methyltestosterone on endocrine profiles and dimensions of sexual function in postmenopausal women with hypoactive sexual desire. *Fertil Steril* 2003;79:1341-52.
20. Shifren JL, Braunstein GD, Simon JA, et al. Transdermal testosterone treatment in women with impaired sexual function after oophorectomy. *N Engl J Med* 2000;343:682-88.
21. Chu MC, Lobo RA. Formulations and use of androgens in women. *Mayo Clin Proc* 2004;79:S3-S7.
22. Kingsberg SA, Althof SE, Leiblum S. Books helpful to patients with sexual and marital problems. *J Sex Marital Ther* 2002;28:219-28.
23. Rosen RC. Psychogenic erectile dysfunction: classification and management. *Urol Clin North Am* 2001;28:269-78.

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