Female Sexual Health: How to Ask, How to Help

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- Non-Declaration Statement: I have no relevant relationships with ineligible companies to disclose within the past 24 months. (Note: Ineligible companies are defined as those whose primary business is producing, marketing, selling, re-selling, or distributing healthcare products used by or on patients.)

Objectives

At the end of this presentation, members will be able to:

- Summarize the definitions pertinent to female sexual health
- Describe normal and abnormal symptoms
- Summarize what we can do to help patients address sexual health concerns
- Compare and contrast various pathologic conditions affecting sexual health
- Explain the risk factors, etiology and presenting symptoms of sexual health conditions
- Summarize the physical exam findings, diagnostic evaluation and treatment of sexual health conditions
- Apply evidence-based medicine to case-based learning scenarios

Sexual Dysfunction

- Relatively prevalent but women are unlikely to discuss unless asked
- Many health care providers are uncomfortable asking:
  - Lack of knowledge/training
  - Inadequate clinical time
  - Underestimate of prevalence
- 43% report sexual concerns; 12% report personal distress

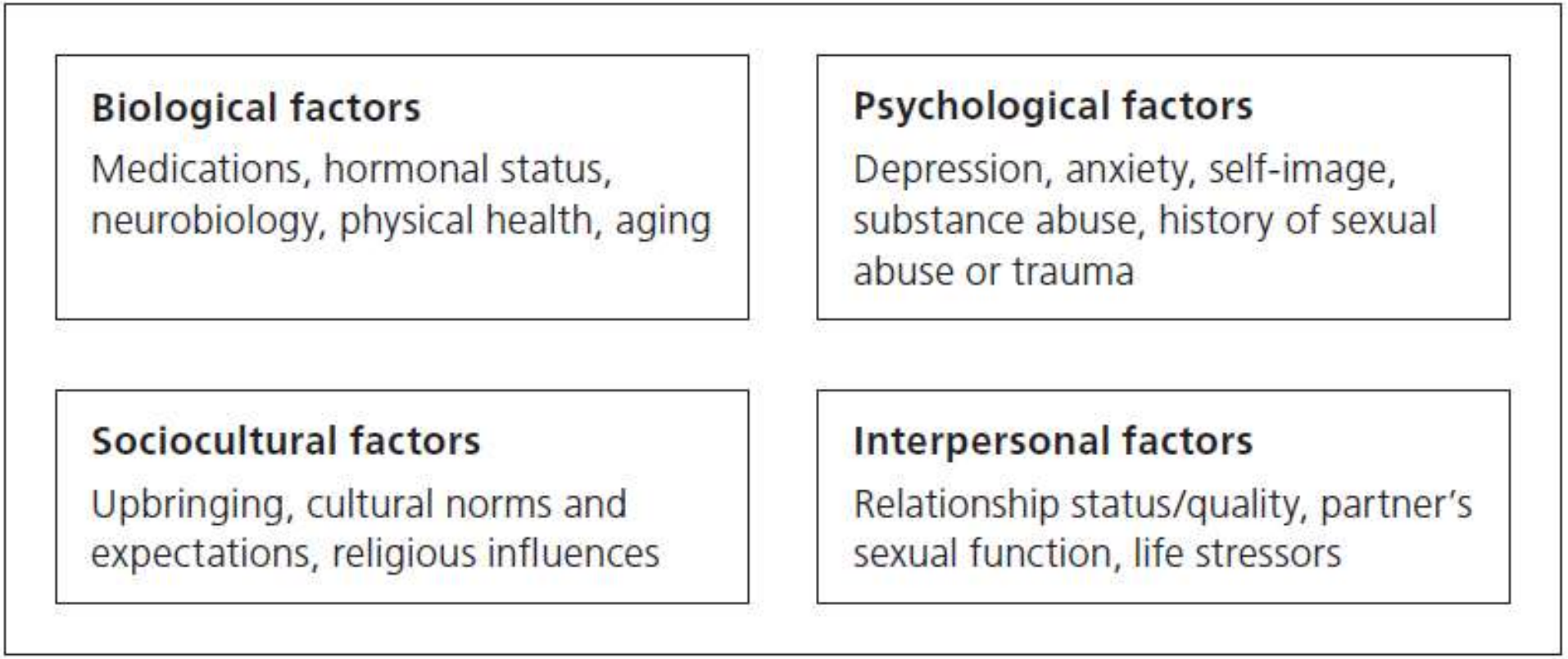
Sexual Dysfunction

- Female sexual dysfunction is the generic term that describes a group of different disorders:
  - Female sexual interest/arousal disorder
  - Female orgasmic disorder
  - Genito-pelvic pain/penetration disorder
  - Substance/medication-induced sexual dysfunction
  - Other specified/unspecified sexual dysfunction
- **Not a dysfunction unless it causes distress!**

Pathologic Influences

- Biological
- Psychological
- Sociocultural
- Interpersonal

Pathologic Influences



Pathologic Influences

- **Biological**
  - Fatigue syndromes
  - Hormonal (menopause/GUSM; breastfeeding; use of hormones)
  - Pain syndromes (pelvic floor dysfunction; chronic pain; trauma)
  - Underlying conditions
    - GU/GYN (bowel or bladder incontinence/prolapse; STI; endometriosis; premature ovarian failure; OB trauma/genital mutilation; hysterectomy; renal failure)
    - Cancer (breast, anal, colorectal, bladder, gyn; radiation therapy)
    - Neurologic (spinal cord injuries; MS; Parkinson's; dementia; head injuries)
    - Endocrine (diabetes mellitus; hypothyroidism; pituitary tumor/hyperprolactinemia)
    - Dermatologic (lichen; eczema; psoriasis)
    - Musculoskeletal (arthritis)
    - Vascular (CAD; hypertension)

Pathologic Influences

- **Biological**
  - Medication/substances
    - Medications
      - Serotonin-enhancing medications (30-70%)
      - Antiestrogens – tamoxifen, aromatase inhibitors
      - OCPs/HRT
      - Antihypertensives
      - Histamine blockers
    - Substances
      - Alcohol
      - Marijuana
      - Nicotine
      - Illicit drugs
      - Narcotics

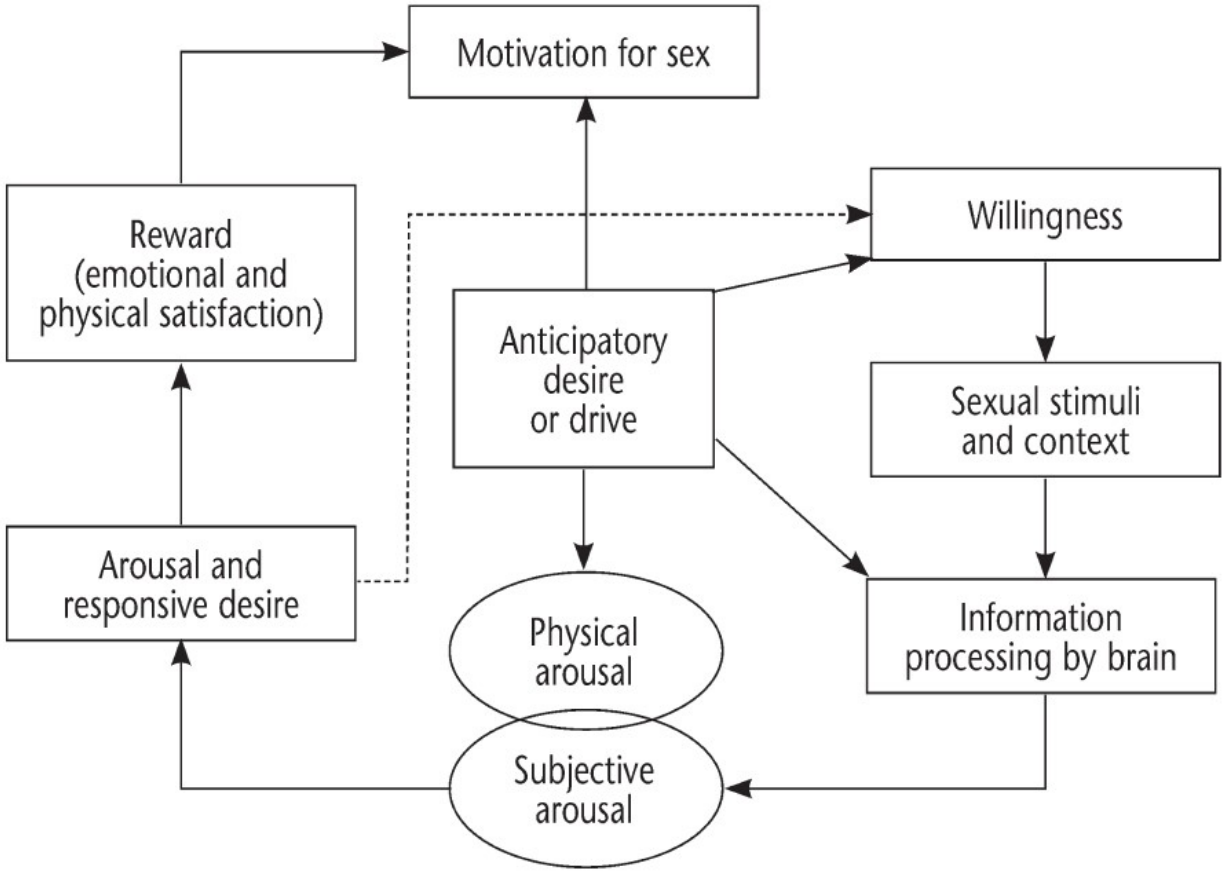
Pathologic Influences

- **Psychological**
  - Depression/anxiety
  - Stress
  - Body image/poor self-esteem
  - Trauma/abuse
  - Substance abuse disorders
  - Distraction
  - History of STI

Pathologic Influences

- **Sociocultural**
  - Limited sex education
  - Conflicts with values
  - Societal taboos
- **Interpersonal**
  - Relationship discord
  - Partner sexual dysfunction

Normal Response and Symptoms



Sexual Dysfunction

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Female Sexual Interest/Arousal Disorder

- DSM-5 combines sexual interest/arousal
  - Sexual desire = motivation to have sex
  - Sexual arousal = physiologic process of arousal
- Women commonly report experiencing these as part of the same process
- Symptoms must have persisted for 6+ months and cause individual distress

Female Sexual Interest/Arousal Disorder

- Diagnosis: lack or decrease in at least 3
  - Interest in sexual activity
  - Sexual or erotic thoughts/fantasies
  - Initiation of sexual activity and responsiveness to partner's initiation
  - Excitement or pleasure during all/almost all sexual activity
  - Interest or arousal in response to internal/external sexual or erotic cues
  - Genital or nongenital sensations during sexual activity in all/almost all sexual encounters

Female Sexual Interest/Arousal Disorder

- What is NOT dysfunction
  - Patient reports little or no spontaneous desire but continues to experience responsive desire
  - Patient maintains spontaneous or responsive desire but reports a desire discrepancy between herself and partner
  - Reduced physiologic sexual arousal related to menopause transition

Sexual Dysfunction

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Female Orgasmic Disorder

- Diagnosis: DSM-5 includes a marked delay, infrequent, absent or less intense orgasm for at least 6 months in 75-100% of sexual interactions causing distress
- Determining distress?
  - Approx ½ of women who do not consistently reach orgasm do NOT report distress
  - If distress exists, assessment follows the biopsychosocial model

Female Orgasmic Disorder

- Lifelong or acquired?
  - Lifelong may suggest:
    - Patient is unfamiliar with self-stimulation
    - Uncomfortable with sexual communication with partner
    - Lacks sex education
  - Acquired may suggest:
    - Aging
    - Medical conditions
    - Substances

Sexual Dysfunction

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Genito-Pelvic Pain/Penetration Disorder

- DSM-5 combines vaginismus and dyspareunia
  - Sexual pain defined as fear or anxiety, tightening or tensing or actual pain with vaginal penetration persistent or recurrent for at least 6 months causing distress
    - Lifelong or acquired

Genito-Pelvic Pain/Penetration Disorder

- Diagnosis: one or more symptoms:
  - Difficulty having intercourse
  - Marked vulvovaginal or pelvic pain during intercourse or penetration attempts
  - Marked fear or anxiety about vulvovaginal or pelvic pain anticipating, during or resulting from vaginal penetration
  - Marked tensing or tightening of the pelvic floor muscles during attempted vaginal penetration

Sexual Dysfunction

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- **Substance/medication-induced sexual dysfunction**
- **Other specified/unspecified sexual dysfunction**

Substance/Medication-Induced Sexual Dysfunction

- DSM-5 defined as a disturbance in sexual function with temporal relationship with a substance/medication initiation, dose increase or discontinuation causing distress

Other Specified/Unspecified Sexual Dysfunction

- DSM-5 defined as distressing symptoms characteristic of a sexual dysfunction that do NOT meet criteria defined in other categories

Sexual Health

- What can we do?
  - ASK/SCREEN, NORMALIZE
    - Initiate the discussion during routine care
      - Generalized statement
      - Open and closed-ended questions
      - Sexual function checklist

Evaluation

- Best approached with a biopsychosocial model
  - Sexual history
  - Physical examination
  - Laboratory testing is generally not necessary unless ruling out an underlying condition
    - Estradiol/testosterone levels are inconsistent

Sexual History

- Inquire about:
  - Patient's sexual and gender identity
  - Nature, duration and onset of symptoms
  - Presence of personal distress
  - Self-care/medication or other efforts to alleviate the symptoms
  - Partner factors (#, gender, health, sexual function, relationship quality, communication)
  - Abuse/violence
  - Physical activity/injuries/behaviors of the genito-pelvic area
  - Sleep quality
  - Body changes/image
  - Rx, OTC and illicit substances

Sexual History

- For example:
  - Are you currently sexually active (with men, women or both)?
  - Do you have any sexual health concerns? **(if NO, assessment can end)**
  - Specifically, any distress related to:
    - Your level of sexual desire/interest? **=SI/AD**
    - Your ability to become or stay sexually aroused? **=SI/AD**
    - Your ability to experience or reach the desired intensity of an orgasm? **=OD**
    - Your experience with any genital pain? **=GP/PD**
    - Other sexual distress? **=S/M or OD**
  - Is this a change in previous functioning?
    - How long have symptoms been present?

Physical Examination

- Gynecologic
- Exam for other possible underlying conditions as indicated by the history

Physical Examination

- Women may benefit from the opportunity to view and contribute to the exam with the assistance of a mirror
- Consider education about the genital anatomy, including illustrations or figures, that identify the location of pain or symptoms

Diagnosis

- Does it cause distress?
- DSM-V
  - And not better explained by another condition
- Women may experience more than one type of sexual dysfunction

Treatment

- MULTIFACTORIAL!!! (Biopsychosocial)
  - Treat underlying biologic/psychologic conditions
  - Consider psychologic intervention if necessary
  - Review medications/substances
  - Consider:
    - Estrogen/estrogen receptor modulator therapy
    - Androgen therapy
    - Nonhormonal medications and devices
    - Treatment options for genito-pelvic pain and penetration disorders
- Patient education (including sociocultural/interpersonal)

Treatment

- Psychological Interventions
  - Sexual skills training
  - Cognitive-behavioral therapy (w/ or w/o pharmacotherapy)
  - Mindfulness-based therapy
  - Couples therapy
- Consult or consider referral to a mental health specialist with expertise/training
  - Sex therapist, psychologist, psychiatrist, marriage/relationship counselors

Treatment

- Psychological Interventions
  - Sexual skills training → tx for orgasmic disorders
    - Exercises to improve communication with partner about needs/preferences, sensate focus education, systematic desensitization, education/behavioral techniques, comfort with body/sexuality alleviating anxiety
  - Trauma-informed psychotherapist → tx for history of assault
  - Group/couples-based CBT→ tx of low sexual interest
  - Mindfulness-based therapy → tx for sexual interest/arousal disorder and acquired anorgasmia
  - Directed masturbation → tx for lifelong anorgasmia

Treatment

- Estrogen or estrogen receptor modulator therapy
  - Clinical assessment with an examination should be completed prior to starting estrogen or a SERM
  - Examination should reveal signs of GUSM
    - Loss of labial fat pad
    - Thinning of labia minora
    - Pale mucosa
    - Loss of vaginal folds
  - Consider lowest effective dose used for the least amount of time

Treatment

- Estrogen or estrogen receptor modulator therapy
  - Low-dose vaginal estrogen is the preferred hormonal treatment
    - Vaginal tablets, gels, creams and rings equally effective
  - Low-dose systemic estrogen with or without a progesterone for women with dyspareunia and/or vasomotor symptoms
  - Selective Estrogen Receptor Modulator (SERM) such as Ospemifene is an alternative for management of dyspareunia caused by GUSM
  - Should **NOT** be used for female sexual dysfunction NOT due to a hypoestrogenic state

Treatment

- Androgen therapy
  - Not FDA approved; mixed evidence
  - Short-term use of transdermal testosterone can be considered for postmenopausal women with SI/AD who have been counseled about risk/unknown long-term effects
    - 3-6 month trial is recommended with assessment of testosterone levels at baseline and after 3-6 weeks to verify levels remain in range
    - Discontinue at 6 months for women who do not respond
    - Continued use deserves clinical and testosterone follow-up every 6 months to assess for androgen excess
    - Long-term safety and efficacy has not been studied
  - Evidence is insufficient in premenopausal women; contraindicated in pregnancy
  - DHEA/other forms of testosterone are not recommended

Treatment

- Nonhormonal medications and devices
  - Flibanserin
    - FDA approved to treat hypoactive sexual desire disorder in premenopausal women w/o depression; not approved for postmenopausal women
    - Minimal to no improvement noted overall; discuss risks of alcohol use during treatment (risk of syncope/hypotension)
  - Bremelanotide injection
  - Sildenafil Citrate: Should not be used; No FDA approval
  - Bupropion: May improve antidepressant-induced dysfunction symptoms
  - Devices
    - No device has been found effective
    - FDA approved battery-powered clitoral suction device intended to improve arousal/orgasm by increasing blood flow/engorgement but effectiveness is limited compared to OTC devices

Treatment

- Genito-pelvic pain and penetration disorders
  - Pelvic floor PT – restores muscle function and can decrease pain
  - Intravaginal prasterone (DHEA), low-dose vaginal estrogen and ospemifene can be used in postmenopausal women for moderate-to-severe dyspareunia (related to GUSM)
  - Lubricants, topical anesthesia, moisturizers to alleviate dyspareunia
  - Vaginal CO2 fractional laser should not be used outside of research
  - Sexual counselors, psychologists, PT, pain specialists

Treatment

- Patient education
  - Eliminate irritants
  - Control underlying health conditions
  - Review medications
  - Decrease or eliminate substances
  - Work on relationships
  - Discuss sexual health

Case 1

- A 31 y/o G0P0 female patient presents with sexual concerns related to past history of abuse when the patient was 8-10 years old. She reports she is newly married and did not have intercourse before marriage. She has now been married for 6 months and has still not had intercourse. Her husband knowns her history of abuse and is supportive.
- PMH: Major depression, recurrent. GAD. PTSD from prior sexual abuse. Hypothyroidism.
- Medications: Sertraline 50 mg qd. Levothyroxine 88 mcg qd.
- Vital signs: WNL

Case 1

- PE:
  - Pelvic exam: Pain with lubricated small, white plastic speculum insertion and removal. Pap smear unremarkable.
  - Otherwise unremarkable

Case 1

- What risk factors does patient have for sexual dysfunction?

Case 1

- History of abuse
- Major depression/anxiety/PTSD
  - On SSRI
- Hypothyroidism

Case 1

- According to DSM-5 which sexual disorder is present and why?

Case 1

- Sexual Interest/arousal disorder
  - Low desire due to biologic and psychologic factors
    - Biologic – Hypothyroidism, medication (SSRI)
    - Psychologic – MD, GAD, PTSD, Hx of abuse

Case 2

- A 62 y/o G3P3 female patient presents with sexual concerns related to difficulty with orgasm. She is happily married but reports she has never had an orgasm related to sexual activity with her husband. She reports they recently remodeled their bathroom and while cleaning discovered orgasm with a detached shower head but has now become distressed that this has not occurred with her husband and that she feels guilty hiding this.
- PMH: DMII, hypertension, pelvic organ prolapse with urinary incontinence, genitourinary syndrome of menopause
- Medications: Metformin 1000 mg bid, lisinopril 20 mg, topical estrogen cream applied twice per week
- Vital signs: WNL
- PE: Unremarkable

Case 2

- What risk factors does patient have for sexual dysfunction?

Case 2

- Age
- DMII
- Hypertension
- Pelvic organ prolapse/urinary incontinence
- Genitourinary syndrome of menopause

Case 2

- According to DSM-5 which sexual disorder is present and why?

Case 2

- Female orgasmic disorder
- Why?
  - Lifelong
    - Patient is unfamiliar with self-stimulation
    - Uncomfortable with sexual communication with partner
    - Lacks sex education
  - Acquired
    - Aging
    - Medical conditions

Take Home Points

- Not a dysfunction unless it causes distress
- There are biological, psychological, sociocultural and interpersonal influences
- There are 5 main classifications of sexual dysfunction
- Ask/screen, normalize
- Treatment is often multifactorial

References

- American College of Obstetricians and Gynecologists Committee on Practice Bulletins. Female Sexual Dysfunction: ACOG Practice Bulletin Clinical Management Guidelines for Obstetrician-Gynecologists, Number 213. (2019). *Obstet Gynecol*. 134(1): e1-e18.
- Basson, R, Gilks, T. Women's sexual dysfunction associated with psychiatric disorders and their treatment. (2018). *Womens Health* (Lond).14.
- Clayton, A, Juarez, E. Female Sexual Dysfunction. (2019). *Med Clin North Am*. 103(4):681-698.
- Faubion, S., Rullo, J.. Sexual Dysfunction in Women: A Practical Approach. (2015). *Am Fam Physician*. 15;92(4): 281-2.
- Leeman, L., Rogers, R.. Sex After Childbirth: Postpartum Sexual Function. (2012). *Obstet Gynecol*. 119:647-55.
- Pup, L, Villa, P, Amar, I, Bottoni C, Scambia, G. Approach to sexual dysfunction in women with cancer. (2019). *Int J Gynecol Cancer*. 29(3): 630-634.
- Starc, A., Trampus, M., Jukic, P., Rotim, C., Jukic, T., Mivsek, A.. (2019). Infertility and Sexual Dysfunctions: A Systematic Literature Review. *Acta Clin Croat*. 58:508-515.
- Thomas, H., Neal-Perry, G., Hess, R.. (2018). Female Sexual Function at Midlife and Beyond. *Obstet Gynecol* Clin N Am. 709-722.

Questions

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