

Decreased Sexual Desire

Navigating the complexities of diagnosis and treatment

PART 2
OF A 3-PART
SERIES

Do patients want to talk with you about sex?

Yes. And they expect you to initiate the dialogue. Few of us are comfortable raising the topic of sexual function. The remedy? Be prepared.

In our hypersexual culture, we cannot avoid the topic of sex. One merely has to go through the grocery store checkout line to see sex trumpeted in the headlines of women's magazines. The implication? Everyone is sexual all of the time.

Even without the cultural hype and the sexual myths it perpetuates, real problems are prevalent. Your patients may have difficulties discussing their concerns with you—and you may not be sure how to begin the conversation.

How common are sexual problems?

Laumann et al reported that in a survey of 1749 women aged 18 to 59 years, 43% had sexual dysfunction (eg, inability to achieve orgasm, pain during sex).¹ This report did not clarify whether these difficulties were present all the time or on occasion, and did not quantify whether the difficulties were associated with significant emotional distress. In another survey of female sexual dysfunction, Bancroft et al estimated the incidence of female sexual dysfunction to be around 25%.²

An accurate assessment of sexual dysfunction depends on how it is defined. In an earlier work, Frank et al interviewed middle-class white couples, and found that 40% of men reported erectile dysfunction and 63% of women reported problems with arousal.³ In this same group, however, 50% of men and 77% of women reported "difficulties" that could not be labeled as



dysfunctions but which caused patients to feel concern and dissatisfaction:

- One's partner chooses an inconvenient time for sex
- Inability to relax
- Disinterest in sex
- Attraction to a person who is not one's partner
- Different sexual practices or habits
- Too little foreplay
- Too little tenderness after intercourse

These difficulties can disrupt sexual relationships and have the potential to affect a couple's overall relationship. Most patients with sexual difficulties do want to talk about these issues, and women are 3 times more likely than men to talk seriously with their physicians about sex.⁴

Mutual discomfort inhibits discussion

Few patients approach the topic of sex with ease. Many of them—68% in one survey—fear they will embarrass their

William D. Petok, PhD

Assistant Clinical Professor
Department of Obstetrics
and Gynecology
University of Colorado Health
Sciences Center
Denver, Colorado

Independent Practice
Baltimore, Maryland



KEY POINT

Establish that you are interested in discussing sexual concerns during your first meeting with a new patient.

physician.⁵ In this same survey, 71% doubted their physician would take their problem seriously. Clinicians may not be any more comfortable than their patients when it comes to discussing sexual function. Taking a sexual history can feel awkward, particularly if it does not relate to a patient's presenting complaint.

Inadequate training about taking a sexual history may be the chief reason that sexual difficulties are overlooked in patient interviews. Less than one third of medical schools offer instruction on how to take a detailed sexual history. As a rule, fewer than 10 hours are devoted to training residents in sexual function.⁶ Even when physicians do take a sexual history, lack of training may leave them without the information or skills to respond appropriately to concerns raised by the patient.

There are other obstacles to discussing sex with patients. Clinicians may be reluctant to discuss intimate issues with patients of a different culture or generation, fearing that they will cause offense or that they lack knowledge of cultural norms. Clinicians may be unfamiliar with the sexual practices a patient discusses or the terminology she uses and worry that they will appear uninformed or insensitive. Fear of litigation for perceived sexual misconduct is another impediment—especially in a male-clinician/female-patient scenario.

Prepare yourself

An informed clinician is one who feels comfortable addressing sexual issues and whose receptive demeanor helps normalize the topic for a patient. One excellent resource is William Maurice's book, *Sexual Medicine in Primary Care*.⁷ His chapter on interviewing methods offers sample questions you can use. The author also provides guidance on questions to avoid. Other chapters offer suggested questions for eliciting more in-depth information on specific sexual dysfunctions. Similar guidelines are available elsewhere.^{8,9}

The website www.femalesexualdysfunctiononline.org/site/about.cfm, sponsored by the Baylor College of Medicine, is another helpful resource that offers a slide library on a variety of topics, such as interviewing about sexual problems, as well as online meetings, CME opportunities, and links to other resources.

When should the discussion start?

A sexual history can be included as part of your review of systems when you first meet a patient. This sets the expectation that you are interested in the whole patient and are a safe person with whom the patient can discuss sexual concerns.

Other times can also be appropriate—a complaint of acute low back pain should prompt a sexual history. Depression, chronic stomachache, migraine, or cough—any of these problems can interrupt lives. Characterizing such sexual problems as an interruption normalizes the topic of sexual function for patients. Assure your patient that sexual problems are common and that there is hope for a solution.

Onset of menopause is a natural time to discuss sexuality. Physiologic changes during this transition are likely to influence a woman's experience of sex, particularly diminished desire and increased discomfort with intercourse related to estrogen deficiency and vaginal changes.

Taking the sexual history of underage patients is equally important. It not only normalizes sexual health but also provides an opportunity for you to correct misinformation and provide education about safer sexual practices and birth control.

A note of caution: avoid taking a sexual history during a physical exam. Taking the sexual history while the patient is clothed and you both are seated may provide a nonthreatening atmosphere. If, however, the subject is broached during an exam, make sure an appropriate "chaperone" is present.

In general, if you do not know the patient well or are uncomfortable with that patient or the sexual issue presented, the presence of a "chaperone" may be helpful. Patients who speak another language should have a professional interpreter who is comfortable with the cultural issues of sexuality; a family member serving as interpreter is not appropriate because it violates confidentiality.

The specifics: Questions to ask

"May I ask you some questions about sexual matters?" should be your first question. By asking permission, you prepare the patient for the upcoming questions and allow the patient to decide if this is

an area that she would like to discuss. If the patient says no, simply say you are available if at any time she wishes to discuss such matters.

Make questions simple and usable. Keep in mind that some patients interpret questions quite literally. “Are you sexually active?” may elicit a no, if the patient remains passive during sex.

Try to be as clear as possible and obtain a chronology of the issues at hand. For instance, if you want a history of sexual activity, ask, “Have you been sexually active in the last 6 months?” An even more focused question might be “Have you been sexually active (or involved) with a partner in the last 6 months?” If you simply ask your patient whether she has been sexually active with a partner, she may answer yes, meaning 20 years ago.

Ask questions that are broad enough to include activities other than heterosexual intercourse. Other questions you may want to ask are “Have you been sexually active with men, women, or both?” and “Do you or your partner have any sexual difficulties, such as your interest level, vaginal lubrication, orgasms, or pain on intercourse?” If the patient acknowledges a problem with any of these 4 factors, your line of inquiry can become much more focused (TABLE).

Keep in mind the possibility that a patient’s specific religious or ethnic/cultural beliefs will influence her attitude about sexual activity. For example, most religions are pro-family and condone—even encourage—sexuality within the context of marriage. Some religions go further and proscribe certain activities. If you do not know a patient’s religious proscriptions, you may offer advice that is unacceptable to her.

A study of sexually active Afro-Caribbean and Afro-American women, aged 40 to 80 years, showed that women in this population felt more comfortable revealing sexual difficulties when asked a universal question, such as “Many women with diabetes have sexual problems. Is this a problem for you?”⁸ The authors suggest that asking this type of question of women in this minority group, especially women older than 60 years, may yield more information than you might otherwise learn. Their findings further showed that, although sexual problems

TABLE

Possible Sexual Dysfunction According to Complaint

Complaint	Possible Dysfunction
Lack of interest	Hypoactive sexual desire disorder or sexual aversion disorder
No vaginal lubrication	Female arousal disorder
No orgasm	Female orgasmic disorder
Pain on intercourse	Dyspareunia or vaginismus

in this group occur in similar frequency to those in a more heterogeneous population, pain during sex seemed to occur more often.

Finally, consider delaying questions you suspect might be too sensitive—eg, asking for details of sexual activity that you think might be relevant to the presenting problem—until you sense that you have earned your patient’s trust.

Slang or formal terminology?

Use clinical language rather than vernacular. One of your goals should be to normalize the topic of sex. Clinical language has less emotionality attached to it and thus maintains an appropriate professional distance between you and your patient, which can be important for the patient’s comfort level. Because clinical language allows people to talk more easily about difficult problems, it also gives you an opportunity to teach.

Proponents of vernacular language say it lessens ambiguity. Certainly, if a patient does not understand the clinical terms you are using, you should resort to more common language.

Involving her partner

Once you have determined that there is a problem, it may be reasonable to ask your patient’s permission to involve her partner in your discussions. If you decide to refer to a specialist, that may also be a time to involve her partner. It might be appropriate to talk with the couple when

KEY POINT

Some patients may be more comfortable answering questions that emphasize the universality of sexual problems.



KEY POINT

Subjective arousal does not correlate well with genital response in women.

considering potential treatments so that the partner has a good understanding of the problem and can help with the solution.

Therapies for sexual problems

Although there may be a biological basis for a sexual problem, sexual behavior is usually interactional. Hypoactive sexual desire disorder can be difficult to treat for this very reason. It can involve cultural, religious, relationship, and perhaps even educational factors, and not just physiologic influences. If, however, you believe that a hormone imbalance is the primary issue, estrogen or testosterone therapy (or both) may be warranted. At present, however, there are no therapies approved by the US Food and Drug Administration for women with lessened sexual desire. Incorporating other modalities, such as counseling, may provide more robust treatment than hormone therapy alone.

A woman's arousal is as much cognitive as it is physiologic. Subjective arousal is not well correlated with genital response. For example, when shown erotic videos, both women who report problems with arousal and women who report no problems with arousal display similar increases in genital vasocongestion. This again speaks to the multidimensional nature of sexual response and enjoyment.¹⁰

Lubrication—water-soluble or non-water-soluble—can also help with arousal disorders. Saliva is not only a great lubricant, its pH is similar to that of vaginal secretions and will not impede sperm motility.

A significant number of women do not experience orgasm during intercourse. Specific questions asked about stimulation may suggest answers: Have you ever had an orgasm? Does it occur only occasionally or with some partners and not others? Can you masturbate to orgasm? If the answer to this last question is yes, the problem may be partner related.

Good protocols exist for treating female orgasmic dysfunction. These therapies include body awareness, relaxation, and exercises to create orgasm (self-stimulation first, then stimulation by the partner).¹¹

The treatment may also involve attention to concomitant disorders such as anxiety or obsessive compulsive disorder that can inhibit "letting go," which facilitates an orgasmic experience.

Basic assumptions that will serve you well

Understand that your patients may be embarrassed at first—use sensitivity when broaching any discussion of sex.

Most patients have limited medical understanding and will not use appropriate terminology. Consider this an opportunity to teach.

Patients may be uninformed about sexuality and reproduction. Encourage them to ask any questions that occur to them.

When dealing with couples, it is safe to assume they have not always been candid with each other or have not shared their most intimate fears or desires about their sexual relationship.¹²

Keep in mind that most sexual problems have multiple determinants and may require multilevel interventions.

Use good interviewing techniques and you will elicit useful information and be most helpful for your patients. ■

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