Many factors, psychosocial and organic, may contribute to sexual dysfunction: an illness or disability, medication or a surgical procedure, aging, relationship difficulties, previous experiences, performance anxiety ... Faced with such a complex topic, and one about which many people feel uneasy, healthcare professionals may not feel confident in pursuing the subject with their patients. However, a sensitive, prepared clinician can facilitate real progress, often with a surprisingly brief intervention of the right kind.

_Fast Facts_ – _Sexual Dysfunction_ provides a well-rounded overview of sexual dysfunction, its evaluation and its treatment in both men and women. The book’s many strengths include a practical approach to communicating with patients and diagnosing their problems, checklists acting as at-a-glance reminders for clinicians, and a list of further resources for both clinicians and patients. A team of experts working in close cooperation combined the disciplines of mental health therapy, gynecology and urology to produce this book with the aim of giving primary care providers the information they need to extend their own knowledge, skill and comfort in dealing with sexual dysfunction, and the ability to recognize when to refer.

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Sexual Dysfunction

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This book is as balanced and as practical as we can make it. Ideas for improvements are always welcome: feedback@fastfacts.com
AIS: androgen insufficiency syndrome

Clitoralgia: pain in the clitoris at rest and/or during and after genital sexual stimulation; it may or may not be associated with clitoral priapism, and is believed to be principally caused and maintained by neurogenic and/or vascular pathologies

DHEAS: dehydroepiandrosterone sulfate

Dilator exercises: a technique used to treat vaginismus, in which lubricated, contoured cylinders of increasing diameter are inserted into the vagina, typically by the patient or her partner, so that the vagina gradually accommodates to an object about the size of the erect penis

Dyspareunia: recurrent or persistent genital pain associated with sexual intercourse

Erectile dysfunction: persistent or recurrent inability to attain and/or maintain a penile erection sufficient for satisfactory sexual performance

FADS: female androgen deficiency syndrome, now known as AIS

FSD: female sexual dysfunction

FSH: follicle-stimulating hormone

HRT: hormone replacement therapy

Hypersexuality: hypertrophied or excessive desire with or without persistent genital arousal

Hypoactive sexual desire: persistent or recurrent deficiency or absence of sexual fantasies/thoughts and/or of desire for or receptivity to sexual activity, which causes personal distress

Kegel exercises: repeated voluntary contraction and relaxation of the vaginal muscles used in the treatment of hypotonic pelvic floor

Lichen sclerosus: full thickness atrophy and/or marked dystrophy of the vulvar tissue, which may involve all the biological structures; it may cause pruritus or a painful sense of vulvar dryness, and may be associated with genital arousal disorders and orgasmic difficulties

NO: nitric oxide, a neurotransmitter

Non-coital sexual pain disorder: recurrent or persistent genital pain induced by non-coital sexual stimulation

Orgasm disorder: persistent or recurrent difficulty or delay in achieving orgasm, or inability to achieve orgasm, following sufficient sexual stimulation and arousal, causing personal distress

Overactive bladder: a condition associated with urge incontinence and/or with urinary leakage at orgasm

PDEI: phosphodiesterase inhibitor

PE: premature (or rapid) ejaculation, that is, persistent or recurrent ejaculation with minimal sexual stimulation, before, on or shortly after penetration and before the person wishes it

Peyronie’s disease: fibrous induration of the corpora cavernosa resulting in curvature of the penis and, often, painful erections

Phimosis: tightness of the foreskin preventing its retraction over the glans

PID: pelvic inflammatory disease

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PLISSIT: permission, limited information, specific suggestions, intensive therapy

Priapism: a pathologic condition of a painfully hard, congested penis or clitoris, which may or may not be triggered during genital sexual arousal, but no longer has a sexual meaning when presented for clinical observation

PSAS: persistent sexual arousal syndrome, a recently described syndrome in women in which excessive, unwanted and often unremitting genital arousal, not associated with increased sexual desire, is not or is only marginally relieved by orgasm; PSAS may last hours, days or months and may cause significant personal distress

RE: rapid ejaculation (see PE)

Sensate focus exercises: behavioral exercises used in sex therapy to enable each partner to engage in intimate touch with no initial expectations of performance (e.g. sexual arousal, orgasm)

Sexual arousal disorder: persistent or recurrent inability of a woman to attain or maintain sufficient sexual excitement, causing personal distress

Sexual aversion disorder: persistent or recurrent phobic aversion to and avoidance of sexual contact with a sexual partner. The aversion causes personal distress and may be general or to specific behaviors or parts of the body

Sexual status examination: a component of the psychosexual evaluation involving the patient's detailed description of a recent or typical sexual encounter. It enables the therapist to assess patterns of setting, initiation, behavior, communication, fantasy and responsiveness as treatment progresses

Sex therapy: a form of psychotherapy used to evaluate and treat the psychosocial and relationship aspects of sexual dysfunction; typically, educational, behavioral, cognitive and relational techniques are employed

Sex therapist: a psychotherapist or other health professional who is trained and often certified in the techniques of evaluating and treating sexual dysfunction

SHBG: sex hormone binding globulin

SSRI: selective serotonin reuptake inhibitor

Stop–start exercises: Penile stimulation exercises used in the treatment of premature or rapid ejaculation, in which the patient or partner stimulates the penis to a high level of arousal and then reduces stimulation so that ejaculation does not occur until the patient desires it

TSH: thyroid-stimulating hormone

Vaginismus: recurrent or persistent involuntary spasm of the musculature of the outer third of the vagina, associated with some degree of fear of or aversion to penetration, that interferes with vaginal penetration and causes personal distress

VED: vacuum erection device

VIP: vasointestinal peptide

Vulvar vestibulitis: inflammation of the vaginal introitus, with three principal symptoms: reddening of the vestibular mucosa, acute burning pain (looking at the introitus as a clockface, mostly positioned at 5 and 7 o’clock) and dyspareunia
Introduction

Sexual well-being is not a luxury but a right. The World Health Organization laid the foundation for understanding the role of sexual health in the first paragraph in the Declaration of Alma-Ata in 1978: ‘The Conference strongly reaffirms that health, which is a state of complete physical, mental and social well-being, and not merely the absence of disease or infirmity, is a fundamental human right and that the attainment of the highest possible level of health is a most important world-wide social goal whose realization requires the action of many other social and economic sectors in addition to the health sector.’ This is the mandate, and it has taken fully 25 years for the health professions to develop to the position where there is now a realistic opportunity of promoting sexual health. This book has been written in the hope of providing further support for the delivery of sexual medicine.

Addressing sexual issues in primary care practice

Individuals sometimes experience discomfort with sexuality or a disturbing change in their sexual performance – loss of interest, problems becoming sexually aroused, difficulties with ejaculation or orgasm, or pain accompanying sex. Such concerns or changes may arise because of an illness or disability, a medication or surgical procedure, changes accompanying the aging process, relationship difficulties, abusive sexual experiences, performance anxiety or any combination of factors such as these. The incidence of sexual dysfunction is greater than one might think. In a study of over 2900 men and women in the USA between the ages of 18 and 60 years, Laumann et al. asked about the incidence of specific sexual dysfunctions over a ‘period of several months or more … during the last 12 months’. Selected overall responses to this question are shown in Table 1.

The likelihood that a person will approach a health professional with a sexual problem has increased over the last few years because of the greater level of openness in our society with regard to sexual issues. Sex and sexuality are now more openly discussed in the public media.
In addition, new medical techniques now available for the treatment of sexual dysfunction have had the effect of ‘giving permission’ to people to express their sexual needs and concerns more readily.

At the same time, sexuality is still an uncomfortable topic for many people, perhaps because of negative messages they have heard, misunderstandings about sexuality that result from poor or misleading education, or unpleasant sexual experiences they have had at some point in their lives. For this reason, it is important that physicians and other primary care providers be proactive in normalizing the discussion of sexual matters, by making it a routine part of the initial history, even if only in a general way. This tells the patient that it is fine to raise such issues should it be necessary at any time. If the patient senses any discomfort on the part of the care provider, he or she may not be as willing to discuss such a sensitive topic.

Physicians may themselves be reluctant to pursue sexual issues because they are uncomfortable with the topic, or because they do not feel sufficiently knowledgeable or skilled to address questions that the patient might raise. Unfortunately, the medical education of most physicians still does not address sexual issues openly or sufficiently, if at all, in either preclinical or clinical coursework.

This book aims to make much of the missing information available in a clear and straightforward form. We provide an overview of sexual dysfunction and its treatment; we briefly examine the various sexual dysfunctions and their etiologies and pathophysiology, and we describe...
current treatment methods that may be used by the primary care provider or by other health professionals who specialize in the evaluation and treatment of such disorders, such as gynecologists, urologists, sex therapists and physical therapists. We discuss when and how to refer a patient to such a specialist or team of specialists. We outline important elements of a psychosexual evaluation and review techniques that may help patients to address their concerns. Finally, we provide a list of resources – reading matter, videotapes and websites – that may be useful to either the clinician or the patient.

The importance of a multidisciplinary, collaborative approach is central to our discussion. In evaluating any sexual dysfunction, both organic and psychosocial issues must be considered. Whatever the cause of a sexual dysfunction, it typically occurs in a relationship context, and successful treatment may depend on addressing relationship issues along with whatever other interventions are suggested. Sexual problems also occur against the backdrop of the patient’s sexual experiences, attitudes and values, which must always be taken into account in assessing and treating such problems.

As daunting as such problems may seem at first to both patient and clinician, those of us who specialize in the treatment of sexual problems see again and again how much can often be accomplished with relatively little intervention and time, and how tangible and satisfying the results can be for a patient. Receiving the announcement of a baby’s birth from a couple who at one point could not have successful intercourse can make the day of any therapist.

Virginia and Keith Laken have described their sexual recovery after Keith underwent surgery for prostate cancer. They were in their 50s and had two children and four grandchildren, and we may not think easily about the importance of sexuality to couples beyond the childbearing years. Nevertheless, they valued the sexual aspects of their relationship and were intent on restoring the physical intimacy they had lost due to Keith’s prostate cancer and surgery. Through their work with urologists, a psychiatrist and a sex therapist, coupled with their sheer determination and the strength of their relationship, they learned over the next few years about the value of a comprehensive approach to the loss of sexual intimacy in general, and loss of erectile capacity in
particular. Keith writes at one point in the book: ‘Impotence is a prime example of the interconnectedness of mind and body. When a man loses his ability to get an erection, he loses more than physical functioning; he also loses a part of his emotional and mental self-perception. I firmly believe that the mind–body connection cannot be ignored if one is to become cured.’ As we will illustrate later, this is no less true for women suffering from a sexual dysfunction than it is for men.

A note on conventions used in this book
For the sake of simplicity, relationships will be assumed to be heterosexual throughout this discussion. However, gay and lesbian couples may present with similar concerns, and most of the issues and techniques described here will apply. When working with gay and lesbian couples, however, it is especially important that the primary care provider neither stereotypes the sexual behavior of homosexual individuals, nor applies heterosexual stereotypes to their behavior. Rather, he or she should be aware of issues that may be pertinent to homosexual men and women.

When certain aspects of evaluation or treatment are best carried out either by sex therapists or by physicians, we will use those terms. We
will use the word ‘clinician’ when referring to any qualified health professional who might be involved in a given aspect of evaluation or treatment.

**Acknowledgments**

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**Key references**

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  [http://www.who.int/hpr/archive/docs/almaata.html](http://www.who.int/hpr/archive/docs/almaata.html)


When to address sexual issues

We recommend that the issue of sexuality be raised when an initial general history is taken from the patient, even if only as a single open-ended question. This at least demonstrates to the patient that the physician is comfortable with the issue and sees it as an important aspect of the patient’s health and well-being, an impression that may increase the likelihood that the patient will raise a sexual concern at a later time. Any sexual concern should be taken seriously, regardless of the patient’s age or medical status. When discussing sexual issues (Table 1.1), be sensitive to gender and cultural factors, but do not make assumptions based on gender or cultural stereotypes. Assume that each

### TABLE 1.1

**Points to remember when addressing sexual issues**

- A proactive, empathic approach to your patient’s sexual life will convey an attitude of availability and acceptance. Sexual issues may be discussed in a number of contexts, including:
  - obtaining background information about sexual function
  - addressing possible consequences of illness, injury, procedure or medication
  - responding to a patient presenting with a sexual problem or question
- It takes courage to disclose a sexual dysfunction or a sexual trauma. Such disclosures should be taken seriously and addressed in a sensitive manner
- All patients may have sexual interests or concerns, including the elderly, the disabled and those with chronic illness
- Patients have diverse experiences, values and preferences. Be sensitive to gender and cultural differences, but do not assume that any one patient necessarily fits a gender or cultural stereotype
- Whenever possible, involve both the symptomatic patient and the partner in evaluation and treatment
patient has his or her unique sexual history and needs. Finally, consider the role of the partner in the sexual relationship and in any intervention recommended.

Whenever a patient has an illness that is likely to have sexual consequences, either in itself or as a consequence of treatment protocols, it is helpful to mention this possibility in advance and to offer assistance should any problems arise (see Chapter 3).

Values and attitudes
To address such sensitive issues successfully, clinicians need to be aware of their own areas of comfort and discomfort. Establishing an atmosphere of comfort and acceptance in the clinical setting is especially important when discussing sexual issues (Table 1.2).

Ethical and legal considerations
The topic of sexuality requires special attention to confidentiality and informed consent, depending on the profession of the clinician and on

<table>
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<th>TABLE 1.2</th>
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<tr>
<td>Values and attitudes</td>
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<tr>
<td>• Try to develop an honest self-awareness of your own areas of comfort and discomfort with sexual issues</td>
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<tr>
<td>• It is easy to avoid asking important questions in an area in which we may be uncomfortable; make a point of addressing such issues in a way that is:</td>
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<tr>
<td>- comfortable for both you and the patient</td>
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<tr>
<td>- effective in securing the necessary information</td>
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<tr>
<td>• Try to refrain from projecting your own values and attitudes onto those of the patient, either verbally or non-verbally. Doing so may:</td>
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<tr>
<td>- reduce the patient’s comfort and feeling of acceptance</td>
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<tr>
<td>- introduce inappropriate assumptions into the history</td>
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<tr>
<td>• Remember that there are no universal norms of behavior – every patient is an individual, in sexual needs as much as anything else</td>
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