Part II

Sexual Dysfunctions In Primary Care: Diagnosis, Treatment, And Referral

. . . .most sexual problems are currently considered the net result of a complex interaction among physical, psychological, and interpersonal factors. Increasingly, clinicians are feeling "baffled" about the etiology and treatment of the sexual complaints greeting them....the increased awareness of the dangers as well as the delights of sexuality are dominating popular consciousness and cooling the sexual climate . . . Sexual attitudes in [the] age of AIDS are markedly different from those in the previous "Age of Aquarius!"

Leiblum and Rosen, 1989[1] (pp. 1-2)

PRIMARY CARE TREATMENT OF COMMON SEXUAL DYSFUNCTIONS: GENERAL CONSIDERATIONS

Health professionals can hardly avoid talking about sexual issues in view of the widespread appearance of sexually transmitted diseases, sexual aggression toward children and adult women, teenage pregnancies, and sexual dysfunctions. Indeed, in some circumstances, it is even hazardous to not talk about these issues (see second case history in the introduction to PART I). The first part of this book explored one of the more common reasons given by health professionals for circumventing the topic of "sex," that is, not being sure of the next questions to ask if the answer to a sex-screening question is 'yes'. PART II examines a second reason: the need for health professionals to know what they can do about a problem *before* a sexual inquiry takes place. *The focus of PART II is on sexual dysfunctions rather than other sexual disorders*. The reasons for the emphasis are twofold. First, sexual dysfunctions are widespread in the community (see Chapter 3 and the epidemiology sections of Chapters 9 through 13). Talking with people about such problems provides almost every health professional the ability to assist those patients directly. Second, talking to people about sexual dysfunctions provides the health professional with an excellent opportunity to rehearse the process of talking to patients about many other sexual issues such as, for example, STDs and their prevention.

Having the capacity to listen to stories of sexual distress and knowing what to do about common sexual problems and when to refer the patient to another health professional, is, for many, a prerequisite to asking sex-related questions. While high-quality guides for the treatment of sexual disorders exist for the specialist health professional,[1,2] there are few guidelines for those working in primary care between those texts and the popular press. PART II attempts to provide this intermediate level of information by reviewing the following five common sexual dysfunctions:

Low sexual desire in women and men (Chapter 9)
Ejaculation/orgasm disorders in men (Chapter 10)
Erectile disorders (Chapter 11)
Orgasmic difficulties in women (Chapter 12)
Intercourse difficulties in women (Chapter 13)

Each is considered from a primary care perspective, providing information about the disorder, diagnostic questions to ask, treatment suggestions, and describing circumstances in which referral might take place.

ASSUMPTIONS

Practice Pattern of the Health Professional

Patterns of practice in primary care vary greatly. Some physicians see patients with their partners if, for example, the couple is retired or flexible work schedules allow for conjoint visits. Others may be seen with other family members or friends, rather than with a partner. When patients are seen alone, a partner may be invited to attend at a later time in response to a request or need. Visits to physicians are often short: 10 to 15 minutes in a family practice setting; the total number of appointments are often limited as a result of other responsibilities, demands, and interests of the professional; and goals of treatment vary from being quite specific to those that are not. With other health professionals such as nurses, psychologists, and social workers visits may be longer and greater in number. However, like physicians, the goals of the other professionals vary substantially.

Classification of Sexual Disorders

One of the "guiding principles" of the primary care version of *The Diagnostic and Statistical Manual of Mental Disorders*, is that it is "user-friendly . . . with technical jargon removed or explained . . ."[3] (p. xii). It includes a section on "Sexual Dysfunction" within a category of "Disorders That Commonly Present in Primary Care Settings." With a complaint that falls into the area of sexual dysfunctions, the reader is instructed to *first* consider several issues:

(a) ". . . whether the presenting symptom is due to the direct physiological effects of a general medical condition" (p.5)
(b) ". . . whether the presenting symptom is the direct physiological effect of a drug of abuse (or) a medication side effect. . ." (p. 6)
(c) ". . . whether the symptoms are better accounted for by another mental disorder." (p. 7).

As with the parent version of DSM-IV-PC, readers are directed to use a subclassification scheme in which problems are subdivided into those which are (1) *lifelong* (having always existed) or *acquired* (following a period of unimpaired function) and (2) *generalized* (existing under all sexual circumstances) or *situational* (existing only under specific circumstances).[4] For any health profes-

sional, this subclassification provides some direction in thinking about cause(s) and treatment. For example, dysfunctions that are acquired and generalized suggest an alteration in the biological capabilities of the individual. In contrast, the situational occurrence of a sexual dysfunction usually bespeaks the integrity of body systems and points to psychosocial difficulties within the patient or between that person and their partner. However, it is possible for a serious medical illness to appear as a situational sexual dysfunction.[5] In addition, a sexual dysfunction that is generalized may *begin* as one that is situational. In an attempt to overcome diminished sexual response, the patient, for example, may deliberately enhance sexual arousal by various psychological and physical means.

Clinicians should be aware that the diagnoses of some sexual dysfunctions are themselves problematic. First, a patient's subjective concern must be considered, not only objective reality. For example, an erectile dysfunction may objectively exist but be dismissed by the patient as unimportant because of his own sexual disinterest or the uninvolvement of his partner. Second, some definitions on which diagnoses are based are quite unstable in that they ". . . are dependent on social expectations which change over time and across cultures . . . [The DSM-IV system] . . . indirectly acknowledge(s) this by leaving much to the judgment of the therapist . . . ".[6]

Investigation of sexual dysfunctions: History-taking (always), Physical Examination (preferably) and Laboratory Examination (selectively)

The three elements of a medical examination that result in a diagnosis[7] are:

(a) history-taking
(b) physical examination
(c) laboratory examination

In the assessment of a sexual dysfunction conducted by any health professional, the history-taking portion of the examination is essential, so much so that on some occasions it may be all that is necessary diagnostically and therapeutically. The explanation for this is that *sex history-taking can itself be healing*, especially when it involves unburdening oneself of sexual secrets and, in the process, receiving acceptance and reassurance instead of the anticipated news that one is "abnormal."

Physical examination is essential diagnostically if a sexual problem could be the result of a disorder of a body system that itself is integral to the function of the genitalia. Like sex history-taking, a genital examination may also be therapeutic in providing a special opportunity to explain and answer questions about the structure and function of the genitalia (see "Physical Examination" in Chapter 6). Health professionals who for one reason or another do not conduct a physical examination (e.g., mental health professionals) but who wish to integrate concepts related to sexual anatomy and physiology into patient care may use paper and pencil self-drawn schematic diagrams (easy and inexpensive) or plastic/rubber models of genitalia for effective and instructive substitutes.

Laboratory examinations can sometimes be used to add information when a biomedical problem is suspected as a result of the other two parts of the investigation.

Context of the Relationship

Other than masturbation, sexual activity always involves another person. Therefore when sexual function in one partner becomes disrupted the other partner is also affected. One consequence is to view at least some aspects of the solution to a sexual dysfunction in the context of both

people (apart from who actually appears with the problem). Correcting whatever difficulty exists, therefore, requires the goodwill, caring, and cooperation of the two people. "Few . . . enjoy the effort or pain [of treatment], but love and commitment can make the work bearable"[8] (p. 92). If these elements are absent (e.g., when one of the partners is secretly sexually involved with another person), the sexual complaint usually becomes an issue of lesser priority than the context within which the sexual activity occurs, that is, the relationship. Treating a sexual dysfunction in primary care (or, indeed, on any level) assumes that the relationship has a reasonably strong foundation.

Therapeutic Focus: Present Versus Past

A treatment approach should be based on (a) specific discovered cause(s). This guideline often seems easier to follow when an exclusively biomedical explanation is evident. However, in thinking about psychosocial causes of a sexual dysfunction, Hawton suggested three groups of factors[9] that one might consider:

1. *Predisposing* factors, including traumatic early sexual experiences and disturbed family relationships (these are issues from the distant past that often require considerable time, effort, and skill in overcoming and as a consequence are best treated by mental health professionals with comfort in this area)
2. *Precipitating* factors, including infidelity and problems related to childbirth (sex-specialists and mental health professionals both see such patients)
3. *Maintaining* factors, including anticipation of sexual failure, poor partner communication, and inadequate information (these are issues related to the present, often seen by a sex-specialist, but usually quite treatable in primary care)

Education/Information as an Element of Treatment

Not long ago, education in the treatment of sexual dysfunctions primarily meant explanation of the following:

1. Aspects of the anatomy and physiology of the genital function of men and women
2. Norms of sexual behavior
3. The epidemiology of sexual problems

Although these are often still necessary, education also now includes other elements such as learning about sexual communication (e.g., partners explaining their sexual desires to one another).

"Self-help" books can be of great educational value in many areas but are best used as an *adjunct* to the health professional rather than as a substitute. The most striking and consistent response of patients to self books is the recognition of "not being alone," that is, there are others with the same problem. Althof and Kingsberg provided health professionals with guidance through the maze of self-help "sex" books for professionals and patients on the subjects of sexual and marital problems.[10] Such books can be specific to a particular problem or generic (such as *In Touch: The Ladder to Sexual Satisfaction*, written by the well-known and popular physician-couple Beryl and Noam Chernick, and available through Sound Feelings Limited, 205-648 Huron Street, London, Ontario, NY5 4J8, phone [519] 672-5420). Specific chapters in this book (*Sexual medicine: primary care*) include suggestions usually located within the 'treatment' sections on self-help books that have been published in recent years or are older but have 'stood the test of time.' Also, Appendix IV lists Web sites that are informative on several sex-related subjects. One must

be aware that, in spite of the information available, books (for example) are often not read the very by people who might have the most to gain. Hence the need for the knowledgeable health professional.

Indications for Referral for Consultation or Continuing Care by a Specialist

Although many sexual problems can be handled within primary care, some should be referred to specialists, *but only after an in-depth diagnostic assessment is completed by the primary care clinician*. Referral may be for consultation only (that is, for one or several visits to provide the patient and referring professional with an expert second opinion) or, alternatively, for continuing care (i.e., to transfer the patient's care to another health professional).

Obviously, the purpose in requesting consultation from another health professional is for the consultant to provide the referring person with diagnostic knowledge or skill that he or she does not have. In the inherently multidisciplinary area of the assessment and treatment of sexual problems, consultation can be enormously valuable and should be exploited.

One of the reasons for referral when the purpose is that of transferring care to another health professional is the character of the disorder itself. It makes little sense to attempt treatment within primary care for a problem that sex-specialists, themselves, find management difficult. Such is the case, for example, with the lifelong and generalized absence of sexual desire.

A second justification for referral for continuing care is complexity of the case. Complexities may exist when, for example, there is coexistence of sexual and psychiatric disorders. The intricacies involved in managing two concurrent issues *may* require care that extends beyond the usual pattern of practice, interest, or level of professional expertise found in primary care.

A third opportunity for referral (at least for consultation and possibly for continuing care) is when treatment at the primary care level was attempted but did not help resolve the major concerns of the patient.

The choice of the kind of health professional to whom referral is made depends, obviously, on the reason for the referral. For the evaluation of possible medical contributors to a sexual dysfunction, the opinion of a specialist physician would be desirable. When considering the contribution of psychological factors to a sexual dysfunction, or the integration of biological and psychological issues, consultation with a health professional who has had supervised training and experience in the care of patients with sexual problems and also a background in the behavioral sciences would be advantageous. Such professionals, from several academic health-related areas such as medicine (psychiatrists, gynecologists, urologists, family physicians), psychology, nursing, and social work over the past three decades, established a discipline that is now known as "sex therapy." The skills of these clinicians, and the extent of the field, has developed over the years to include patients with sexual dysfunctions, as well as individuals with various sexual problems associated with medical, psychiatric, and other sexual disorders.

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