

UNIT 6: HUMAN SEXUALITY

Educational Topic 56: Sexuality and Modes of Sexual Expression

Rationale: All physicians should be able to provide a preliminary assessment of patients with sexual concerns and make referrals when appropriate.

Intended Learning Outcomes:

A student should be able to:

- Obtain a sexual history; including sexual function and sexual orientation
- Describe the physiology of the female sexual response
- Describe the common patterns of female sexual dysfunction
- Identify the physical, psychological and societal impact on female sexual function

TEACHING CASE

CASE: A 29 year-old G1P1 woman comes to see you because of decreased sex drive and pain with intercourse. She reports that since the birth of her child about one year ago, her sexual relationship with her husband never returned to normal. She does admit to being very stressed out lately because she started a new job six months ago and she is trying to balance it out with being a mother. She also reports being very tired most of the time. She is using oral contraceptive pills for birth control.

COMPETENCY-BASED DISCUSSION & KEY TEACHING POINTS:

Competencies addressed:

- Patient Care
- Medical Knowledge
- Interpersonal and Communication Skills
- Professionalism

1. What are the key components of a sexual history?

The issue of sexuality should be raised in the context of the general history. Simple open-ended question such as, “Are you happy with your sexual life?” demonstrates to the patient that the clinician is comfortable discussing the topic. Other things to keep in mind include:

- Be matter-of-fact and use simple terms
- Start with easier subjects
- Be sensitive to the optimal time to ask the most emotionally charged questions
- Look for non-verbal cues that may signal discomfort or concern
- You should ask your patient if they are having sex with women, men or both. However until you are sure of their sexual orientation, use gender-neutral language in referring to partners until you have specifically broached this topic with the patient.
- If you are unsure of the patient’s gender identification, then ask the patient what their gender identity is and their “gender-preferred pronoun.” You can also ask them their birth sex.
- Explain and justify your questions.

2. Describe the physiology of the female sexual response.

Masters and Johnson originally described the sexual response cycle in 1966 as a four-part cycle (excitement, plateau, orgasm, and resolution). It was thought that the sexual response had to proceed from point A to B to C to D. Basson’s intimacy-based model is a more accurate model to depict the female sexual response. Rather than a linear model it is a circular model that may start with emotional intimacy or sexual stimuli, proceeds to sexual arousal, sexual desire, and emotional and physical satisfaction. Emotional and physical satisfaction leads back to emotional intimacy.

3. What is the definition of sexual dysfunction?

Female sexual dysfunction is a multifactorial group of disorders. There are two main types of sexual dysfunction. The first type consists of six specific diagnostic categories that have to do with three phases of the sexual response cycle: sexual desire (hypoactive sexual desire disorder and sexual aversion disorder), sexual arousal, and orgasmic (both primary and secondary). The second type of dysfunction focuses on the sexual pain disorders: dyspareunia and vaginismus.

4. What are the potential etiologies of this woman’s sexual dysfunction?

Careful history and physical exam need to be done to rule out any possible underlying medical problem such as anemia, hypothyroidism or diabetes. The health care provider should also evaluate for substance abuse disorders (such as smoking or alcohol use), or any other medications that can affect sexual function. The practitioner should evaluate for PID or endometriosis via a physical examination. This patient may have underlying emotional problems and possible depression. She needs to be counseled on marriage expectations in light of her exhaustion and ability to cope with new and stressful responsibilities. Breastfeeding or oral contraceptive pills can cause vaginal dryness, which could be the etiology of her dyspareunia.

5. How do you treat this patient's sexual dysfunction?

Depending on the etiology or the problem, single disorders of less than 1-year duration in the context of a stable relationship are more likely to be amenable to simple interventions. Patients with one or more problems in the context of unstable relationships are best referred to a sex therapist. Couples counseling might also be helpful.

CASE 2: L.W. is a 22-year-old G0 who comes to the office for a health maintenance exam. Her previous medical and surgical history is negative. She has regular menses, has never had a history of abnormal Pap tests. Her last one was 2 years ago. She lives with Lisa, her current partner of 6 months. She smokes 1 pack per day and has for the last 10 years. She does not use alcohol or any other drugs. She is on no medications. She has no complaints.

Physical exam:

Young healthy woman in no distress. Exam all normal.

COMPETENCY-BASED DISCUSSIONS & KEY TEACHING POINTS:

Competencies addressed:

- Patient Care
- Medical Knowledge
- Interpersonal and Communication Skills
- Professionalism

1. What issues should be discussed at this patient's well-woman visit?

This is a young healthy woman whose only issue is smoking and so the topic of smoking cessation should be discussed. Routine cervical cancer screening is recommended for all women. The onset and interval for this testing should be based on current recommendations and risk factors, and she should be counseled appropriately. You should be alert to the signs and symptoms of depression, substance abuse, and intimate partner violence and conduct appropriate screening and intervention. You also need to be sympathetic to lesbian issues, so she is comfortable discussing any relationship problems. There are no definitive psychological or dynamic traits that differentiate lesbian women from heterosexual women except the wish for psychological and physical intimacy with another woman. Her sexual orientation does not put her at any additional risk for STI's, but does not exclude her from contracting a sexually transmitted infection. While contraception is not an issue, protection from sexually transmitted infection is a concern and should be discussed where relevant. Some lesbian women have, in the past, had sexual relationships with men, and this should be a consideration in their care. Be prepared to discuss desire to have/raise children. General recommendations for mammography, colorectal cancer screening, hormone therapy, and osteoporosis screening should be followed for all lesbian women.

2. What are some special concerns regarding health care and women in same- sex relationships?

Patients and providers sometimes have limited understanding of health risks for women in same-sex relationships. Lesbian patients face social stigma, hostility, hatred, and isolation, and are at higher risk for depression, suicide, victimization, sexual risk behaviors, substance use, tobacco use, and eating disorders. Obesity, cervical cancer, ovarian cancer, endometrial cancer and breast cancer are more prevalent in lesbian women. Therefore, it is important for practitioners to ask about sexual activity with males and/or females, attraction to males and/or females, and self-identification as lesbian or bisexual. Women in same-sex relationships encounter bar-

riers to health care that include concerns about confidentiality and disclosure. They also face discriminatory attitudes and treatment, and may have limited access to health care and health insurance. Lack of legal recognition of their relationships may adversely affect health insurance coverage for themselves and their partners.

REFERENCES

- Beckman CRB, et al. *Obstetrics and Gynecology*. 7th ed. Philadelphia: Lippincott, Williams & Wilkins, 2013.
- Hacker NF, Moore JG, et al. *Essentials of Obstetrics and Gynecology*. 5th ed. Philadelphia: Saunders, 2010.
- Basson R. Clinical Updates in Women's Health Care: Sexuality and Sexual Disorders. *ACOG* 2003;11(2):22-32.
- Plaut SM, Graziottin A, Heaton JW. *Sexual Dysfunction (Fast Facts), Indispensable Guides to Practice*. Health Press. March 2004.
- ACOG Practice Bulletin 119 "Female Sexual Dysfunction" April 2011 (reaffirmed 2013)
- ACOG Committee Opinion 525 "Healthcare for Lesbians and Bisexual women" May 2012 (reaffirmed 2014)