


Talking about sex, quality of life and impact on relationships

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Female Sexual (FSD)

Female Sexual Desire/Arousal Disorder
(concept of responsiveness)

Female Orgasm Disorder

Genito-Pelvic/Penetration Disorder
- Dyspareunia
- Vaginismus

<u>Must cause personal distress</u>

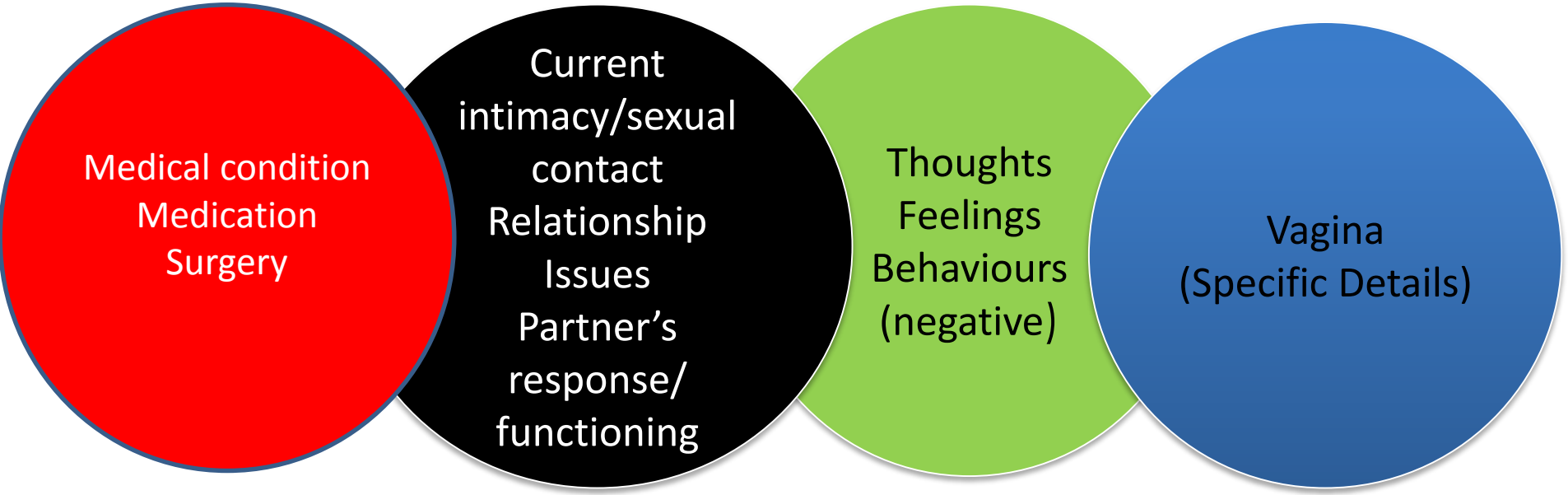
DSM V

Basson R. Women's sexual dysfunction: revised & expanded definitions. Can Med Ass J 2005

DURING ASSESSMENT……

Organic, Psychogenic, Mixed

Primary, secondary, situational



Successful Communication

- Start communication by listening, try not to interrupt or write anything for 2 minutes
- ***"Tell me"*** is a good opening line as is ***"I need to ask you some personal questions"*** or "***menopause/diabetes/surgery can sometimes cause sexual problems but there are treatments available so please let me know if you have any concerns or want to discuss anything with me"***
- Eye contact and positive body language are important throughout the consultation. ***Remember they will be watching You!***
- Patients only tell us what they think ***WE*** can handle. If you're not comfortable talking about sex, it's likely your patients will not tell you their problems

Successful Communication

- Understand the language your patient uses eg ***"my libido is low"***, ask them to give an example
- Always be sure that patients understand the words you are using
- Ask for clarification, "I ***NEVER*** feel like sex", "my erection ***ALWAYS*** fails "sex hurts ***EVERYTIME*** ", "we have sex ***A LOT"***
- Provide an alternative way of seeing things – Cognitive re-framing

Male Sexual Dysfunction

Erectile Dysfunction
Premature Ejaculation
Delayed Ejaculation
Male Hypoactive Sexual Desire Disorder

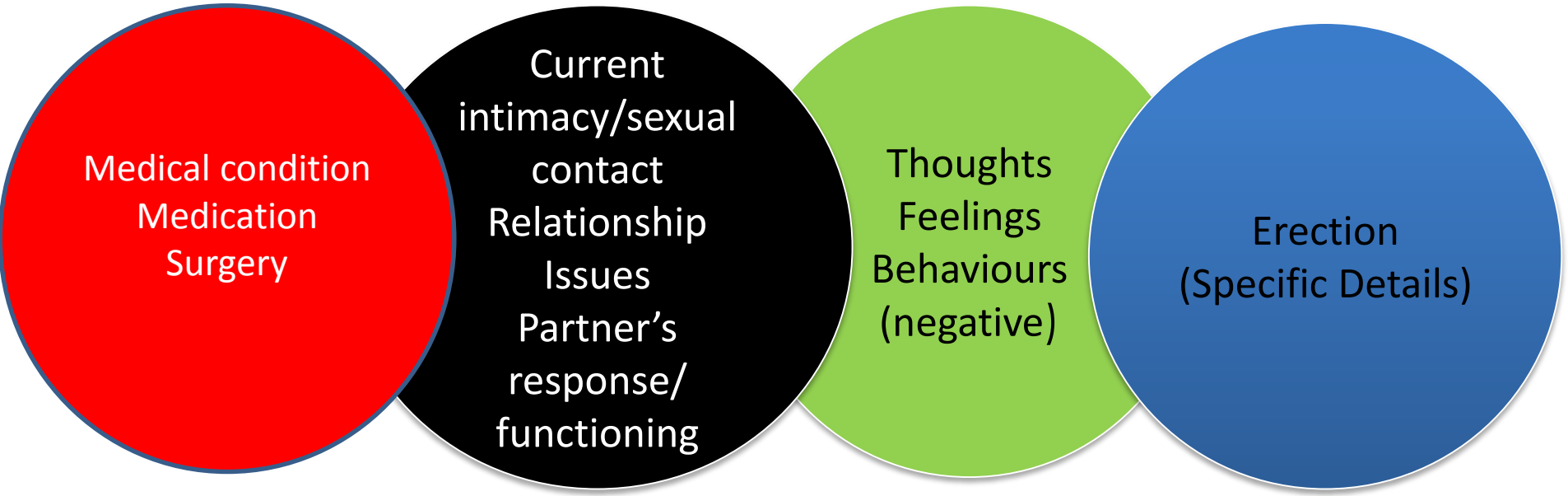
Must cause personal distress

DSM V

DURING ASSESSMENT……

Organic, Psychogenic, Mixed

Primary, secondary, situational



Masturbatory frequency and technique provide a wealth of diagnostic information

(Perelman 1994)

Useful questions

1. Are they aware whether they get night-time erections?
2. Do they get erections for masturbation?
3. How often they masturbate and do they use porn?
4. Do they ‘test’ out their erectile responses?
5. With premature ejaculation and delayed ejaculation ask more details about technique?

Goals of management of ED

The symptoms of ED can be treated but cannot generally be cured

Symptomatic treatment aims to re-establish a satisfactory sexual relationship, as defined by the individual patient/couple

Underlying disease and risk factors should also be identified and treated/modified

Patient satisfaction and quality of life concerns need to be addressed

EAU Guidelines 2013

PST referral

Dear Angela

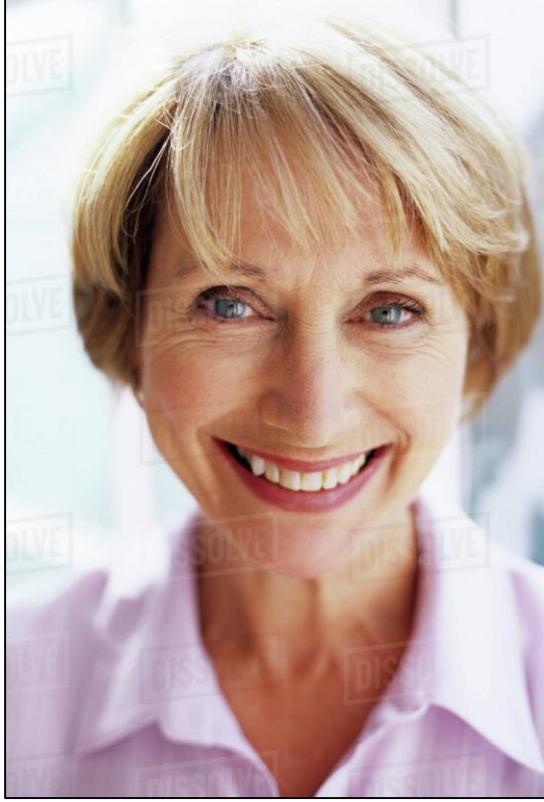
I would be grateful if you could kindly help this lady with regards to her vulvodynia. She has been put on Gabapentin by myself about six months ago which has not helped. She has also been put on Nortripyline by her GP which I have asked her to continue.

I hope the psychosexual counselling helps.

Yours sincerely

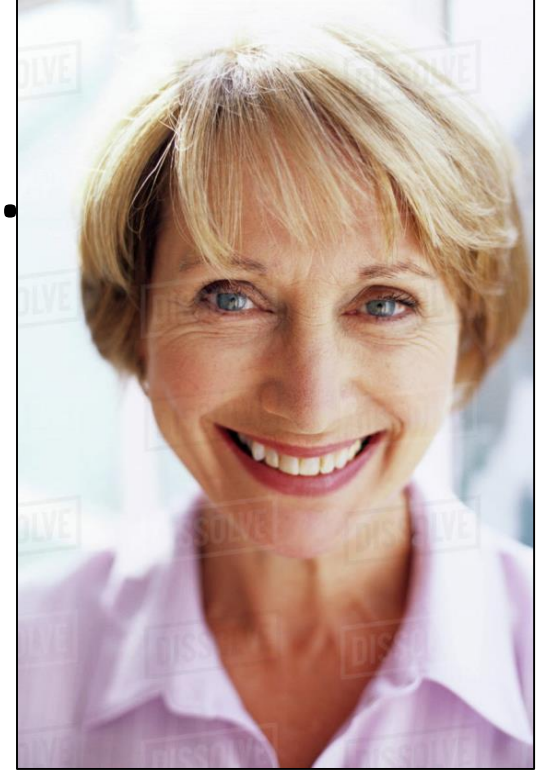
Consultant Gynaecologist

JANET



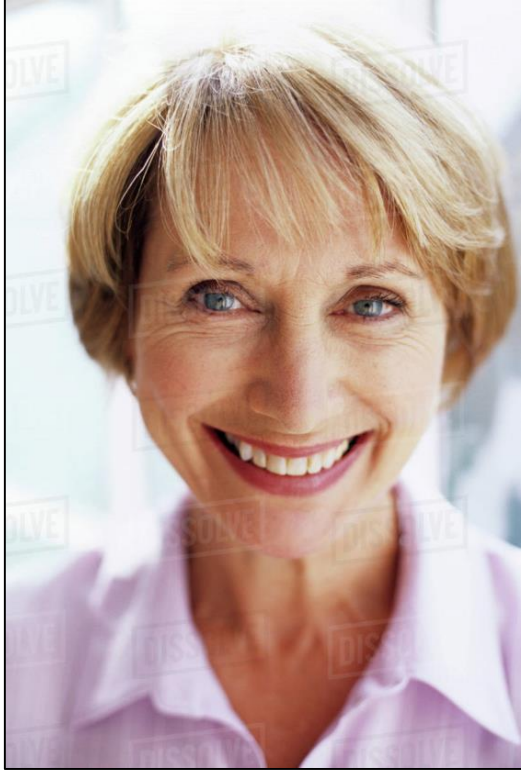
- 58 years old
- Happily married with 2 adult children, who no longer live at home
- Retired
- Ovarian cancer – total abdominal hysterectomy and bilateral salpingo-oophorectomy age 45. Discharged from follow-up
- Non-smoker, occasional alcohol
- Medically well, apart from vulval soreness – GP referred to gynaecology
- Gynaecology referred for psychosexual therapy assessment…

First impressions……

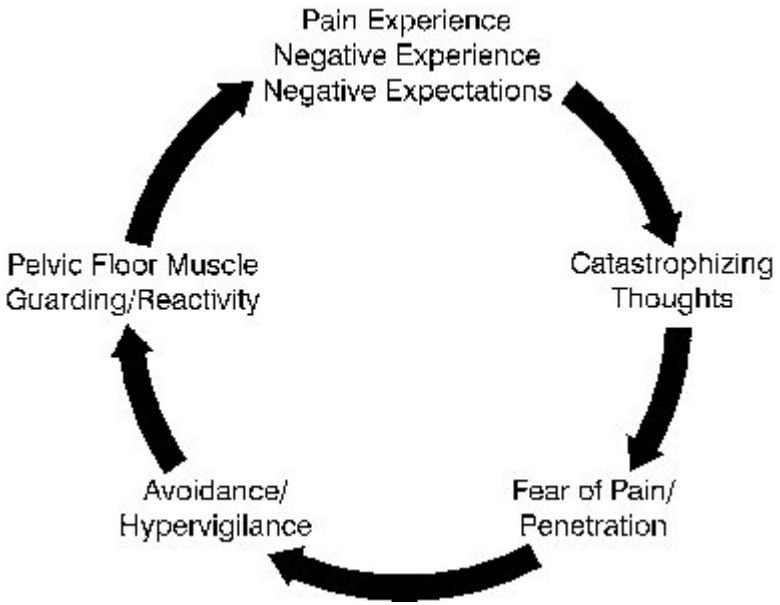


- Very tense and angry
- Didn’t want husband present
- Unsure whether she wanted to resume a more intimate/sexual relationship

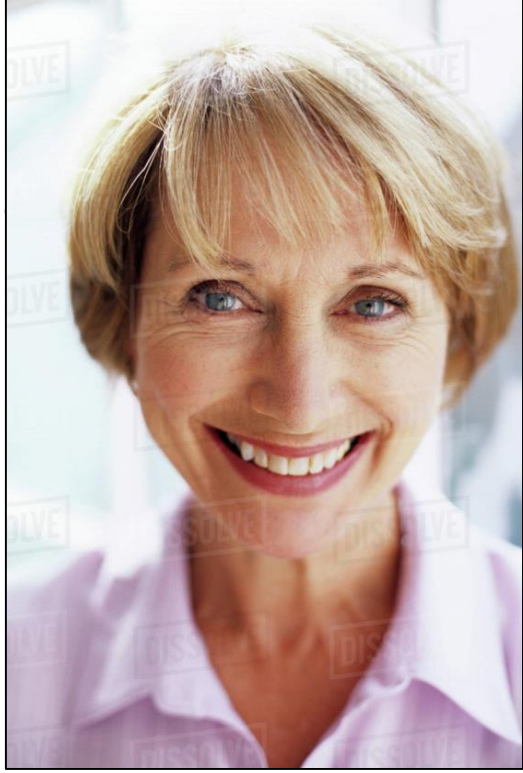
- Self-diagnosed with interstitial cystitis
- Found Replens irritating
- Doesn't want HRT
- Daily pelvic floor 'tensing exercises' since hysterectomy
- Finds it difficult to relax generally
- Concerns about cancer returning
- Concerns about vaginal shortening
- Occasional sexual desire
- Still orgasmic although this takes much longer
- Not had sexual intercourse for many years
- Rarely sexual with husband
- Avoidance of activities she feels may 'trigger' symptoms



The cycle of sexual pain

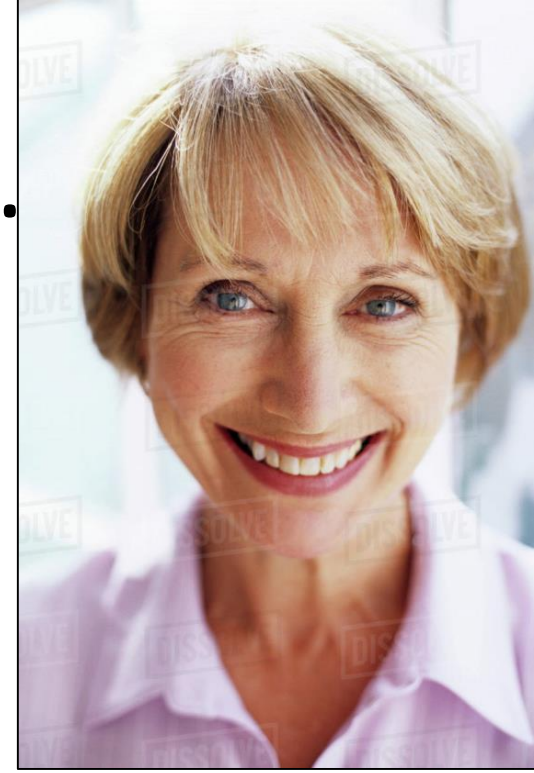


Hypothesis……



- Vulval symptoms related to menopause?
- Urethral symptoms related to menopause and pelvic floor hypertonicity?
- Vulval/Vaginal symptoms related to pelvic floor hypertonicity?
- Anxiety
- Inability to relax
- Lack of arousal

Session one, advice given…..



- Given advice and handout on different lubricants/vaginal moisturisers
- Given samples of ‘Yes’ lubricant and vaginal moisturiser
- Discussed role/impact of pelvic floor muscles with vaginal and urethral discomfort/pain
- Suggested she speak to husband about whether or not they wished to resume a sexual relationship

The Contribution of the Pelvic Floor Musculature to Dyspareunia

Pelvic-floor muscle hypertonus has been demonstrated to contribute to interstitial cystitis (1), provoked vulvodynia (2), and generalised vulvodynia (3).

Studies have demonstrated that pelvic floor muscle hyperactivity is a part of an overall response to heightened anxiety (4). Genital pain may also trigger pelvic floor dysenergia (5).

1 Peters KM, Carrico DJ, Kalinowski SE et al (2007) Prevalence of pelvic floor dysfunction in patients with interstitial cystitis. Urology 70 16-18

2 Reissing ED, Brown C, Lord MJ (2005) Pelvic Floor muscle functioning in women with vulvar vestibullitis syndrome. J Psych Obs & Gynae 26 107-13

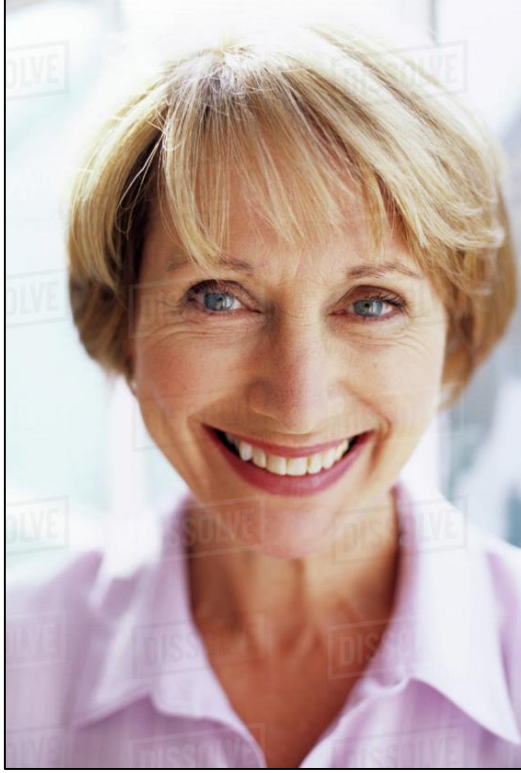
3 Glazer HI, Jantos M, Hartmann ED (1998) Electromyographic comparisons of the pelvic floor in women with dysesthetic vulvodynia and asymptomatic women. J of Reprod Med 43 959-62

4 Van der Velde J, Everaerd W (2001) The relationship between involuntary pelvic floor muscle activity, muscle awareness and experienced threat in women with and without vaginismus. Beh Research & Therapy 39 395

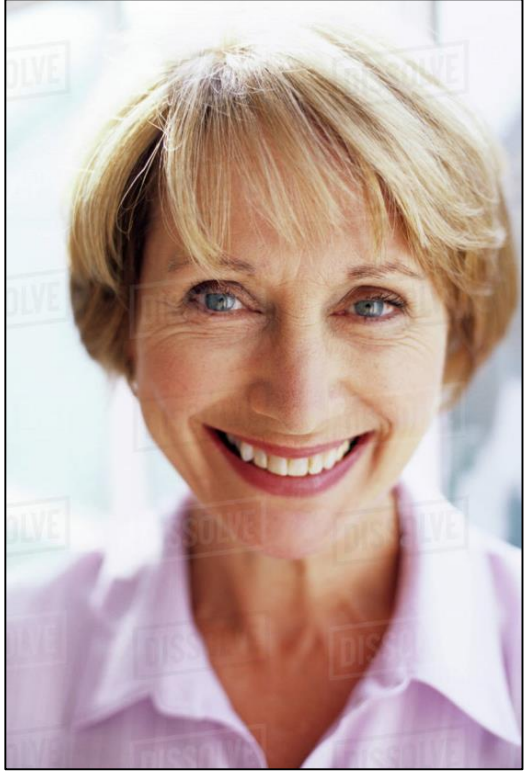
5 Rosenbaum TY Physical Therapy Evaluation of Dyspareunia Chapter 6 in Female Sexual Pain Disorders eds Goldstein AT, Pukall CF, Goldstein I 2009

Session two

- Felt she had more understanding about her condition after initial assessment
- Vaginal moisturiser has helped reduce her vulval symptoms
- Will consider re-establishing a more intimate relationship but with clear boundaries
- Would like more whole body touch
- Agreed to use size 0 vaginal trainer
- Breathing and pelvic floor relaxation exercises given



Session three



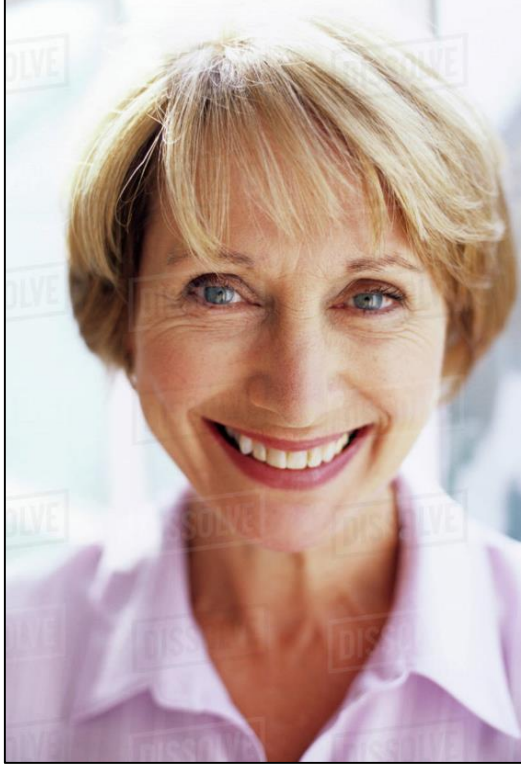
- Used trainer but only once per week due to concerns about triggering symptoms
- She has been sexually intimate with Husband – no sexual intercourse
- She feels better in herself

Action Plan

- Book ‘Anxiety for Beginners’
- Use trainer more frequently
- Intimacy x 1 per week with clear boundaries and to explore context and touch
- Handout re ISC and pelvic floor

Session Four

- Handout really help her understanding
- General mood much improved
- Had sexual intercourse x 2 which they both enjoyed
- Experienced some urethral symptoms afterwards but she managed these and they didn't 'trigger' spiral of health anxiety
- Due to see Physiotherapist so doesn't feel she needs to see me again but did request 3 month 'open' appointment



Talking about Sex……

1. If you ask the right questions

2. You can give the right treatment

3. And manage expectations

4. And offer practical suggestions

WHY?

BECAUSE A PARTNER ……

- Will be affected too!
- They can encourage and support treatment for sexual dysfunction
- May contribute to the maintenance of sexual dysfunction after surgery/treatment

‘A partner is a participant not just a spectator’

Sexual intimacy in heterosexual couples after prostate cancer treatment: what we know and what we still need to learn. Uro-oncol 2008 mar-apri;27920:137-43

'Sex is not a natural act like breathing, it is a talent, like dancing. Some are good at it, some are not but most can learn how to make it better'

Dr Leonore Tiefer