

# The Basics Identification of Sexual Health Problems & Epidemiology

Juliana (Jewel) M. Kling, MD MPH NCMP FACP  
Professor of Medicine  
Chair, Division of Women's Health Internal Medicine  
Associate Chair, Equity Inclusion & Diversity DOM  
Mayo Clinic Arizona

International Society for the Study of Women's Sexual Health  
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# Disclosures

- **Relevant Financial Relationships**
- Consulting for Triangle Insights Group, Everyday Health and Kindra and Proctor and Gamble
- **Off-Label and/or Investigational Uses**
- None



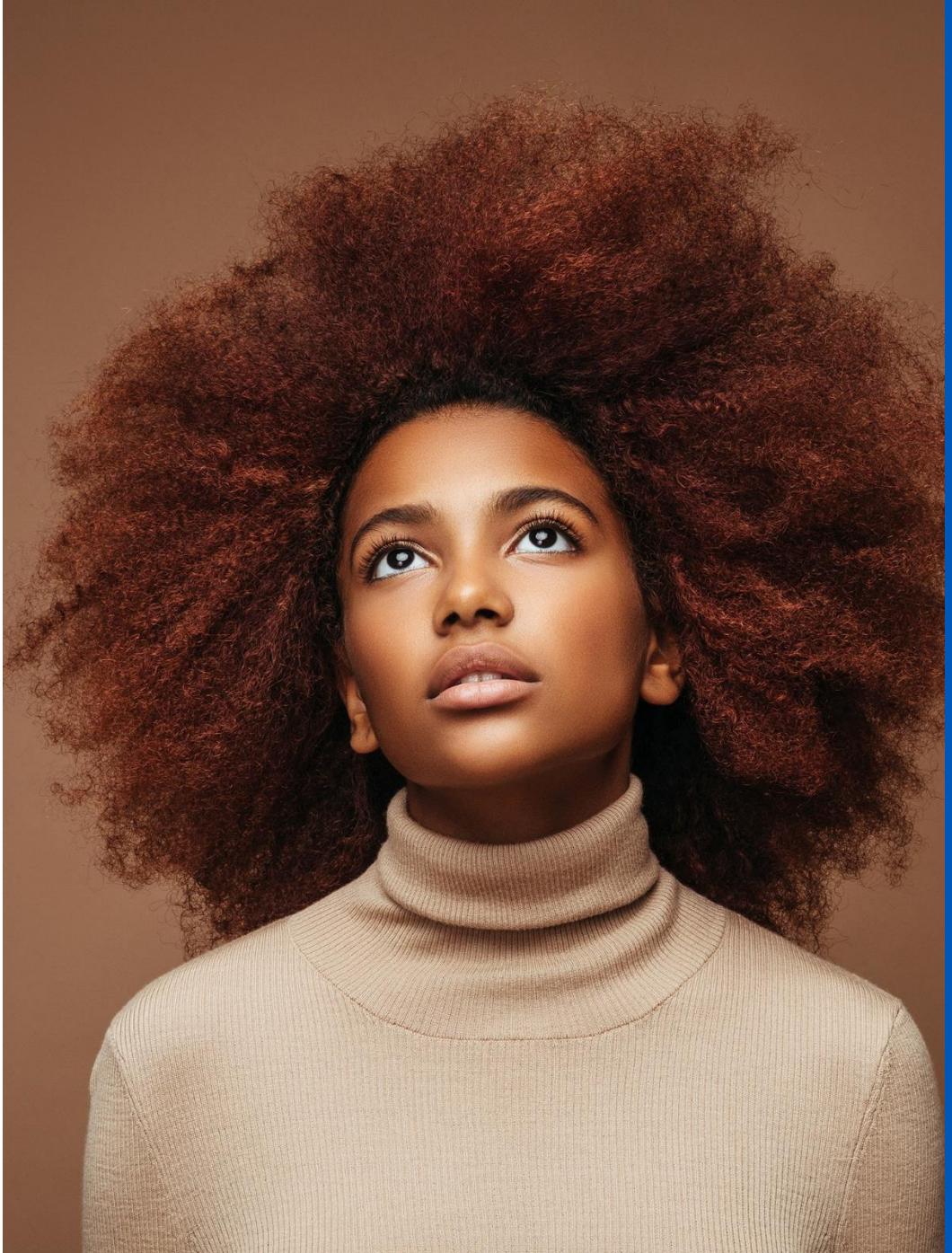
Most research in this field has been done in N. America and in cisgender people, and thus may not be generalizable to other populations including transgender and nonbinary people.

# Learning Objectives

- Recognize the epidemiology and type of distressing sexual problems in women
- Discuss recommendations for identification of sexual problems in women using the ISSWSH process of care 
- Develop an understanding and plan for screening, education, management and referral for women with sexual problems through a case example

Parish JP et al. The International Society for the Study of Women's Sexual Health Process of Care for the Identification of Sexual Concerns and Problems in Women. Mayo Clin Proc. 2019; <https://doi.org/10.1016/j.mayocp.2019.01.009>

The most fundamental recommendation of the POC is **simply to ask** about sexual satisfaction, concerns or problems.



## **Case: Ronda is a 28 yo computer engineer**

- She has a question about her sex life but doesn't know who to ask...

# Myth vs. Truth: Patients don't want to talk about sex

- **MYTH**
- 85% of men and women want to talk to their providers about sexual health
  - 90 % prefer we initiate the topic
- 94% of patients state sexual enjoyment is important in their lives
- Sexual problems common: 43% of ♀ & 31% of ♂
- Dysfunction → decreased quality of life, depression, low self-image

Laumann, Paik, & Rosen, 1999; Marwick, 1999  
Kingsberg SA. JWH. 2014  
Biddle AK, et al. Value Health. 2009.  
Sadovsky R, Nusbaum M. J Sex Med. 2006.  
The Women's Sexual Health Foundation. [www.twshf.org/survey.html](http://www.twshf.org/survey.html)

# Myth vs Truth: Sexual problems are rare in women

## Myth

### Epidemiology

- 44% of women reported any sexual problem
- When distress combined with a sexual problem  
→ **12% experienced any distressing sexual problem**
- More common in women aged 45 to 64 years



10.8%

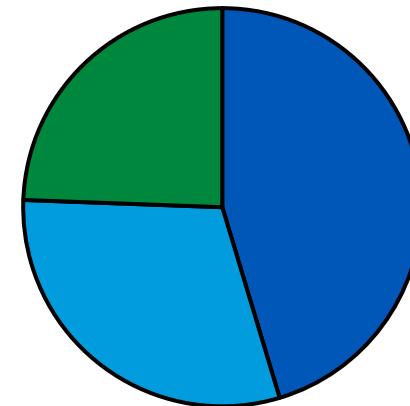


14.8%



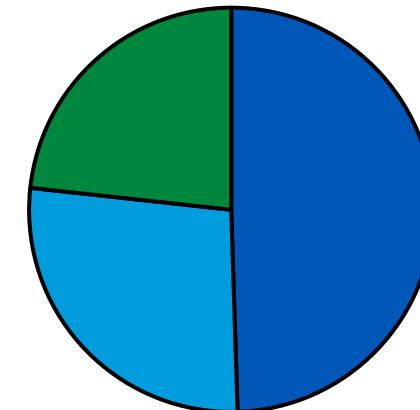
8.9%

### Sexual problems



- Low Desire (39%)
- Low Arousal (26%)
- Orgasm problem (21%)

### Sexual problems + distress

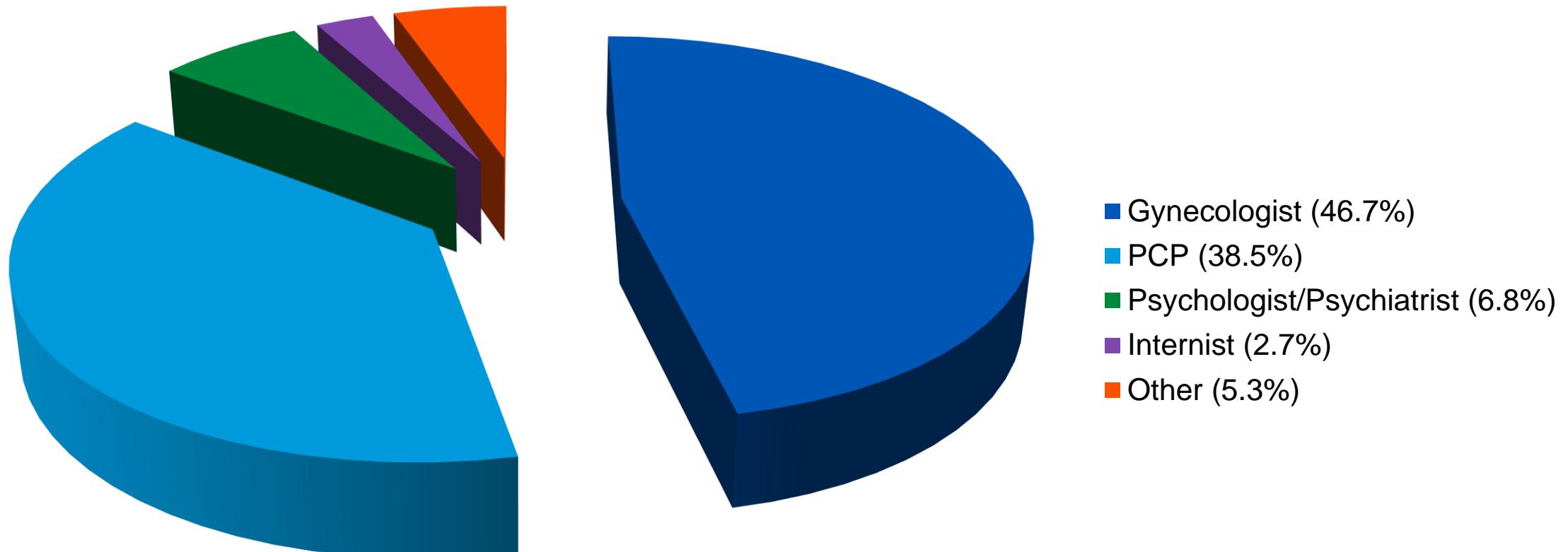


- Low Desire (10%)
- Low Arousal (5.5%)
- Orgasm problems (4.7%)

*Prevalence of Female Sexual Problems Associated with Distress and Determinants of Treatment Seeking (PRESIDE)*

# Of those seeking treatment...

- Most sought help from PCP or Gynecologist



Shifren JL, et al. J Womens Health. 2009;18(4):461-468.

# **Patients believe their doctors are unconcerned about their sexual problems**



**They did not give me a diagnosis (85%)**

**They did not thoroughly examine my complaints (76%)**

**They did not want to hear about the problem (52%)**

**They didn't set up a follow-up (87%)**

# Meanwhile, clinicians are thinking...

I'm not sure if I'll know how to treat their issue

I never learned about this in medical school

What if it embarrasses my patient to ask?

We have to first discuss their hypertension, immunizations, knee pain, mammogram, etc... (in 20 minutes!)

I'm not familiar with any treatments



Korenman, SG, 1998, Brokeman, CPM et al, 1994, Eid JF et al, 2001, Baum, N et al. 1998.

# A simple place to start: **Screen all women**

- Simple, direct language
  - “just ask,” ubiquity statement screen, asking in context of relationship or basic assessment of sexual functioning
- Compassion, normalizing statement
- Declare lack of embarrassment
- Ensure confidentiality
- Avoid judgement & assumptions

“Do you have any sexual health concerns? I ask all my patient this because its an important aspect of health. Anything you tell me is confidential.”



## Case cont...28 yo computer engineer

“What sexual health concerns do you have?  
Anything you tell me is confidential.”



- She has noticed she's not interested in sex like before and it is causing her distress
- Started an antidepressant (SSRI) about 6 months ago for anxiety
- She is healthy and denies any other sexual problems



# *Following screening & detection*

## Four-Step Model

### STEP 1

Elicit the patient's story

### STEP 2

Name &  
(re)frame  
attention to the  
sexual concern  
or problem

### STEP 3

Empathic  
witnessing

### STEP 4

Referral or  
assessment  
& treatment

# Case continued...

## Ronda - 28 yo computer engineer

Patient-centered communication:

Open-ended questions

Ask-tell-ask

### 1. Elicit the story

- Tell me more about your symptoms?
- How has this impacted your life?

Invite the pain into the room

### 2. Name & (Re) Frame attention to the Sexual problem or concern

“It seems to me that in addition to your decreased interest in sex, what you’ve just told me about your concern for your orgasm is just as important and worthy of attention.”



### 3. Empathic Witnessing

- Powerful & healing and amplified when the clinician reflects her or his understanding of the patient's life and efforts in words.
- "I am impressed with how committed you are to addressing your sexual health problem despite how difficult that is."
- "You are determined to try and solve this problem."

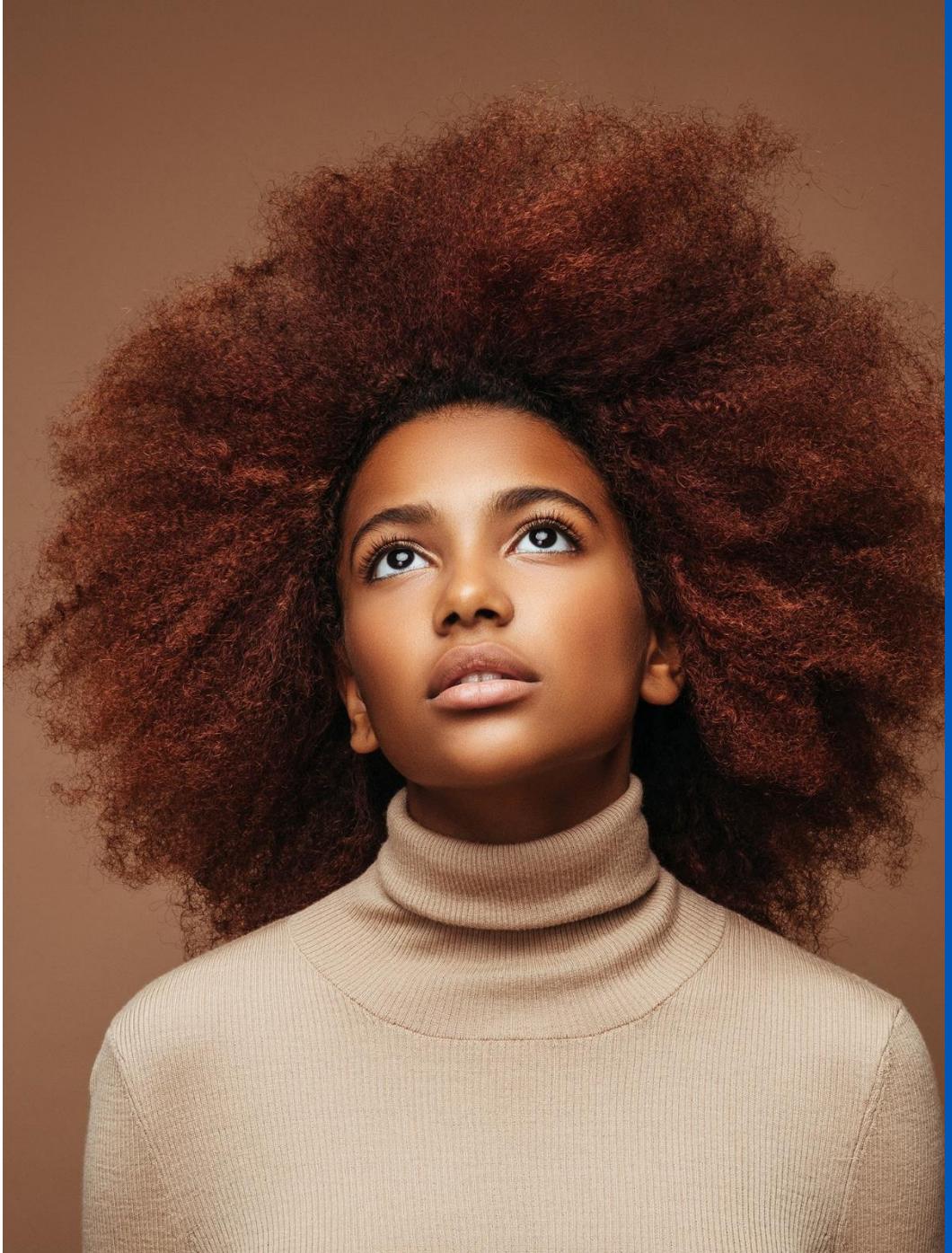
*Where the beginning of treatment starts for many women*



### 4. Referral or Assessment & Treatment

- If refer, set it up
- "I consider sexual health to be important to your overall health...I have a colleague who specializes in treating this."

Let's assess & treat Ronda



## **Case continued: Ronda is a 28 yo computer engineer**

- “I am impressed with how committed you are to addressing your sexual health problem despite how difficult it may be.”
- Let’s talk about next steps including what may be contributing to your sexual problems and how we can address it...

Where  
do I  
start?



# Defining Female Sexual Dysfunction (FSD)

- Must cause significant distress or interpersonal difficulty to be a dysfunction
- Not better account for by another disorder (e.g. depression), medical condition (e.g. GSM) or substance (e.g. alcohol)
- Persist for a minimum of 3 months, with at least 75% of sexual experiences
- Defined by
  - Onset → lifelong vs. acquired
  - Context → generalized vs. situational
  - Characteristics → mild, moderate or severe AND duration (longer than 6 months)

## ***Physiological***

- Neurological problems
- Cardiovascular disease
- Cancer
- Urogenital disorders
- Gynecologic disorders
- Medications
- Fatigue
- Hormonal loss or abnormality

## ***Psych/emotional***

- Anxiety, stress
- Self-image
- Depression
- Hx of abuse or trauma
- Alcohol/substance abuse

# **Female Sexual Dysfunction**

## ***Sociocultural influences***

- Limited sex education
- Conflict with religious, personal or family values
- Societal taboos

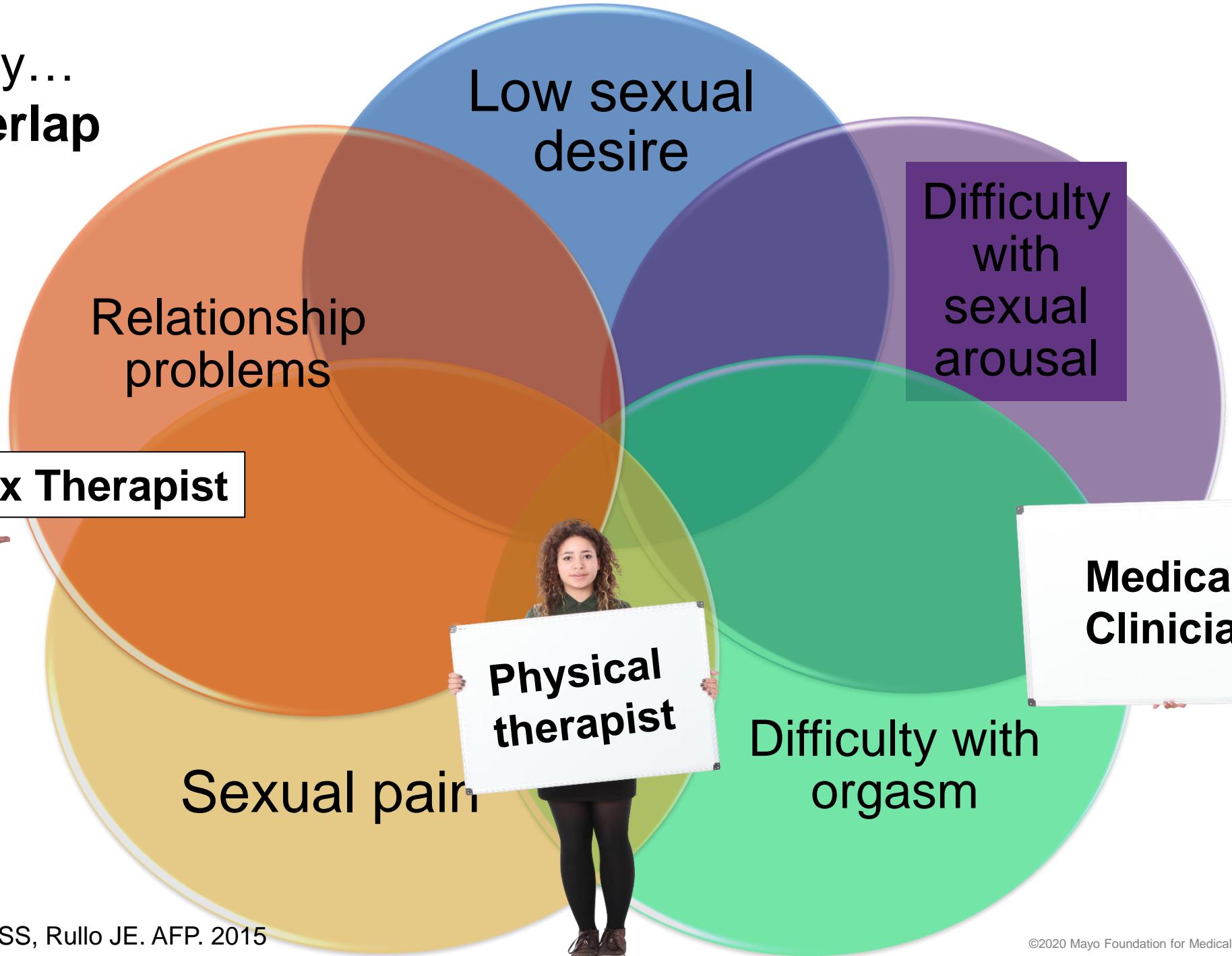
## ***Interpersonal relationships***

- Partner performance and technique
- Lack of partner
- Relationship quality, conflict, communication
- Logistics, lack of privacy

# ISSWSH & ICSM FSDs: Nomenclature and Definitions

Disorder		
Hypoactive sexual desire disorder	Lack of motivation for sexual activity Loss of desire to initiate or participate in sexual activity	Desire
Female sexual arousal disorder Female cognitive arousal disorder Female genital arousal disorder	Distressing difficulty or inability to attain or maintain mental excitement associated with sexual activity Distressing difficulty...genital response	Arousal
Persistent genital arousal disorder	Persistent or recurrent, unwanted or intrusive, distressing feelings of genital arousal or being on the verge of orgasm	
Female orgasm disorders	Persistent or recurrent distressing compromise of orgasm frequency, intensity, timing or pleasure with sexual activity	Orgasm
Female orgasmic illness syndrome	Peripheral or central aversive symptoms that occur before, during or after orgasm (not related to orgasm quality)	
Genitopelvic pain penetration dysfunction	Persistent or recurrent difficulties with vaginal penetration, vulvovaginal/pelvic pain during genital contact, fear or anxiety in anticipation of pain, hypertonicity or overactivity of pelvic floor muscles +/- genital contact	Pain

The reality...  
They overlap



# Common Medical Issues Affecting Sexual Functioning

- Oral Contraceptives
- Depression & Antidepressant medication
- Other medications
  - Tamoxifen, aromatase inhibitors, gonadotropin-releasing hormone agonists, antihypertensives, antihistamines
- Genitourinary syndrome of menopause
  - Affects at least 50% of postmenopausal women
- Partner Sexual Problems

Like in  
Ronda's case

# Assessment of FSD: Biopsychosocial approach

Medical, Social & Relationship History

Medications too!

Detailed Sexual History

Sexual health domains

Physical Exam

Pelvic exam including vulvovaginal exam & pelvic floor assessment

Lab testing

Not often required (consider STI screening, additional labs based on her symptoms and findings on physical exam)

## **Desire**

- Frequency of interest in engaging in sexual activity
- Spontaneous vs responsive desire

## **Orgasm**

- Frequency of orgasm, ease & methods of achieving
  - Intensity & satisfaction with orgasm

## **Arousal**

- Difficulty with lubrication, diminished genital engorgement & sensation
- Sufficient sexual stimulation?

## **Pain**

- Constant (unprovoked) vs only during penetration/genital contact
  - Superficial vs deep
- Relationship with arousal & context



# Case continued...

- Basic Assessment → based on sexual response domains
  - Low sexual desire
  - Difficulty with sexual arousal
  - **Difficulty with orgasm**
  - Sexual pain/genitopelvic pain penetration dysfunction
  - Relationship problems
- **Empathetically helping delineate the problem can be therapeutic and help your patient start to solve the problem**



You can provide basic education:

- Medication adverse sexual effects
- Sexual function changes due to menopause
- Role of lubricants & moisturizers

TABLE 3. Treatments for Female Sexual Dysfunctions<sup>34,36,52,55</sup>

Medication category	Product name	Formulation	Indication
<b>Pharmacologic treatments</b>			
Local vaginal estrogens	Estradiol or CEE cream (Estrace, Premarin) Estradiol vaginal tablet (Vagifem, Yuvaferm) Estradiol vaginal gel cap (Imvexxy) Estradiol vaginal ring (Estring) Ospemiphene (Osphepa)	Cream Vaginal tablet Vaginal gel cap Vaginal ring Oral tablet	Genitourinary syndrome of menopause Genitourinary syndrome of menopause
Selective estrogen receptor modulator			
DHEA	Prasterone (Intrarosa)	Vaginal suppository	Genitourinary syndrome of menopause
Testosterone (Not FDA approved in women, approved in countries outside the United States)	Testosterone	Transdermal cream or gel	Hypoactive sexual desire disorder
Serotonin agonist/antagonist	Flibanserin (Addyi)	Oral tablet	Hypoactive sexual desire disorder
<b>Nonpharmacologic treatments</b>			
Lubricants	Multiple products	Water-based Silicone-based Hybrid (water- and silicone-based) Oil-based	Used as needed for to reduce friction and enhance comfort with sexual activity
Moisturizers	Multiple products	NA	Used regularly for maintenance of vulvar/vaginal moisture
Sex therapy	NA	NA	Helpful for all FSD diagnoses
Pelvic floor physical therapy	NA	NA	For treatment of pelvic floor dysfunction
Mechanical devices	Vibrators Clitoral vacuum device (Eros)	NA	Used to enhance vulvar, clitoral, and vaginal stimulation
Vaginal lasers (FDA cleared, but no specific indication for genitourinary syndrome of menopause)	Carbon dioxide fractional lasers Erbium YAG lasers	NA	Genitourinary syndrome of menopause

CEE = conjugated equine estrogen; FDA = Food and Drug Administration; FSD = female sexual dysfunction; NA = not applicable; YAG = yttrium-aluminum-garnet.

# Treatments for FSD

## Directed by the type of dysfunction

# Sexual Dysfunction in Transgender People

- Limited research and no standard diagnostic criteria
- Both Gender Affirming Hormone Therapy (GAHT) and Gender Affirming surgery (GAS) may modify the sexual response physiology via multiple mechanisms, but the impact on overall sexual health is not well understood
- Systematic review in 2021 of transgender women and men showed:
  - increase in sexual desire after GAHT (testosterone) in **transgender men**, which increased within months of initiation of treatment. Route didn't matter.
  - Studies on sexual desire after GAS in **trans men** were small and results mixed
  - Sexual satisfaction demonstrated improvement after GAHT/GAS for **trans men**
  - Reduction in sexual desire was noted after GAHT for **transgender women**, but not distressing → transient and ultimately returned to baseline
  - Orchiectomy decreased desire, but vaginoplasty and breast augmentation did not impact sexual desire for **transgender women**, and overall positive affect on sexual satisfaction after GAS
  - Studies in **transgender women** found mixed results regarding orgasm after GAHT and GAS
  - Pain appeared to occur more commonly in **transgender women** with a neovagina compared to those without a neovagina
  - When compared to cisgender women, **transgender women** scored lower overall on the Female Sexual Function Index (FSFI), indicating poorer sexual function



Risk of sexual side effects with antidepressants is ~ 40%

Arousal 80%  
Desire 72%  
Orgasm 42%

## Case continued: Ronda

- **Diagnosis:** Female orgasm disorder caused by her SSRI, with resultant impact on desire
- ***Options***
  - Augmentation therapy with mirtazapine or bupropion
  - Behavioral therapies
    - Exercise, vibratory stimulation
  - Dose reduction or brief drug holiday
  - Switch antidepressants
    - Mirtazapine or bupropion (not as beneficial for anxiety)



**What if you don't know what  
to do next?**

# Establish a robust referral network

Gynecologist,  
urogynecologist, sex  
therapist, pelvic floor physical  
therapist



[www.assect.org](http://www.assect.org)  
[www.starnet.org](http://www.starnet.org)  
[www.menopause.org](http://www.menopause.org)  
[www.cancer.org](http://www.cancer.org)  
[www.womenshealthpta.org/pt-locator/](http://www.womenshealthpta.org/pt-locator/)  
[www.isswsh.org](http://www.isswsh.org)

# In Summary

- Sexual problems are common in cisgender women
- Clinicians should feel empowered to identify sexual problems in women and provide basic management strategies
  - Consider biological, psychological, sociocultural and relationship factors that may play a role
- Goal is to provide education, management and referral when appropriate for women with sexual concerns/problems





**THANK YOU**

**Questions &  
Answers**

*Kling.juliana@mayo.edu  
@DrJewelKling*

# Professional Organizations and Resources for Referral

International Society for the Study of Women's Sexual Health	<a href="http://www.isswsh.org">www.isswsh.org</a>	Provides accurate information about women's sexuality and sexual health
American Association of Sexuality Educators, Counselors, and Therapists	<a href="http://www.asset.org">www.asset.org</a>	A resource to locate sexuality educators, counselors, and sex therapists
Society for Sex Therapy and Research	<a href="http://www.sstarnet.org">www.sstarnet.org</a>	Another resource for locating sex therapists
North American Menopause Society	<a href="http://www.menopause.org">www.menopause.org</a>	A source of information for providers and patients on menopausal health. Also provides a resource for NAMS certified providers
American Cancer Society	<a href="http://www.cancer.org">www.cancer.org</a>	A source of comprehensive information about sex after cancer
American Physical Therapy Association-Section on Women's Health	<a href="http://www.womenshealth.apta.org/pt-locator/">www.womenshealth.apta.org/pt-locator/</a>	A resource to locate pelvic floor physical therapists in your area

## Appendix I. Professional Organizations and Resources for Referrals