

Psychosexual Evaluation of the Woman With Sexual Complaints

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Most physicians who provide care for women are familiar with the possible physical causes of common sexual problems. However, as such disorders often have psychological components or sequelae, these factors must also be assessed.

Sexual experiences rarely occur in a vacuum. And, although sexuality is an integral component of quality of life and individual/relationship satisfaction,¹ sexual complaints are extremely difficult to admit and articulate—especially in the kind of detail required for optimal management. The physician must obtain a complete medical history and perform thorough physical and genital examinations, but this is just the beginning. Because sexual behavior is inextricably intertwined with emotional, psychological, and cultural factors, no evaluation is complete without considering these aspects.

Ideally, the woman with sexual complaints should be assessed together with her partner.² Assessment of the partner can shed light on the etiology, presentation, and prognosis of sexual complaints, and can also indicate whether both members of the couple are sufficiently motivated to work on

the problem. If the clinician is equipped to see both partners and both are willing, assessment is best performed over two separate sessions (Key Points).

To clarify problems of desire, arousal, orgasm, and pain, the couple can be asked to recall a recent sexual episode, and to explain in detail to the clinician what transpired—including their thoughts, emotions, and behavioral reactions.

CONJOINT SESSION

The goal of the first session is to clarify the sexual problem, assess all aspects of the sexual response cycle, explore the impact of the problem on the couple's sexual and relationship satisfaction, and evaluate the nonsexual dynamics of their current and past relationship.² By inviting the woman and her partner to describe the sexual complaint in their own words

the clinician gains a window into their language for discussing sexuality, their level of insight, and a sense of their sexual knowledge. To clarify problems of desire, arousal, orgasm, and pain, the couple can be asked to recall a recent sexual episode, and to explain in detail to the clinician what transpired—including their thoughts, emotions, and behavioral reactions.

They should also be asked about the range of stimuli used to evoke her sexual arousal, how effective such stimuli are, and her emotional and sexual reactions to them.³ For example, do they engage in sufficient foreplay (pleasurable activities that reliably elicit arousal), or do they bypass all forms of sexual touching and immediately engage in intercourse, resulting in dyspareunia due to insufficient genital lubrication?

The context of the sexual experience should also be discussed.⁴ This consists of both interpersonal factors (eg, emotional closeness, sexual attraction, privacy, safety, contraception, infertility, sexually transmitted infections [STIs]) and intrapersonal factors (eg, personal worries, distractions, depression, fatigue). Barriers to arousal may involve the partner—eg, lack of attraction, unreliable erections, lack of sexual skill—such that the clinician may wish

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KEY POINTS

Key Points of the Psychosexual Evaluation

Conjoint interview

- Patient's description of the problem
- Sexual stimuli used to evoke her arousal
- Interpersonal/intrapersonal context
- Responsive versus spontaneous sexual desire
- Sexual experiences despite the current problem
- Couple's sexual and relationship history
- Motivation for seeking treatment

Individual interview(s)

- Psychosexual history
- Masturbation patterns and frequency
- Partner's sexual response
- Interpersonal/intrapersonal context for each partner
- Brief psychiatric history, focusing on depression and anxiety
- "Family of origin" history
- Cognitive myths about sexuality

to elicit this information during an individual interview.⁵

Because lack of desire is the most common sexual complaint among women,⁶ it is important to inquire about the woman's "responsive desire"—ie, the patient's desire to continue sexual activity after arousal is achieved.⁴ Spontaneous (non-triggered) desire that may drive her to seek sexual contact can also be assessed, but she should be reassured that lack of such desire does not constitute sexual dysfunction. Recent conceptualizations of female desire disorders focus more on "responsive" than on "spontaneous" desire, which may be hormonally dependent and thus more common in younger women.⁷ Understanding this can be normalizing and validating for the patient, and may be sufficient to resolve her sexual concerns.

The clinician should explore whether the couple still engages in any type of sexual activity, and which of these activities are pleasurable and satisfying. If a couple has found other modes of experiencing sexual pleasure despite a sexual problem, this can indicate resiliency and willingness to try alternatives.² It can also give the clinician a sense of their motivation for complying with treatment suggestions.

Another aspect of the conjoint interview is an assessment of the couple's sexual and relationship history. When and how did they meet? When did they begin to have sexual contact? Often, a woman with vaginismus may have overanticipated "the first time," leading to physical tension and psychological anxiety that trigger vaginismus.⁸ For the couple who experienced positive and satisfying sexual experiences in the past,

it is important to focus on exactly when things began to "go wrong." Sometimes life stressors can precipitate sexual complaints—eg, a new job, relocating, the arrival of children, busy schedules, caretaking for elders, psychological disturbances.⁴

The conjoint interview might end with an inquiry into the couple's motivation for seeking treatment. This can be especially informative if the complaint has existed for some time. For example, are relationship deterioration and the prospect of a separation motivating the visit? Or is the wish for conception or the discovery of an STI the trigger for seeking treatment?

INDIVIDUAL SESSION

If the woman's partner is involved in the assessment, the second session will involve individual evaluations of each person, followed by a group meeting to integrate the findings, propose treatment, and/or provide information. If the partner is unable/unwilling to participate, or if the woman has no partner, this session can proceed with the patient alone. During the individual session(s), each member of the couple is asked about their sexual history—first sexual experiences, sexual history prior to current partner, and any experience of unwanted sexual contact.⁴ The individual is also asked about past and current masturbation frequency and motivation. For a woman complaining of loss of sexual desire, masturbation patterns can provide insight into her need for nonpartnered sexual activity.⁹ For the woman with loss of arousal, exploring masturbation and capacity for arousal and orgasm with her alone can clarify the partner's contributions to the impaired sexual response.

The partner's sexual responses are then explored for both members of the couple. If the patient's partner is male, his erectile function, orgasmic latency, desire, and sexual satisfaction should be discussed. Research suggests that the restoration of erectile function via one of the new phosphodiesterase-5 inhibitors (sildenafil, tadalafil, vardenafil) can cause strain in a relationship, particularly if sexual activity now becomes intercourse-focused.¹⁰

Continuing the assessment of

the patient's cultural and sexual beliefs to see whether there are misconceptions—eg, only multiorgasmic sex is satisfying; only spontaneous sex is pleasurable.

A comprehensive assessment of the woman's sexual dysfunction should also include a medical history.¹² A genital examination of the woman may be warranted, however, it is not advised to do so in the early stages of assessment before rapport and an assurance of trust is established. For both the general medical exami-

psychological contributors and/or consequences, as well as the larger sociocultural context in which these problems occur.

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interpersonal/intrapersonal context, each member of the couple should be asked about their sexual and nonsexual feelings for the partner. Has one of them kept secrets that may be contributing to the patient's sexual complaints?

A brief psychiatric history can then focus on past and present mood and affect, as well as current and past psychotropic medications.¹¹ Depression is a common comorbidity for all sexual complaints⁶ and may be assessed with a brief, validated tool (eg, Beck Depression Inventory). Marked depression or anxiety may require referral to a qualified therapist to address these disorders prior to initiating sex therapy. In addition, from an attachment-theory perspective, exploration of the family history (ie, family of origin) can reveal relationships with early caregivers, sibling relationships, and earliest sexual teachings. This may be a good time to explore

and the specific genital examination, if the clinician is a mental health provider, this will entail a referral to a gynecologist or a family physician.

The individual interviews are then followed by a reunion of the couple, where the clinician will attempt to integrate all information and propose a theory of the problem's causes and a treatment plan. Although these two sessions will yield a wealth of information from which to establish a management strategy, information emerging in later sessions should be incorporated to direct ongoing treatment.

CONCLUSION

Physical and genital examinations are usually essential when evaluating the patient with sexual complaints, but provide only a partial picture. To comprehensively treat these women, the physician must also consider any