



Association of
Reproductive
Health
Professionals

SEXUAL HEALTH FUNDAMENTALS

Clinician Competencies for Sexual Health

Female sexual concerns and dysfunction are commonplace and affect the lives of many women worldwide. Yet many women suffer in silence, reluctant to broach the subject with their health care providers. Unfortunately, providers often fail to ask about sexual health concerns. One reason for this communication gap is a lack of adequate formal medical sexual training for health care providers in the assessment and management of female sexuality and sexual dysfunction. There has also been an historic paucity of effective medication options for treating female sexual dysfunction. Existing and potential future technologies may increase the interest of both patients and health care providers in addressing female concerns and sexual dysfunction. In general, frontline health care providers need to gain greater competency addressing sexual health concerns to help improve their patients' quality of life.

To address this need for improved competency, ARHP hosted a series of consensus meetings of clinical and behavioral science experts in sexuality. The explicit aims of this consensus process were:

- (1) To supplement expert guidelines with recommendations specifically designed to fill a practice gap for frontline women's healthcare providers on sexual function, health, and wellness; and
- (2) To develop open-access assessment and practice tools for professional societies and advocacy groups.

Throughout the course of the meetings, the experts identified a number of competencies that clinicians must acquire to provide ideal female sexual health care. These included medical knowledge (encompassing both specific facts and broader conceptual ideas about female sexual health), understanding of relevant psychosocial issues, and clinical skills, including communication skills, diagnostic skills, clinical management skills, and practice-related skills.

Medical knowledge

Broad concepts:

- A great deal of heterogeneity exists in sexual response and satisfaction, and no one model explains all aspects of the response for all patients;
- Orgasmic response is variable and as many as 60 percent of women do not reach orgasm through intercourse alone;¹
- Intimacy or sexual behavior does not necessarily equate to vaginal intercourse, and vice versa;
- Desire and arousal may not be synonymous; and

- It is a myth that women's sexuality is finite and related to age or a specific condition (e.g., after childbearing, after menopause, or during the later years of life, after a medical illness diagnosis).

Specific facts:

- DSM IV diagnostic criteria (including the understanding that distress and marked interpersonal conflict are among the criteria for sexual dysfunction);
- Basic female genital/pelvic anatomy and neurophysiology as they relate to sexual function (e.g., anatomy of clitoris, time to orgasm, etc.) across the life/reproductive cycle;
- Basics of hormonal regulation including the role of estrogen and testosterone in the female sexual response cycle;
- Models of the female sexual response;
- Basic understanding of female sexual complaints, disorders, and dysfunction and the four broad categories of dysfunction (i.e., desire, arousal, orgasm, and pain);
- Epidemiology of female sexual dysfunction;
- Most common problems in each phase of life; and
- Male sexual disorders.

Understanding of relevant psychosocial issues

The experts identified a number of psychosocial topics that they believed to be essential for providers to understand in order to provide ideal female sexual health care. These include the following:

- Sexual function does not exist in a vacuum—it is influenced by the relationship, fatigue, stress, and other sociocultural factors in a woman's life—and understanding the patient/client's relationship status and the context within which the sexual complaint occurs are crucial to understanding the situation and making an accurate diagnosis;
- The health and stability/status of the women's relationship will affect her sense of sexuality and desire;
- Providers should not assume that all patients are heterosexual or that all engage in monogamy;
- There is an important difference between drive (primarily the biological components) and motivation (primarily the intrapsychic and interpersonal components);²

- Providers often have inherent personal biases about sexuality or sexual health which are unrecognized. Panelists noted that providers should gain an understanding of their own viewpoints, assumptions, and biases about sexuality and how these may affect patient care;
- Sexual abuse (current or past) can play a very influential role in sexual dysfunction and its treatment; providers often neglect to consider or ask about history of sexual abuse in routine health care examinations;
- Cross-cultural issues can influence sexual health; sexuality is expressed differently in different cultures;
- Differences in sexual orientation, ethnicity, or culture can affect the conversation about sexual health and whether a patient will introduce the topic at all;
- The patient/client may be trying to please her partner by seeking help for the sexual complaint or trying to please her health care provider by avoiding discussion of a potentially uncomfortable topic; and
- A partner's sexual dysfunction will affect the patient/client's sexuality (i.e., male sexuality indirectly and directly affects female sexuality).

Clinical skills

Meeting attendees agreed that there are several skills that clinicians need to master to be able to provide ideal sexual health care. These skills fall into four categories: communication skills, diagnostic skills, clinical management skills, and practice-related skills. The expert group agreed that the PLISSIT 2model might be a helpful tool for health care providers to use when discussing sexual health or concerns with patients/clients (PLISSIT: Permission; Limited information; Specific Suggestions; Intensive Therapy).³ Meeting attendees opined that when fully understood and properly applied, the model is an excellent foundation for providers to use when working with women around sexual concerns.

Communication skills

Panelists felt strongly that effective communication is essential for effective care of sexual health concerns. They believe that health care providers should be able to:

- Initiate a frank concise conversation about sexual health;
- Complete a detailed or directed sexual health history depending on time and complaint;
- Bring closure to a current appointment and segue to a subsequent appointment for further discussion without sending the wrong message to patient, such as being disinterested, insensitive or unconcerned;
- Use empathetic communication skills (i.e., PEARLS—empathetic education skills, partnership, empathy, apology, respect/reflect/ reinforce, legitimize, support);

- Recommend and refer a patient/client, either alone or with her partner, to a competent sexual health specialist without alienating her (i.e., be able to stop a discussion about a complex issue by saying, "It sounds like you have a lot to talk about" and refer to an appropriate expert);
- Use effective communication skills, including alternating between open- and closed-ended questions and using appropriate pauses, silence, and body language;
- Create and maintain an appropriate health care environment, including exam rooms for questioning and examination (e.g., private space, door closed, provider sitting down and looking at patient, patient properly clothed, questions never asked during physical exam, intake forms with appropriate language that supports sexual diversity).

In addition, the experts felt that health care providers should appreciate the importance of sensitive use of terminology. Providers should understand the difference between the terms "common" and "normal," and appreciate that it is preferable to tell patients/clients that a concern or disorder is common, rather than to say it is normal, which may be interpreted as being dismissive. Providers also should appreciate that sexual health is not a "relative good"; for example, it is not appropriate to tell a cancer survivor seeking treatment for sexual dysfunction that they should just be appreciative of surviving cancer and "not to worry" about their sexual health.

Diagnostic skills

Meeting attendees identified several specific diagnostics skills that health care providers need to deliver sensitive, effective care for women with sexual health concerns. These skills include being able to:

- Perform age-appropriate screening via a sexual history;
- Conduct a contextual assessment;
- Use validated screeners or algorithms where available;
- Correctly diagnose each type of sexual dysfunction, recognizing that they often overlap;
- Diagnose challenges to basic sexual function through an initial evaluation and by asking probing questions. Examples include:
 - Does this problem present in every situation or only in certain situations?
 - Have you always had this issue or is it newly acquired?
- Identify multi-factorial contributing or precipitating factors (e.g., depression, urogenital atrophy, medications, bladder dysfunction, menopause) that affect sexual function;
- Appreciate that decreased sexual interest is a symptom rather than a diagnosis and that the underlying cause (e.g., medication side effect, hormonal issue,

relationship issue) needs to be investigated;

- Know when a physical exam is necessary for diagnosis and management;
- Perform a respectful physical exam that is: as painless as possible; in a private environment with a comfortable temperature; free from interruptions; and includes a chaperone or patient advocate, as requested.

Clinical management skills

Meeting attendees felt that health care providers should be able to differentiate between the sexual disorders or concerns that they are competent to diagnose and treat and those which they need to refer for expert management. This is an especially sensitive issue because of the paucity of FDA-approved treatments for female sexual dysfunction and the resultant reliance on use of drugs approved for other indications. Meeting attendees proposed that vulvovaginal atrophy and SSRI-induced sexual dysfunction are common sexual complaints which frontline providers should be able to diagnose and treat.

There are also more complex disorders that should likely be referred to a specialist, such as sexual identity disorder, sexual aversion, fetishes, and treatment of sexual abusers. Between these two extremes are disorders for which frontline providers should be able to make an initial differential diagnosis and then refer the patient to an appropriate expert (examples of more complex treatments that should be referred include bioidentical hormone therapy, treatment with off label androgens, etc.). Expert panelists felt that the decision about which specific disorders an individual provider decides to manage should depend on the degree of training and the interest level of the practitioner. They emphasized that management should be guided by evidence-based medicine with the goal of avoiding misinformation, the perpetuation of myths, and heightened anxiety in patients. Each health care provider should recognize his or her limits and set their own personal and professional guidelines to which he or she ascribes too. Providers should refer patients out of their clinics if they feel ill-equipped or uninterested in treating disorders of a sexual nature. They should not deny the existence of sexual complaints but should recognize patient

concerns and refer as needed.

Practice-related skills

The group identified a few required skills that relate specifically to a provider's practice management. These include being able to:

- Identify sources for additional information when needed (e.g., Internet sites, organizations, textbooks, other health care providers);
- Create an effective means (i.e., triage patterns for both psycho-behavioral and medical management) for referring patients/clients to sexual health experts;
- Incorporate the management of female sexual dysfunction into routine practice (e.g., dealing with time allotment and billing); and
- Code for reimbursement for diagnosis and treatment of sexual dysfunction.

For more information on this topic, refer to the other *Sexual Health Fundamentals* fact sheets, For more information on this topic, refer to the other *Sexual Health Fundamentals* fact sheets, *The Top 10 Things You Need to Know about Female Sexuality* (www.arhp.org/SHFTop10), *Talking with Patients About Sexuality and Sexual Health* (www.arhp.org/SHFTalking), *Sex Therapy for Non-Sex Therapists* (www.arhp.org/SHFTherapy), and *Common Myths about Female Sexual Health* (www.arhp.org/SHFMyths).

1. Komisaruk BR, Beyer-Flores C, and Whipple B. *The Science of Orgasm*. Baltimore, MD: The Johns Hopkins University Press; 2006.
2. Levine SB. Reexploring the concept of sexual desire. *J Sex Marital Ther*. 2002 Jan-Feb;28(1):39-51.

Sexual Health Fundamentals is a publication of the Association of Reproductive Health Professionals (ARHP) for health care professionals, educators, and researchers working in the field of reproductive health. This fact sheet is part of the Sexual Health Fundamentals for Patient Care Initiative [www.sexualhealthfundamentals.org], which was guided by principles established by a consensus committee of renowned experts in female sexuality, led by co-chairs Michael Krychman, MD, and Susan Kellogg Spadt, CRNP, PhD. The goals of this initiative are to assist "frontline" members of the reproductive health care team with expert, evidence-based guidance on sexual function, health, and wellness, and to provide freely available needs assessment tools for professional societies to customize for their specific constituencies. Sexual Health Fundamentals are available at www.arhp.org/factsheets.