Clinical Algorithms

Psychosexual problems

ELIZABETH STANLEY

Although it is now more common for women to declare their sexual problems directly to the doctor, many still present them indirectly disguised as gynaecological complaints. Some of these patients have taken the first step of acknowledging to themselves that such a problem exists, but the second step of disclosing it to the doctor can be daunting. Not only is the subject embarrassing and difficult to talk about, but the patient is also reluctant to waste the doctor's time with apparently non-medical matters. A physical symptom legitimises her visit. The algorithm shows some of the more common indirect ways in which sexual problems present and suggests possible lines of action to elucidate their nature and attempt their resolution.

Initial history

When taking a history of the presenting gynaecological complaint, it is often not what the patient says but how it is said that suggests an underlying sexual problem. For example, discordance between verbal and body language may indicate that the patient is not telling the whole truth. The doctor's sensitivity to such unspoken words will facilitate recognition and disclosure of the sexual problem. Further diagnostic information may be obtained from physical findings at vaginal examination and also the patient's reaction to the procedure.

Vaginal examination

In relation to psychosexual problems vaginal examination is the moment of truth, since the woman's response to it can speak volumes about her attitude towards her sexuality.^{1,2} Sometimes this is the first point in the consultation at which the doctor is alerted to the possibility of an underlying sexual problem. Physical exposure of intimate parts seems to facilitate exposure of equally intimate emotions and may provide a suitable opportunity to explore the patient's feelings about her sexuality.

Further history

Although the line of questioning indicated in the algorithm is purely factual, understanding the patient's feelings about the facts is as important as eliciting the facts themselves. History taking should therefore be expanded accordingly. Sections of the algorithm also

illustrate strategies for dealing with sexual problems presented directly without the pretext of a gynaecological complaint.

Causes and management of sexual problems

Some sexual problems have simple causes. Ignorance, cultural taboos and myths, and poor communication skills are among the more common; unrealistic expectations and performance pressures, often themselves born of ignorance, are other contributing factors.³ Communication should be adequate between a couple in both sexual and non-sexual matters. Failure to discuss and resolve day to day problems as they arise may manifest itself as a sexual problem caused by the ensuing repressed anger and resentment. A belief that arousal in both partners should always proceed at the same rate, leading to simultaneous orgasms on every occasion during intercourse, is an example of an unrealistic goal still held by many couples; it inevitably causes undue performance pressures, especially for women. Simple intervention by the doctor providing education, "permission giving," and teaching of communication skills often provides swift resolution of the underlying sexual problem.⁴ Specific techniques may also be useful in dealing with problems arising from unrealistic goals and performance pressures.⁵ For anorgasmic women a book entitled *Becoming Orgasmic* may be helpful.⁶ Treatment of vaginismus requires a psychosomatic approach in which the woman's fears and fantasies about her body need to be explored and rationalised; she should also be taught how to bring her vaginal muscles under voluntary control.⁷ Many problems are more complex, however, and if simple intervention proves ineffective referral for specialised help may be indicated.

Referral

Once a sexual problem has been identified it may be tempting to persuade the patient to seek further help elsewhere, but this may be counterproductive if she is not ready to accept help. There are three main referral resources.

Sex therapists—Their approach is based on the methods of Masters and Johnson.⁸ This is largely a behavioural approach, although it incorporates psychodynamic and other relevant theoretical concepts when appropriate. The relationship of the couple, rather than the woman herself, is the focus of therapy, the key element of which is teaching communication skills. Sex therapists include medical practitioners, clinical psychologists, and family planning nurses as well as others trained in different health care professions. A list of their centres is available from the Association of Sexual and Marital Therapists, PO Box 62, Sheffield S10 3TS.

Marriage guidance counsellors trained in marital sexual therapy are experienced marriage guidance counsellors who have received additional specialised training in managing sexual dysfunction by methods similar to those used by sex therapists. A list of their clinics is available from the National Marriage Guidance Council, Little Church Street, Rugby CV21 3AP.

Psychosexual problems

Psychosexual counsellors are medical practitioners, usually women, who have attended training seminars run by the Institute of Psychosexual Medicine. Their therapy is psychodynamically oriented and focuses on the individual rather than the relationship. Such counsellors are particularly suitable for women with vaginismus. A list of psychosexual counsellors may be obtained from the Institute of Psychosexual Medicine, 11 Chandos Street, London W1M 9DE.

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Prescribing in Pregnancy

Antibiotics

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Young women often develop infections, particularly of the urinary tract. Therefore pregnant women commonly require antimicrobial treatment. Bacteriuria occurs in about 5% of pregnancies, and if it is not treated between a quarter and a third of patients may develop pyelonephritis with consequent danger to their own health and an increased incidence of fetal loss.¹ Because pregnant women are often in an environment with young children they are at greater risk of developing the more trivial upper respiratory infections, which may require treatment. Occasionally, pregnant women need treatment for more serious infections. It is therefore necessary to know which antimicrobial agents can be used with negligible risk for the minor infections and to have some appreciation of the balance of risks for more serious cases.

In assessing the risk to the fetus several points should be considered. For many antimicrobial agents we now have more than 25 years' experience of freedom from congenital abnormality. Many studies have been performed in animals, but, although important, their results should be viewed with some reservation. For example, sulphonamides can cause gross fetal malformations when given in high doses to mice and rats,² but 50 years of use would surely have shown a teratogenic propensity in humans, which, to my knowledge, has not been recorded. One of the reasons why laboratory animals make poor models for studying fetal damage is the profound effect large doses of antimicrobial agents have on the animal's gastrointestinal flora and consequently on the animal's metabolism. On the other hand, certain drugs should definitely be avoided. For example, streptomycin causes neonatal ototoxicity after long term treatment of maternal tuberculosis.^{3,4} It therefore follows, by implication rather than by hard information, that the other aminoglycosides, such as gentamicin, tobramycin, netilmicin, and amikacin, should be avoided for minor infections. In the treatment of serious maternal infection, however, their undoubted efficacy should be balanced against these theoretical risks.

Pregnant and non-pregnant women differ considerably in the way in which they handle antimicrobial agents, and this may influence treatment. Philipson showed that serum concentrations of ampicillin in women who were 9-36 weeks' pregnant were half the values found in the same women when they were not pregnant.⁵ Low maternal

concentrations have been described after ingestion of most antimicrobial agents, including aminoglycosides. The therapeutic implications of these low concentrations are difficult to assess. Failure of antibiotic treatment might incorrectly be blamed on the wrong choice of antibiotic and the drug might be replaced by a potentially more toxic agent. This could be particularly dangerous when treating a serious infection with an agent such as an aminoglycoside, when the natural caution of the doctor against giving what he might consider to be high doses will in fact cause more problems. In general, full adult doses should be used when treating infections in pregnant women. When serious infections are to be treated with an aminoglycoside, for example, assays should be performed to ensure that the patient is receiving sufficient drug and that neither she nor her fetus is being exposed to unacceptably high levels. Similarly, the length of treatment should be dictated by the disease and not be influenced unduly by the fact that the patient is pregnant. Inadequate treatment, which may be followed by further courses of antibiotics, is likely to put mother and fetus at greater risk than a full course of the correct antimicrobial agent. In the case of bacteriuria in pregnancy a 7-14 day course of treatment is usually prescribed, but some investigations suggest a single dose^{6,7} or high dose short course.⁸

Antimicrobial agents

Table I lists various antimicrobial agents together with their possible toxic effects on the fetus in early or late pregnancy. I have attempted to give a safety rating: "probably safe" indicates that no significant risk to the fetus has been documented and hence such agents constitute a first choice if an antimicrobial agent has to be used; "caution" indicates that effects on the fetus have been recorded with the agent (or a chemically related compound) or that its mode of action suggests a theoretical risk, but there may well be times when the balance of risks suggests that such compounds should be used. "Avoid" indicates that the agent carries a definite risk and its use might imply negligence (unless there was an overwhelming reason to the contrary). Such division of the compounds is obviously somewhat subjective.

Treatment of common conditions

Table II lists some of the common infections likely to be encountered in pregnancy. The first choice of treatment is usually

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