International Journal of
Health Science & Biomedicine (IJHSB)

CASE REPORT OPEN ACCESS

Case Report Navigating Complex Sexual Health Challenges

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Citation: Boof M, Cardello D (2024) Case Report Navigating Complex Sexual Health Challenges. Int. J. Health Sci. Biomed. 1: 1-3.

Received Date: 2024-03-04, **Accepted Date:** 2024-03-21, **Published Date:** 2024-03-30

Abstract

Sexual health is a fundamental aspect of overall well-being and quality of life, encompassing physical, emotional, mental, and social dimensions related to sexuality. Dysfunction in any of these areas can lead to significant distress for individuals and their partners. This case report details the presentation, diagnostic workup, and multidisciplinary management of a 48-year-old male presenting with erectile dysfunction (ED) and decreased libido, alongside his 46-year-old female partner experiencing dyspareunia and anorgasmia. The couple's sexual health issues were intertwined with underlying psychological stressors, relationship dynamics, and physiological factors. Through a comprehensive biopsychosocial approach involving medical intervention, sex therapy, and couples counseling, significant improvements in sexual function, satisfaction, and relationship quality were achieved. This case highlights the complexity of sexual health issues and underscores the necessity of a holistic, patient-centered, and collaborative care model for effective management.

Introduction

Sexual health, as defined by the World Health Organization (WHO), is "a state of physical, emotional, mental and social well-being in relation to sexuality; it is not merely the absence of disease, dysfunction or infirmity" [1]. It is a critical component of human identity, intimate relationships, and overall life satisfaction. Sexual dysfunctions are highly prevalent conditions, affecting a significant proportion of both men and women across the lifespan [2, 3]. Male sexual dysfunctions commonly include erectile dysfunction (ED), premature ejaculation, and disorders of libido [4]. Female sexual dysfunctions encompass issues such as desire, arousal, orgasmic, and pain disorders, including dyspareunia and vaginismus [5].

The etiology of sexual health issues is often multifactorial, involving a complex interplay of biological, psychological, social, and relational factors [6]. Medical conditions such as cardiovascular disease, diabetes, neurological disorders, and hormonal imbalances can contribute to sexual dysfunction . Pharmacological agents, including antidepressants, antihypertensive, and opioids, are also recognized contributors. Psychological factors such as anxiety, depression, stress, and body image issues play a substantial role. Furthermore, relationship problems, communication deficits, cultural norms, and past traumatic experiences can significantly impact sexual function and satisfaction.

Despite their high prevalence and profound impact on quality of life, sexual health issues remain underreported and undertreated due to stigma, embarrassment, and a lack of adequate training among healthcare professionals. This case report aims to illustrate the intricate nature of sexual health challenges in a couple, emphasizing the importance of a comprehensive assessment and a multidisciplinary, integrated therapeutic approach.

Case Presentation

Mr. J, a 48-year-old male, presented to the urology clinic complaining of a gradual onset of erectile dysfunction over the past 18 months, characterized by difficulty achieving and maintaining erections sufficient for satisfactory sexual intercourse. He also reported a significant decrease in libido during the same period. His medical history included well-controlled hypertension, for which he was on a calcium channel

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blocker, and hyperlipidaemia managed with a statin. He denied smoking, excessive alcohol consumption, or illicit drug use. He reported moderate work-related stress.
Concurrently, his partner, Ms. K, a 46-year-old female, accompanied him and reported experiencing dyspareunia (painful intercourse) for approximately 12 months, which she described as a deep, sharp pain during penetration. She also reported difficulty achieving orgasm (anorgasmia) and a general lack of sexual interest. Her medical history was unremarkable, with no history of gynecological issues, surgeries, or chronic illnesses. She was premenopausal, experiencing irregular menstrual cycles but no significant menopausal symptoms like vaginal dryness.
The couple had been married for 20 years and reported a previously satisfying sexual relationship. However, over the past two years, their sexual activity had progressively declined, leading to significant marital distress, communication breakdown, and feelings of frustration and inadequacy for Mr. J, and anxiety and avoidance for Ms. K. They both expressed a strong desire to address their issues and improve their intimacy.

Initial Assessment

For Mr. J:

Physical Examination: Normal male genitalia, no signs of Peronei's disease or other structural abnormalities. Normal secondary sexual characteristics.

Laboratory Investigations:

Fasting blood glucose: 95 mg/dL (normal)
Lipid profile: Within target ranges with medication.
Total testosterone: 350 ng/dL (borderline low, reference range 300-1000 ng/dL)
Prolactin: Normal
Thyroid-stimulating hormone (TSH): Normal
PSA: Normal for age.

Sexual Health Inventory for Men (SHIM) Score: 10 (indicating moderate ED).

Psychological Screening: Mild to moderate symptoms of anxiety and performance anxiety related to sexual activity.

For Ms. K:

Physical Examination: General gynecological examination revealed no signs of vulvovaginal atrophy, infection, or structural abnormalities. Pelvic floor muscle tone appeared normal, with no significant tenderness on palpation of the pelvic floor or vaginal walls.
Laboratory Investigations: Hormonal profile (FSH, LH, Estradiol) consistent with perimenopause. Female Sexual Function Index (FSFI) Score: 18 (indicating significant female sexual dysfunction).
Psychological Screening: Moderate symptoms of anxiety, particularly anticipatory anxiety regarding sexual pain, and mild depressive symptoms related to the decline in intimacy.

Diagnostic Formulation

The couple's sexual health issues were determined to be multifactorial.

Mr. J: His ED likely had a mixed etiology, with a physiological component (borderline low testosterone, potential vascular effects from hypertension/hyperlipidaemia despite control, and medication side effects) compounded by significant psychological factors (performance anxiety, stress, and relationship distress). His decreased libido was likely linked to both the ED and the underlying psychological and relational issues.

Ms. K: Her dyspareunia appeared to be primarily psychogenic, fueled by anticipatory anxiety and potentially contributing to pelvic floor muscle guarding, despite no obvious physiological cause on examination. Her anorgasmia and low desire were strongly linked to the painful experiences, anxiety, and the overall decline in intimate connection.
Couple Dynamics: The lack of open communication about their sexual difficulties and the escalating avoidance patterns were significant perpetuating factors for both partners' individual issues.

Management

A multidisciplinary treatment plan was formulated, involving a urologist, a gynaecologist, a sex therapist, and a couples counsellor.

Medical Management (Mr. J):

Testosterone Replacement Therapy (TRT): Given his borderline low testosterone and symptoms, a trial of transdermal testosterone gel was initiated after thorough discussion of risks and benefits. His testosterone levels were monitored regularly.

Phosphodiesterase-5 Inhibitors (PDE5Is): Mr. J was prescribed sildenafil, with instructions on proper use and potential side effects. Emphasis was placed on using it as a tool to break the cycle of performance anxiety, rather than a sole solution.

Medication Review: His existing antihypertensive medication was reviewed, and it was determined that the calcium channel blocker was unlikely to be a primary cause of his ED, but its potential contribution was acknowledged. Lifestyle modifications (diet, exercise, stress management) were reinforced.

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Medical Management (Ms. K):

Vaginal Lubricants/Moisturizers: Despite no overt atrophy, Ms. K was advised to use a high-quality, silicone-based lubricant during intercourse and a vaginal moisturizer regularly to ensure optimal vaginal comfort.

Pelvic Floor Physical Therapy Referral: Although her examination was normal, a referral to a pelvic floor physical therapist was made to address potential subtle hypertonicity or guarding, and to teach relaxation techniques.

Sex Therapy (Individual and Couple Sessions):

Psychoeducation: Both partners received extensive psychoeducation on the physiology of sexual response, common sexual dysfunctions, and the biopsychosocial model of sexual health. This helped normalize their experiences and reduce feelings of shame.

Sensate Focus Exercises: The couple was introduced to sensate focus exercises, a cornerstone of sex therapy, designed to reduce performance pressure, enhance non-genital intimacy, and reintroduce pleasure and touch without the immediate goal of intercourse. These exercises were performed in stages, gradually progressing from non-genital touching to genital touching, and eventually to intercourse, only when both partners felt comfortable and ready.

Communication Skills Training: Sessions focused on improving open and honest communication about sexual desires, fears, and boundaries. They learned to express their needs constructively and listen empathetically to each other.

Cognitive Restructuring: Mr. J's performance anxiety was addressed through cognitive restructuring techniques, challenging negative self-talk and unrealistic expectations. Ms. K's anticipatory anxiety regarding pain was similarly addressed, helping her reframe sexual activity as a potentially pleasurable experience.

Addressing Anorgasmia: For Ms. K, specific techniques for enhancing arousal and facilitating orgasm were explored, including masturbation education and exploring different types of stimulation.

Couples Counseling:

Beyond the sexual aspect, the couple's general relationship. dynamics were explored. Underlying resentments, communication patterns, and emotional distance were identified and addressed. The counsellor helped them rebuild emotional intimacy, trust, and mutual support, recognizing that a healthy relationship foundation is crucial for sexual well-being [Figure 1]

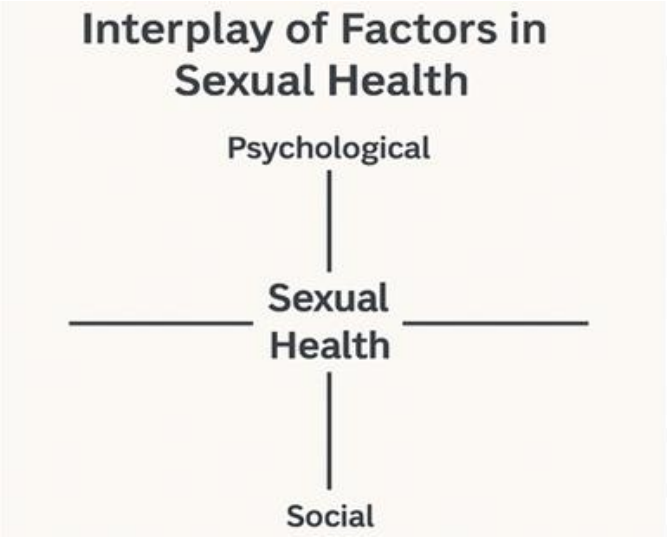


Figure 1: A conceptual diagram illustrating the intricate and bidirectional interplay of biological, psychological, social/cultural, and relational factors that collectively influence an individual's and couple's sexual health and function.

Progress and Outcomes

Over a period of 9 months, the couple engaged consistently with their multidisciplinary treatment plan.

Mr. J: His testosterone levels normalized with TRT. He reported improved erectile rigidity and confidence with PDE5I use. His SHIM score improved from 10 to 20 (mild ED). His performance anxiety significantly decreased as he experienced more consistent success and shifted his focus from performance to intimacy.

Ms. K: Her dyspareunia gradually resolved as her anxiety diminished and she learned pelvic floor relaxation techniques. She reported increased arousal and, for the first time in years, was able to achieve orgasm consistently with direct clitoral stimulation. Her FSFI score improved from 18 to 28 (normal range).

Couple Dynamics: The most profound changes were observed in their relationship. They reported enhanced emotional intimacy, improved communication, and a renewed sense of connection. Sexual activity became more frequent and mutually satisfying, characterized by spontaneity and pleasure rather than obligation or anxiety. They learned to prioritize intimacy and support each other's sexual well-being.

At the 12-month follow-up, both Mr. J and Ms. K maintained their improvements. They continued to practice the

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skills and intimacy-building exercises learned in therapy. Mr. J remained on TRT and used PDE5Is as needed, while Ms. K no longer experienced dyspareunia and reported consistent orgasms. They expressed profound gratitude for the holistic approach that addressed not just their individual symptoms but their intertwined relational and psychological needs.

Discussion

This case report vividly illustrates the biopsychosocial model of sexual health, where biological, psychological, and social factors are inextricably linked and collectively influence sexual function and satisfaction [6]. Mr. J's erectile dysfunction, initially presenting with a physiological component (borderline low testosterone and potential medication effects), was significantly exacerbated by performance anxiety and relationship distress. Similarly, Ms. K's dyspareunia, initially without a clear organic cause, was deeply rooted in anticipatory anxiety and compounded by the decline in her partner's sexual function and the resulting communication breakdown. The anorgasmia and low desire in Ms. K were direct consequences of the painful experiences and the emotional distance that had developed.

The success of this case hinged on the integrated, multidisciplinary approach. Medical interventions, such as TRT and PDE5Is for Mr. J, addressed the physiological underpinnings, providing a foundation for psychological and relational work. However, pharmacological solutions alone are often insufficient for complex sexual dysfunctions. The crucial role of sex therapy and couples counseling cannot be overstated. Sex therapy, particularly sensate focus, effectively de-emphasized performance, reduced anxiety, and allowed the couple to rediscover pleasure and intimacy without pressure. By focusing on non-genital touch and gradually reintroducing sexual activity, the couple learned to connect emotionally and physically in a safe, structured environment.

Furthermore, addressing the broader relationship dynamics through couples counseling was paramount. Unresolved conflicts, poor communication, and emotional distance can severely impede sexual intimacy. By improving their general relationship health, the couple created a more fertile ground for sexual healing. This comprehensive strategy aligns with current best practices in sexual medicine, which advocate for a holistic assessment and tailored treatment plans that consider all contributing factors [1].

The case also highlights the importance of screening for sexual health issues in routine clinical practice. Many patients do not spontaneously report sexual concerns due to embarrassment or the belief that these issues are not "medical." Healthcare providers across specialties should be comfortable initiating conversations about sexual health and be equipped to provide initial guidance or appropriate referrals. The collaborative care model, involving urologists, gynaecologists, sex therapists, and counselors, proved highly effective here, demonstrating that no single specialty can adequately address the multifaceted nature of sexual health challenges.

Limitations of this case report include its single-case nature, which limits generalizability. The specific interventions and their sequence were tailored to this couple's unique needs and may not be universally applicable. However, it provides a valuable qualitative insight into the complexities and successful management of intertwined sexual health issues in a real-world setting. Future research could explore the long-term sustainability of such interventions and the cost-effectiveness of integrated care models.

Conclusion

Sexual health issues are prevalent, complex, and profoundly impact individual and relational well-being. This case report of a couple presenting with intertwined erectile dysfunction, decreased libido, dyspareunia, and anorgasmia underscores the necessity of a comprehensive, multidisciplinary, and biopsychosocial approach to diagnosis and management. By integrating medical interventions with sex therapy and couples counseling, significant improvements in sexual function, satisfaction, and overall relationship quality can be achieved. Healthcare providers are encouraged to adopt a proactive, empathetic, and holistic approach to sexual health, recognizing its critical role in overall human health and happiness.

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