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ScienceDirect
Taiwanese Journal of Obstetrics & Gynecology 50 (2011) 268–274
www.tjog-online.com

Review Article

Sexual health care for women with dyspareunia

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Accepted 30 March 2011

Abstract

Female dyspareunia is a serious impairment with a prevalence of up to 39.5%, imposing a significant burden on women's health, relationship, and quality of life. Because the causes of female dyspareunia are associated with multiple biological, medical, psychological, sociocultural, and interpersonal dimensions, all members of the health team should help fill this gap in the total care of the patient. The nurse is an ideal member of the health team to counsel patients in the sensitive and highly charged area of human sexuality. The purpose of this article was to explore the essential components of female dyspareunia from nursing care perspective to help women suffering from dyspareunia. The article provides a set of tools, including description and clinical presentation, obtaining a history and clinical data for the evaluation of dyspareunia, and a counseling tool of the Permission, Limited Information, Specific Suggestions, and Intensive Therapy model; suggestions are also provided for health care professionals during the treatment process.

Keywords: Female dyspareunia; Nursing care; PLISSIT; Sexual health care

Introduction

Most of the health care providers have proposed that discussing sexual issues with their patients should be their responsibility and duty [1–4]. However, data reveal that few are addressing the sexual issues with their patients. In the United States, only 9% of the patients aged 40–80 years have been asked about sexual concerns by their physicians [1]. Also, another study on urogynecologists found that, though most stated screening for female sexual dysfunction is somewhat or very important, only 22% have always screened for female sexual dysfunction, and 23% have never or rarely done it [4]. Reasons of their reluctance include "sexual problems are too biopsychosocial complex and take much time to unravel"; "sex is not identified as a priority or as relevant to the patient's presenting problems"; "the physician is personal discomfort with the sexual topics"; "the physician lacks of knowledge or skills dealing with patient's sexual problems" [5]. In Japan, 32.4% of doctors have been consulted about sexual issues by patients or families, but their attitude toward sex-related statements show that, although most recognize the importance of patients' sexuality-related concerns, they do not necessarily think that they have a professional responsibility to deal with the sexual issues [2]. A study in Taiwan reveals that 77.9% of nurses seldom or have never provided nursing assessment on sexual health; 43.1% seldom discuss patients' sexual difficulties with them. Regarding nurses' attitudes on discussing patients' sexual difficulties with them, about 74.8% of nurses would talk to the patients only when the patients propose to do so, and about 58.3% of nurses experienced patients' requests for discussions on sexual difficulties [3]. Tsai [6] found that the two major perceived desire facilitators for a nurse to know a patient's sexual history are related to the patient's illness and when the patient specifically mentions the sexual problems; on

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1028-4559/$ - see front matter
doi:10.1016/j.tjog.2011.07.002

the other hand, the two major perceived barriers for a patient to discuss his or her sexual history are the patient's embarrassment discussing the issues of sexuality or the patient's perception of no association of his or her treatment with his or her sexuality and a lack of professionals for referral for further consultations. A similar study conducted in Sweden found that nurses feel that their patients could be upset (67%), embarrassed (72%), or anxious (68%) if they are asked about sexual concerns [7]. Moreover, in the current clinical environments with constraints on the amount of time that can be spent with each patient, individuals will not likely have their sexual concerns addressed during a standard medical encounter [8].

Dyspareunia is the symptom with persistent and recurrent urogenital pain occurring before, during, or after sexual intercourse because of physical or psychological causes. It is reported most typically as a unique problem to women, although it can also occur in men with a relatively rare instance [9]. Dyspareunia has been identified as the most common sexual complaint in women spontaneously reported to gynecologists [10]. In women, common physical causes of dyspareunia include interstitial cystitis, irritable bowel syndrome, pelvic inflammatory disease, chronic pelvic pain, and endometriosis [11]; psychological causes result from fear of pain, interpersonal disturbance, and sexual abuse [12–15]. Women experiencing dyspareunia will report higher levels of catastrophizing; fear of pain; hypervigilance [12]; and mood disturbance, such as nervousness and depression [15]. Moreover, dyspareunia may place a woman at risk for the development of vaginismus as well as secondary desire, arousal, and orgasmic dysfunctions [16]. The prevalence of dyspareunia in women is found to be 8–39.5% [15,17,18].

Because female dyspareunia is a complex problem, associated with multiple biological, medical, psychological, sociocultural, and interpersonal dimensions, patients typically seek several clinicians in an effort to evaluate and treat their conditions. In an online study of 428 women experiencing vulvar pain [19], about 50% reported to have consulted four to nine physicians during the treatment process because 57% reported that their pain had stayed the same or worsened since initiating treatment and only 40% trusted their current physician to manage the pain. Therefore, clinicians, nurses, and other health care providers should help fill this gap in the total care of the patient by initializing conversations with the patient. The health care provider's background reflects education in the physical, social, and behavioral sciences, as well as theory and practice in counseling techniques. To counsel patients in the highly sensitive area of human sexuality, knowing how to use communication skills and expressing a supportive attitude to approach patients and establish a trust relationship would be an important task to health care providers. The purpose of this article was to explore the essential components of female dyspareunia to help women suffering from dyspareunia. The article provides a set of tools, including description and clinical presentation, obtaining a history and clinical data for the evaluation of dyspareunia, and a tool of the Permission, Limited Information, Specific Suggestions, and Intensive Therapy (PLISSIT) model; suggestions are also provided for health care providers during the treatment process.

Description and clinical presentation

Pain is a subjective experience with the heterogeneity of its etiology, and therefore, careful measurement and description of pain is necessary. Dyspareunia is defined as persistent and recurrent urogenital pain occurring before, during, or after sexual intercourse, which is not caused exclusively by lack of lubrication or by vaginismus [9]. It cannot be accounted for by another Axis I disorder (except another sexual dysfunction) and cannot be attributed to the direct physiological effects of a substance (e.g. a drug of abuse, a medication) or a general medical condition [20].

The prevalence of dyspareunia in women has been found to be varying between 8% and 39.5% [15,17,18]. This variation is caused by the following factors: inconsistent use of case definitions, variation in study design and conduct, and different outcome measures used to assess dyspareunia [21]. Therefore, developing an understanding of what is considered "dyspareunia" is important and can help determine the range of conditions causing a patient to experience sexual difficulties within the sexual issues. The American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders, 4th Edition (DSM-IV) [20] and the World Health Organization's International Classification of Disease, 10th revision (ICD-10) [22] define dyspareunia as pain associated with sexual intercourse. However, Basson et al [23] propose that dyspareunia should include pain with attempted or completed vaginal entry. Binik [24] also points out that dyspareunia should be defined as the experience of pain during sexual intercourse and/or nonsexual pain with vaginal penetration. DSM-IV and ICD-10 stipulate that sexual pain should not be classified from "general medical conditions" or "local pathology" and exclude sexual pain because of lubrication problems. In addition, diagnostic systems usually classify dyspareunia and vaginismus as separate, mutually exclusive sexual dysfunctions [21]. Furthermore, dyspareunia is highly comorbid with other treatment-resistant pain-related conditions, such as interstitial cystitis, irritable bowel syndrome, pelvic inflammatory disease, chronic pelvic pain, endometriosis, or a history of sexually transmitted disease/pelvic inflammatory disease, chronic urinary tract infection, colitis, and sexual abuse [11,13].

Women with dyspareunia may have pain with localized or generalized genital contact, and the most common type of dyspareunia is vulvodynia that occurs in the absence of physical findings or a specific disorder [9]. Vulvodynia is divided into two main categories based on the vulvar area affected by the pain. Localized vulvodynia refers to pain in one vulvar area (e.g. vestibule), and generalized vulvodynia refers to pain over the entire vulvar region. Each category is further subdivided into provoked (i.e. it occurs in response to stimulation of the affected area), unprovoked (i.e. it occurs independent of stimulation), or mixed temporal pain patterns. Provoked pain, which is called provoked vestibulodynia (PVD) (formerly termed as vulvar vestibulitis syndrome), can occur during sexual, nonsexual, or both kinds of activities [25]. PVD is believed to be the most frequent cause of vulvodynia in women of childbearing age, with a prevalence rate

of up to 12% in the general population [12]. Painful intercourse is the defining symptom of PVD and is often the patient's presenting complaint. It can be present from coitarche (i.e. the first intercourse attempt and the primary PVD) or it may develop after a period of pain-free intercourse (i.e. secondary PVD) [25–27].

In addition to physical pain, a woman's experience of dyspareunia is usually more complicated, associated with psychological, sexual, and interpersonal disturbances. She may experience embarrassment, shame, guilt, loss of self-esteem, frustration, anxiety, nervousness, depression [14,15], and/or diminishing sexual satisfaction [28]. Also, a woman's cognitive and emotional response may exacerbate pain or increase intercourse pain intensity by greater catastrophizing, fear of pain, and hypervigilance, in addition to lower self-efficacy [12].

Obtaining a history and clinical data for the evaluation of dyspareunia

It is essential that a thorough patient baseline assessment, including medication history, physical evaluation, and psychological evaluation, shall be completed for each dyspareunia patient before any treatment interventions are initiated. It is noted that the initial discussion with the patients is of upmost importance as some problems can be handled without referral. In obtaining a history and clinical data process, information is obtained from the patient in a direct and structured manner through observations, interviews, and physical/psychological examinations. For a thorough sexual history, medical, reproductive, surgical, psychiatric, social, and sexual information should be included. Relevant content would include a past medical history, current health status, reproductive history, endocrine system review, thyroid conditions, and psychiatric illness [9]. In addition to a general medical, psychophysiological, and sexual history, the multidisciplinary assessment should ascertain the following: (1) the location, quality, intensity, and duration of the pain; (2) circumstances in which pain is noticeable, including both sexual and nonsexual situations; (3) the perception of muscle tension in sexual and nonsexual situations; (4) changes that the woman and her partners have made to sexual activity to limit or control pain; (5) the degree to which the woman experiences sexual arousal in sexual situations, both with regard to subjective excitement and to genital sensations and lubrication; and (6) the motivation and expectations of treatment, especially for the direct contact the genitals [29]. Holistic health care requires the health care providers to complete an assessment of the patient's biological, psychological, and sociocultural health status. Through this process, the health care providers should respect the individual's autonomy and accept the patient's subjective experience, and focus on the patient's problem and determine her motivation for treatment.

Preparation

The assessment process is an interactive, systematic, and individualized way to achieve the outcomes of health care. Therefore, during preparation, the health care provider's task is to establish a climate of trust, understanding, and acceptance relationship. To achieve this goal, the health care providers must take care of environment and time constraints when obtaining a sexual history. During the interview interaction, the health care providers should refrain from being either too formal or too casual when obtaining the medical or sexual history and make sure that the patient is in a comfortable and relaxed position face to face with the health care providers. The health care providers should feel comfortable using sexual terminology (e.g. vagina, penis, orgasm, and others) and be ready to listen actively. The health care providers should be sensitive on behaviors of communication because the behaviors can either facilitate the development of a therapeutic relationship or serve as a barrier to it. Behaviors of communication include individual's eye contact, facial expression, speech tone, gesture, position, and statement; especially, the use of eye contact is vital in gaining the individual's trust and confidence. For the environment preparation, private setting is crucial in making a comfortable exchange of information as the patient is being asked the most intimate and detailed questions of her private life. Moreover, it is suggested that no desk be placed between the patient and the health care providers as this may create a feeling of a boundary to the discussion [8].

Medication history

The pharmacological assessment should be integrated with the principles of the assessment process. The health care provider is in a pivotal position to educate the patient and her family about medications and to coordinate the treatment modalities. Many prescribed medications, such as selective serotonin reuptake inhibitors (SSRIs), serotonin-norepinephrine reuptake inhibitors (SNRIs), monoamine oxidase inhibitors (MAOIs), antipsychotics, benzodiazepines (BZD), beta-blockers, alpha-blockers, diuretics, digoxin, histamine H2-receptor blockers, anticonvulsants, and steroids, have sexual side effects [9]. Therefore, it is essential to develop a timeline of medication use to compare with the timeline of the patient's sexual pain history. Because the patient may be taking other prescription medication, a discussion of the patient's current use of medicine, including prescription drugs, over-the-counter medications, and alterative medicines, should also be identified. Because of the specific Taiwanese culture, herbal supplements, such as traditional Chinese medicine, herbs, vitamins, folk therapy, and alternative therapies, should be recorded during the medication history. Furthermore, although antibiotics, which are the most common prescription medication that women use, do not directly cause sexual pain, its long-term exposure will predispose women to chronic yeast infections, which may be a causative agent of the pain [14]. Hormonal influence from oral contraceptive has, among other things, been suggested as a causative factor for vulvar vestibulitis [30] and is identified as the most common cause of dyspareunia in premenopausal women [14]. Psychotropic medications are more frequently implicated as a cause of

hypoactive sexual desire disorder and female sexual arousal disorder than sexual pain [31]. Both hypoactive sexual desire disorder and female sexual arousal disorder can contribute to dyspareunia because of their effects on vaginal lubrication [14]. Therefore, medication assessment and education are important key points to the effective and safe use of prescribed medications, to patient collaboration in the treatment plan, and to patient adherence with drug treatment regimens.

Physical evaluation

Physical evaluation is mandatory during assessment of dyspareunia. Genital pain may result from a variety of medical conditions and anatomical variations that should be ruled out by physical examination. Therefore, a woman with dyspareunia should undergo a thorough physical examination to collect data for determining the potential etiology of the sexual pain. It is highly recommended that the procedure is explained in detail to the patient (i.e. what will and will not occur), and the patient's understanding and consent is obtained [23].

Colposcopic examination of the vulva, commonly referred to as vulvoscopy, in a woman with sexual pain, may be needed. A sensory examination is performed using moistened cotton swab to determine if there are areas that exhibit an abnormal pain response. This examination should be performed systematically to ensure that all areas of the anogenital region are tested. The labia majora, clitoral prepuce, perineum, and intralabial sulci should then be palpated. A speculum examination of vagina is the next step. In general, a pediatric-sized Graves speculum should be used, and all efforts should be made to insert the speculum through the hymeneal ring without touching the vulvar vestibule. A manual examination should also be performed with one finger instead of the usual two fingers. The examiner's index finger is inserted through the hymen without touching the vestibule. Moreover, the vaginal discharge may need to be examined with microscopy and culture as infection is one potential cause of dyspareunia [23]. Thus, a cotton swab should be used to collect some discharge for pH testing, wet mount, and potassium hydroxide testing. In addition, culture should be obtained and sent for speciation and sensitivity [14]. Serum testing is not necessary in all cases of sexual pain, but because hormonal abnormalities are common causes of sexual pain, blood should be obtained to examine the levels of serum estradiol, total testosterone, free testosterone, albumin, sex hormone–binding globulin, follicle-stimulating hormone, and prolactin [14,32]. A decreased serum estradiol is frequently found in a woman with vestibulodynia or atrophic vaginitis [14].

Psychological evaluation

Because the experience of pain includes sensory and affective aspects, the clinical interview has to cover multiple areas affected by dyspareunia to elicit descriptions important to treatment planning. A comprehensive psychological evaluation can provide valuable information about predisposing factors, such as family of the original and cultural schema about sexuality, sexual experiences, and any history of sexual abuse/trauma [33]. This evaluation brings another perspective to the health care providers with an unbiased receptivity to patients and their problems.

The assessment of pain properties, mediators, interference, comorbid disorders, and self-reported effectiveness of past treatment attempts can be preceded during the psychological evaluation. For pain properties, it is important to collect the lifetime onset of the pain (the onset within an intercourse episode, duration of the pain, and its specific location) with qualitative descriptions and the severity of pain, which can be elicited by means of visual analog or numerical rating scales. For pain mediator, it is focused on examining what tends to exacerbate or improve the pain. Some potential mediators include length of foreplay, intercourse positions, use of lubrication aids, level of desire/arousal, timing, fatigue, stress, mood, feelings toward the sexual partner, and overall relationship quality. For pain interference and comorbid problems, the comorbidity of other sexual dysfunctions, mood disturbances, and relationship difficulties should be relatively well documented, although it can be difficult to separate cause and consequence [33]. This is because a woman experiencing dyspareunia is reported to have higher levels of catastrophizing; fear of pain; hypervigilance [12]; and mood disturbance, such as nervousness and depression [15], and pain intensity has a significant association with marital adjustment, partner solicitousness, and partner hostility [12].

For self-administrated measures, sexuality questionnaires play an integral role in the diagnosis and treatment and provide specific indicators for evaluating the outcomes of treatment of female dyspareunia [9,33,34]. The defining characteristics of sexuality questionnaires are particularly helpful because they often reflect the behaviors that are the target of clinical intervention and research. The questionnaires can include (1) the McGill-Melazack Pain Questionnaire to assess the severity of pain in dyspareunic women; (2) Changes Sexual Functioning Questionnaire, Female Sexual Function Index, McCoy Female Sexuality Questionnaire, and Female Sexual Distress Scale to identify/diagnose individuals with sexual dysfunction; and (3) Golombok-Rust Inventory of Sexual Satisfaction (GRISS) and The Sexual Satisfaction Scale for Women to measure improvement or satisfaction with treatment. If depression or anxiety is suspected, the Back Anxiety Inventory can be used because it is psychometrically sound and brief.

The PLISSIT model for sexual counseling

To address patients' concerns about sexuality effectively, the health care providers need to learn how to approach sexuality as they act proactively in providing opportunities for patients to present concerns. For example, even when physicians are comfortable about initiating sexual inquiry, they may tend to overemphasize the biological basis of problems and neglect the psychological, interpersonal, and cultural determinants of difficulties [16]. Therefore, sexual-counseling strategies can be used by the health care providers during the

assessment and treatment processes [35,36]. A number of sexual-counseling frameworks [16,36–43] are available for health care providers to use as supportive and effective strategies to conduct sexual intervention in clinical practice. It is recommended by the authors to use the PLISSIT model for sexual counseling on a woman experiencing dyspareunia because the model has been used extensively in clinical practice [5,8,35,36,38,43–49] and can easily be incorporated into routine practice to assist the health care providers in gradually discussing the topic of sexual health and providing short-term supportive counseling [5,8,43–46,49]. The PLISSIT model, which consists of four levels of counseling (Permission, Limited Information, Specific Suggestions, and Intensive Therapy), was developed by Annon [38] for use by the health care providers in meeting the sexuality and sexual health care needs of patients (Table 1). By providing this support, the health care providers can help patients to know and understand their own abilities and disabilities brought on by their experiences of illness or surgery, allowing them to adjust accordingly. The details of how to apply the PLISSIT model by the health care providers on a woman experiencing dyspareunia are described as follows.

Permission

Permission is the first level of the model giving the patient permission to initiate sexual discussion and empowering her to make choices and changes [5,38]. When performing the assessment, the health care providers create a comfortable and open-minded climate, demonstrate active listening, freely interact with the patient and her partner, simply ask questions about all aspects of sexual health to give the patient the opportunity (permission) to share her sexuality and what it means to them, and identify any concerns. However, the woman may hesitate or feel embarrassed to describe her sexual problems; therefore, it is important to explain that sexuality is an essential quality-of-life issue, and that you are open to discuss it. This helps to normalize the discussion and may help the patient feel less embarrassed or alone. When a patient is not ready to deal with her sexual issues, the health care providers can acknowledge that the time might not seem appropriate now and the patient could ask for information any time. Moreover, the woman may have several different complaints; hence, it will be important to understand her perspective of pain, clarify her expectations, and further determine which of these she feels is her main complaint. Therefore, the process should be focused but open ended, progressing from general to specific and allowing spontaneous patient self-expression. The common questions can be started by "What concerns do you have about your sexual functioning or sex life?"; "Are you having any sexual difficulties at this time?"; and "Do you have pain during or after sex?" The health care provider's role is to maintain the flow of the interview and to listen to the verbal and nonverbal messages conveyed by the patient. All health care providers also must be aware of their responses to the patient [37,39,49] and should be able to function at this level.

Table 1
The PLISSIT sexual-counseling model

Permission:
- Give the patient the permission to initiate sexual discussion and empower the patient to make choices and changes.
- All health care providers should be able to function at this level.

Limited Information:
- Provide factual information to the patient in response to a question or observation.
- Most health care providers should be able to give this type of information.

Specific Suggestions:
- Explain the causes of the problems to the patient and assist the patient with very specific directions on how to address the problems.
- Most health care providers should be able to function at this level.

Intensive Therapy:
- Provide the patient the treatment for severe or more longstanding problem of dyspareunia.
- The health care providers need to be trained to identify situations that require intensive therapy and to make appropriate medical referrals when necessary.

Limited information

The second level, *Limited Information*, refers to factual information given to the patient in response to a question or observation. The health care providers address prevalent sexual concerns, norms of behavior, and attempt to correct myths and misinformation. This is reserved for relatively straightforward and noncomplex problems [8]. For instance, women often believe sex pain tolerance will meet their partners' needs [28], or some women have a very difficult time localizing their sexual pain or actual areas affected by the pain. They may not seek help and try to avoid disclosure about the nature of the problem or incorrectly identify the location of their dyspareunia. It is not surprising to find that a patient localizes the pain to the vagina, but an examination reveals that the pain originates from the vulva or bladders [14]. The health care providers can teach the basic anatomy of the genital organ and physiological response of sexual function, and explain to the patients how disease or treatment may affect sexual functioning and what changes in anatomy occur after surgery or birth delivery. Moreover, the health care providers can emphasize the importance of communication and trust within a partner relationship; dispel misconceptions and lead to the sharing of accurate information; and review the needs for sexual health, comfort, belief, and emotional safety [5,36]. Most health care providers should be able to give this type of information.

Specific suggestions

Specific Suggestions is the third level of PLISSIT and involves making a specific suggestion to the woman, which requires a deeper level of expertise. After explaining the sexual concerns and how a woman has evolved over time, the health care providers may explain the causes of the problems and assist the woman with very specific directions on how to address the problems. These suggestions include telling the patient what she can do for herself and what other patients

have tried or found helpful, and may include pharmacological and/or psychological intervention (e.g. prescriptions, exercise, multimedia aids) and alternative methods of sexual expression [8,36]. For example, Kegel exercises may be suggested to help the patient relax her pelvic floor muscles. During the process of providing guidance to the patient, the health care providers can give the patient responsibility and encourage her active involvement in finding a solution that becomes internalized to her. It is essential that, during the sexual-counseling process, the health care providers and the patient emerge as partners in a relationship built on trust and directed toward maximizing the patient's strengths, maintaining integrity, and promoting adaptive responses to her problems. Moreover, sexual satisfaction is strongly positively correlated with sexual communication between the woman with dyspareunia and her sexual partner [28], and therefore, assessing the couple's sexual communication and providing alternative methods of sexual expression are needed and are important. These suggestions may include focusing on sexual sensations; recording negative thoughts and analyzing them when sexual pain occurs; teaching the couple to engage in extended foreplay as it can help lengthen the vagina before penetration; using music, candles, and incense to enhance the sexual experience; using water-based vaginal lubricants during foreplay and penetration and vaginal moisturizers; using mutually agreed upon fantasies; and using stimulating devices [8,28,38].

Intensive therapy

For the fourth level of *Intensive Therapy*, the patient needs intensive therapy for severe or more longstanding problem of dyspareunia. In this level, the treatment may include psychiatric diagnoses, such as depression, anxiety disorder, personality disorders, or substance abuse, or by interpersonal or intrapersonal conflict [8,48], and specialized treatment (e.g. marital or couple counseling, or in-depth psychotherapy) may be needed in cases that are complicated by the coexistence of other complex life issues. However, the health care providers need to be trained to identify situations that require intensive therapy and to make appropriate medical referrals when necessary [38].

Sometimes, the "homework" assignments are needed in a counseling session for the couple, or individual, to practice what was discussed and learnt in the session. For example, the patient can be taught "the giving and receiving pleasure of sensate focus" in individual or mutual pleasuring. The assignments are intended to turn the idea of sexual obligation into pleasure; learn to focus on sensations rather than anxieties, fears, or penetration; and encourage the patient to be open, honest, and express feelings, needs, or frustration during the practice process. The couple may be asked to deliberately avoid orgasm, penetration, or even touching sexual organs during the practice process [8].

Conclusion

Female dyspareunia is an underrecognized and poorly treated constellation of disorder with prevalence of up to 39.5% that significantly impacts the affected women and their partners. Because women experiencing dyspareunia would experience a variety of sexual health difficulties and their most significant barriers to seeking help often result from embarrassment and feeling the physician would not be able to provide help [50], it is important that the physicians and other health care team members have the expertise to communicate effectively and determine how the patient can be best supported or treated [36].

Sexual counseling requires interpersonal skills, knowledge, and effective communication. The PLISSIT model can be used in a tailored and patient-centered approach in conducting sexual assessment and management of female dyspareunia. It can assist health care providers to understand what a patient experiences, what matters to her, and how to improve her sexual health. Including sexuality in the treatment of a woman experiencing dyspareunia will ensure practice standards with the holistic care. We hope that the recommendations in this article can provide a framework for the health care providers to facilitate access to recognition and treatment of female dyspareunia.

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