FEMALE SEXUAL DYSFUNCTION…

A SILENT CONDITION

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Sexual functioning is an integral part of health involving the psychological, physiological and socio-cultural aspects of an individual. In an era sometimes called "The Graying of America," aging women from the baby boomer generation no longer speak about life expectancy – now they talk about *health* expectancy, meaning they want to live longer with a minimum of health issues while enjoying sex throughout their life. Our culture has shifted from considering sex as mainly a means of procreation to seeing it as a form of recreation. Sex is openly discussed by many, and is seen in a positive light unless one is suffering from a sexual dysfunction. People tend to suffer with sexual problems silently.

Male sexual dysfunctions began earning media focus in a predominant way in the late 80's with the introduction of Viagra-like agents. This began the era of sexual pharmacology. A number of "Viagra failures" made it clear that a pill alone would not create an adequate sexual relationship. The complexity of sexual functioning was recognized and gave birth to the field of sexual medicine.

To understand sexual functioning, we turn to the sexual response cycle. The linear version was described by Masters and Johnson (Masters, Johnson, 1970) and modified by Singer Kaplan (Singer Kaplan, 1974). This model states that the desire phase leads to the arousal phase which leads to the orgasm phase resulting in the resolution phase. Some of the limitations of this model are that desire may be initially absent, desire and arousal may overlap, arousal and orgasm may be on a continuum, and orgasm may not lead to satisfaction. Basson came up with an alternate sexual response model – the intimacy-based model (Basson, et al., 2001). This model states that the neutral woman, when faced with intimacy, will be propelled by biological and psychological factors that govern arousal. If she experiences arousal, if she remains focused and the arousal is enjoyable, she may be driven by the desire of intimacy to complete and repeat the sexual encounter.

Over the last several years there has been a growing collection of clinical research and treatment. Researchers face the challenge of meeting the highest level of evidence-based medicine while demonstrating the complexity of sexual life. Not typically discussed in scientific literature is the vital part that love plays in interpersonal and sexual intimacy (Levine, 2007; McCabe, et al., 2010). "Mechanistically treating sexual problems without considering or discussing the quality of caring and love between partners is not likely to resolve the sexual problem, particularly over the longer term." (McCabe, et al., 2010).

THE IMPORTANCE OF A SEXUAL ASSESSMENT

Why is it important to take a sex history? Adequate assessment leads to adequate treatment. Female Sexual Dysfunction (FSD) is a condition experienced by women who largely suffer in silence. It is common for someone to present for treatment with complaints that are medical or psychological in nature but underlying these disturbances may be a sexual difficulty. An adequate sex life is associated with well-being and happiness.

Clinicians may be hesitant to ask questions related to sexual health. In reality, their training may be limited in sexual medicine. Time constraints, cultural barriers and their own biases may be other influences that cause clinicians to pause and not inquire.

There are five steps to an initial inquiry regarding sexual health:

1. General questions: Are you experiencing any changes in sexual functioning?
2. Specific questions: Are there changes in desire? Arousal? Orgasmic functioning?
3. Is there an increase or decrease in sexual response, satisfaction, or frequency of activity? You may ask the patient to rate the level of distress on a 10-point Likert scale with 10 being the most distress that someone may experience. If a patient reports 5 or more on this distress scale, they may need to be evaluated by an expert in the field of sexual medicine.
4. Educate and inform.
5. Refer to a specialist for a comprehensive sexual evaluation, if indicated.

In conducting a comprehensive sexual evaluation of the presenting symptom, one needs to clarify the sexual problem by considering the following:

- Are the symptoms acquired or lifelong; generalized or situational?
- What phases of the sexual response cycle are involved?
- Does the problem bother the patient or her partner?
- What is the context of the symptom in terms of past and present relationships and/or are they currently active?
- What is the partner's response?
- Is the problem psychological, organic, or a combination?

Other considerations in a comprehensive assessment are the following:

- A general clinical history and physical examination which identify psychological, medical and sexual disorders.
- A more specific evaluation of mood and cognitive disorders, trauma, substance abuse, stressors, interpersonal relationships, medications and medical conditions would be essential.
- It is important to obtain lab values such as an ovarian hormone profile to determine the influences of estrogen and testosterone on sexual functioning.

The clinician may ask the following questions to determine the factors involved in the dysfunction (McCabe, et al., 2010):

- Is it a result of predisposing factors such as sexual trauma or disturbing family relationships; or
- Is it a result of precipitating factors such as infidelity, problems related to childbirth, fertility difficulties, ovarian decline, or other age-related changes; or
- Is it a result of maintenance factors such as anticipation of sexual failure, poor communication, or inadequate education?

Another question to consider: Is the FSD related to mood, hormones or both? Consideration of an existing mood disorder, e.g., Anxiety/Depression/Bipolar Disorders, is important in doing an evaluation. There are many times that menstrual cycle-related disorders, e.g., PMS, PMDD, Perimenopause, Menopause, or disorders during pregnancy, e.g., Affective Disorder or Postpartum Affective Disorder, may trigger the onset of a sexual problem (Futterman, Jones, 2000; Clayton, 2001; Burt, Stein, 2002). Another consideration is that any hormonal disorder may occur simultaneously with a sexual disorder.

WHAT ROLE DOES MOOD PLAY IN SEXUAL FUNCTIONING?

When looking at mood and sexual functioning there needs to be a distinction made between a mood state and a mood disorder. In addition, menstrual cycle-related disorders such as PMS, PMDD, Perimenopause, Menopause or disorders during pregnancy may trigger the onset of a sexual disorder (Futterman, Jones, 2000; Clayton, 2001). In addition, any mood disorder may occur simultaneously with a sexual disorder. In either case inhibition or activation of the psychoneuroendocrine system will effect the sexual response cycle. The result will be a change in desire, arousal or orgasmic functioning.

State-anxiety has been shown to be arousing for most women except if they suffer from a sexual dysfunction or mood disorder. There is a high comorbidity of Anxiety Disorders and Sexual Disorders (Palace, Gorszalka, 1990; van Minnen, Kampman, 2000; Aksaray, et al., 2001; Figueira, et al., 2001; Bonierbale, et al., 2003; Bradford, Meston, 2006; Corretti, et al., 2007; McCabe, et al., 2010).

This comorbidity is also seen in woman with a Depressive Disorder (Ekselius, von Knorring, 2001; Kuffel, Heiman, 2006; Kanaly, Berman, 2008). The relationship between sexual dysfunction and depression is complicated by the use of antidepressant therapy as part of a treatment regime (Ferguson, 2001). These psychotropic medications carry sexual liability with them (Clayton, 2002; Kanaly, Berman, 2008; Derogotis, 2009). Selective Serotonin Reuptake Inhibitors (SSRIs) are the most common medications associated with FSD. The overall incidence of FSD was 59% when all antidepressants were considered. Seventy percent of female patients on antidepressants experience loss or delay of orgasm with reduced sexual desire and arousal. (Clayton, 2002; Kanaly, Berman, 2008; Derogotis, 2009). However, if depression is untreated there is a 50% reduction in sexual desire and arousal and a 15-23% delay in orgasmic functioning. Longer periods of untreated depression may predispose women to increased rates of FSD (Kennedy, et al., 1999; Ekselius, von Knorring, 2001). There is no empirical evidence on untreated anxiety and FSD. It's possible that any form of mental disorder would negatively impact sexual functioning.

TREATMENT FOR FSD IS MULTIDEMENSIONAL: EAST MEETS WEST

Non-medical approaches often address root causes and can assist in prevention of FSD. Individual and couples psychotherapy combined with biomedical interventions from western and eastern schools of medicine produce the optimum outcomes. Use of hormonal stabilization which includes ovarian hormones, thyroid or both may augment therapy. Eastern approaches that have been useful are acupuncture, homeopathic medicine and herbal therapies. Some of the psychotherapeutic techniques used include Mindfulness training; Meditation; Clinical Hypnosis; Cognitive-Behavioral Therapy (CBT); and Eye Movement Desensitization and Reprocessing (EMDR), as well as psychodynamic approaches.

The clinician will need to contemplate ways to balance the psychoneuroendocrine system using western and eastern therapies. The aim of all treatments is the stabilization and elimination of the presenting symptoms.

PSYCHOLOGICAL TREATMENTS

Psychological treatments are specific to each of the sexual disorders (Lieblum, 2007). A differentiation between spontaneous vs. responsive desire is important. A lack of responsive desire may be a stronger

indication of FSDD than spontaneous desire (Basson, 2001; Leiblum, 2001). In assessing a desire disorder, some questions to consider are:

- What factors are impeding the sexual interest?
- What is disturbing their ability to be intimate?

This may be approached from a psychodynamic, cognitive, or behavioral perspective or a combination of modalities. Empirical data on Cognitive-Behavioral techniques have shown a significant improvement in quality of sexual and marital life, sexual satisfaction, and a decline in desire disorders (Trudel, et al., 2001). Cognitive strategies aimed at changing negative to positive beliefs related to sexual encounters have used the technique of imaging scenes which incorporate higher levels of sexual interest. In addition, a traditional behavioral strategy that has been used with couples is called sensate focus, which relies on relaxation techniques to overcome the stress related to intimacy. The concept of discouraging genital touching or intercourse while affectionately engaging in bodily caressing is an *in vivo* desensitization exercise. Clinicians have also utilized Eye Movement Desensitization and Reprocessing (EMDR) or other systematic desensitization techniques to assist patients in overcoming performance anxiety and inhibitions.

Treatment for arousal disorders can incorporate sexual skill training or fantasy training. To assist patients in developing a sense of confidence, the clinician may encourage the use of positive imaging of sexually arousing scenes, either with or without masturbation. Fantasy and masturbation exercises can be in combination with manual devices such as vibrators or the EROS device to enhance genital arousal. These exercises can be done in masturbation where the fantasy incorporates the existing partner; once familiarity with arousal is experienced, interactive sex may become easier. “Sexual scripting” involves an overt script between the partners and the ideal or imagined script of each individual partner. Assisting the couple to create flexible or unconventional scripts can enhance sexual arousal and positively effect sexual interactions.

Arousal and orgasm are considered to be part of a continuum. A heightened state of arousal can lead to orgasm. It is important to determine if this is a primary orgasmic problem, in which case the woman has never reached orgasm, or a secondary orgasmic problem, in which case she has a history of being orgasmic and is suddenly unable to reach orgasm. Another consideration is situational: whether she has been able to achieve orgasm through masturbation and/or with a partner. Many women with orgasmic dysfunctions may not know ways to increase arousal and sustain the arousal long enough to reach orgasmic levels. Building on the skill of sexual fantasy development during masturbation while incorporating the partner into the fantasies can be a prelude to interactive sexual encounters (Heiman, Meston, 1997; Heiman 2002; Kilmann, et al., 1986; Segraves, Althof, 1998). The goal is to assist in achieving successful encounters that will lead to orgasmic functioning.

Contributing factors that can result in orgasmic dysfunction are organic, psychological, sociocultural and interpersonal (Lieblum, 2001). Physical/gynecological and in some cases neurological examinations are essential to rule out an organic component. A psychological evaluation includes an assessment of the influence of religion, education, age, relationship status, life style factors, and history of sexual and/or physical trauma on sexual functioning. Orgasmic dysfunctions may be viewed as a developmental arrest within the individual. The unconscious obstacle to letting go and becoming vulnerable to another person may become overwhelming and result in anxiety and fear. The focus is to assist the individual in reaching psychological differentiation and an enhanced sense of self esteem. Orgasmic dysfunctions may also be viewed as a learned response to sexual experiences that have been traumatic. This may result in interference with the ability to relax and enjoy the sexual interaction, thereby inhibiting the

orgasmic responses. In addition, if the partnership is fraught with discord, issues with vulnerability may arise.

Common painful sexual disorders are dyspareunia and vaginismus. It is thought that dyspareunia and vaginismus are not primary sexual disorders but are secondary responses to recurrent experiences of genital pain and should be considered as pain disorders (Reissing, et al., 2004). The diagnosis of these two classifications is based on complaints of painful sexual penetration and on location of the pain. Increased multidisciplinary attention is given to various diagnostic labels such as vulvodynia, vulvar vestibulitis, vestibulodynia, and focal vulvitis, in addition to the labels of dyspareunia and vaginismus (Lieblum, 2007).

One approach to treating these disorders is to shift the focus from sex to pain and fear. The goal is to decrease the avoidance and traumatic pain response which results in increased pelvic floor and bodily tension, in order to attain a relaxed response to vaginal penetration. A combination of physical therapy, medical/pharmacological interventions, education and psychological interventions are used. Psychological interventions that increase relaxation such as cognitive-behavioral therapy, clinical hypnosis, eye-movement desensitization and reprocessing (EMDR), meditation and biofeedback have been used.

In summary, sexual functioning and dysfunction need to be addressed from a psychoneuroendocrine model. As psychologists, we are in the perfect position to view ourselves as primary care clinicians. We can take time to understand the complexities surrounding sexual functioning and intimacy. A comprehensive assessment which takes into account the predisposing, precipitating, maintaining and contextual factors can identify the multidimensional aspects involved in sexual dysfunction. Given that no single intervention will be sufficient in treating these conditions, we can utilize multiple treatment options and facilitate the levels of care needed.

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