Psychosexual problems

Claudine Domoney

Abstract

Sexual problems commonly present in gynaecology clinics. They require both a physical and psychological approach to their management due to the combination of mind and body involvement in sexual activity. The skills involved in psychosexual medicine can be practised by all gynaecologists as they use the consultation and examination to recognise and treat the underlying problem in addition to addressing any physical factors.

Keywords arousal disorder; desire disorder; dyspareunia; female sexual dysfunction; orgasmic disorder; psychosexual medicine; vaginismus

Introduction

Sexual health is a significant component of general well-being as determined by the World Health Organisation, 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. As gynaecologists are primarily involved with the function of the pelvic organs with respect to both physical and psychological performance, the ability to engage with sexual difficulties is paramount. The health professional may feel inadequate in the face of overt or covert presentations of sexual dysfunction (see Table 1) and the patient frequently brings her awkwardness during sexual activity to the consultation. Encouraging the doctor and patient to share these difficulties and from there to 'problem solve' is helpful for both. Approaching the patient as the 'expert' in her condition and using the feelings generated between the doctor and patient during the consultation to explore the meaning and context of her difficulties can lead to resolution and satisfaction for both patient and doctor. A simple pathway of care and an understanding of psychosexual medicine may enable the general gynaecologist to help their patients without referral to another health professional.

Female sexual function

The range of sexual behaviour in women makes categorisation of abnormality more difficult than the quantitative measures in men – e.g. erection and ejaculation. Sexuality in women may be more qualitatively measured. The models of female sexual behaviour have been modified over time: from the Freudian concept of sexual dysfunction being symptomatic of adverse childhood experiences leading to disorders of maturation and personality, abnormal child–parent relationships and an inability to form future intimate bonds to the next pivotal perspective of Masters and Johnson in the mid 20th century. Figure 1 illustrates the linear model reflecting male sexuality more accurately than female: progression from desire to arousal and excitement, leading to single (or multiple) orgasm followed by a refractory period. These phases were observed within laboratories using sex workers and volunteers – perhaps not a true representation of heterosexual intercourse? More recently, an International Consensus group has expanded the female sexuality models developed over the latter 20th century to include the importance of intimacy and sexual stimuli for the innate sexual drive (Figure 2). This suggests a female perspective where an innate drive or libido may not be necessary for a healthy and satisfying sexual life. Sexual motivation in women is complex and may start from a position of sexual neutrality. Reasons for being sexual include the desire to reinforce the physical and, therefore, emotional intimacy of their relationship. Sexual stimuli can then be processed in the mind, influenced by biological and psychological factors. This may result in arousal, sexual excitement and

Common presentations of sexual problems in the gynaecology clinic

OVERT presentation	Covert presentation
Loss of libido	Pelvic pain
Anorgasmia	Vaginal discharge
Loss of sensation	Prolapse symptoms
Non-consummation	Vulval pain
Vaginismus	Vaginismus
Coital urinary leak	Difficulty with smear taking
Vaginal dryness	Requests for labial reduction
Dyspareunia	Dyspareunia

Table 1

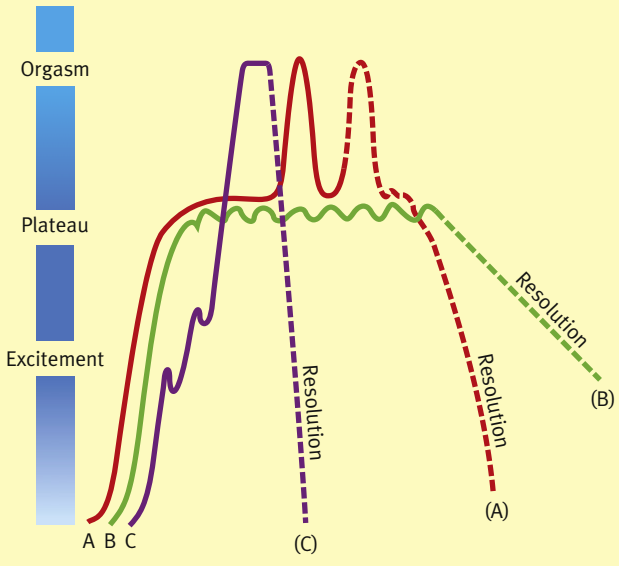

Figure 1 Masters and Johnson model of female sexual response cycle (Source: Masters WH, Johnson VE. The human sexual response. Boston: Little, Brown & Co; 1966).

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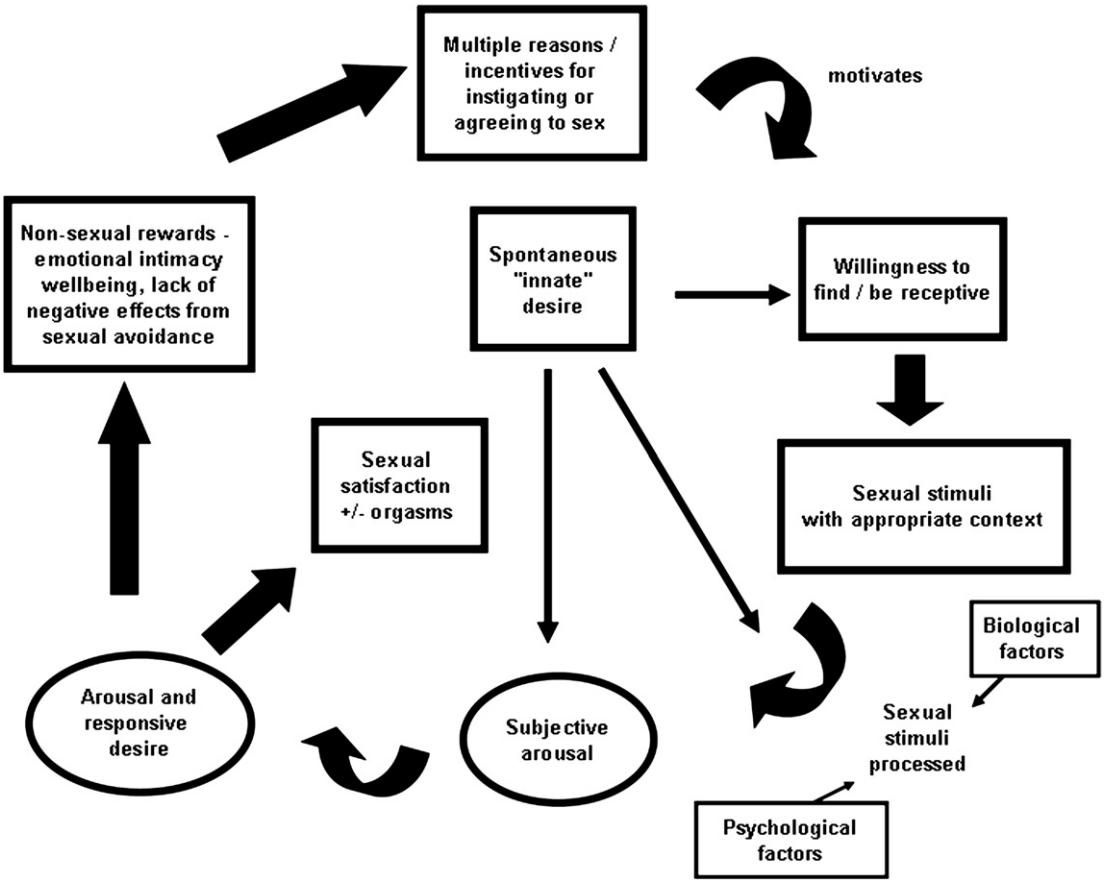

Figure 2 International Consensus group female sexual response cycle.

satisfaction, with or without orgasm. However, mental and physical pain may easily disrupt this cycle and the ability of the woman to focus. Sexual satisfaction in turn promotes further sexual activity. There may be pressures from outside influences such as the media that propose criteria for 'normal' function. This promotes performance anxiety in women as well as men. A negative feedback cycle may develop that then facilitates the development of a psychosexual disorder.

Hormones

It is not clear at present what role hormones play in female sexuality. Low sexual desire is frequently found in younger, oophorectomised women without hormone replacement and is a licensed indication for testosterone replacement in addition to oestrogen. However, androgen levels do not correlate with other measures of sexual behaviour although there is some correlation noted in studies of the menopause indicating oestrogen maintains higher sexual functioning. Overall, the most important factor in persistent sexual activity with age is presence of a sexually functioning partner. For this reason, hormone assays are rarely helpful.

Case 1

A 65-year-old married Caucasian woman presented to a clinic with overactive bladder symptoms. After she reported her symptoms having improved with anticholinergic medication and bladder retraining, she seemed reluctant to leave a follow-up consultation. 'It is odd that now I can't feel my bladder, I also can't feel anything during intercourse.' Vaginal oestrogens were prescribed and a follow-up consultation organised for further discussion. It is important to note the opportunity for the patient or the doctor to 'flee' in the 'hand on door' situation when a significant problem is brought up at a time the patient can leave if she/he senses discomfort from the doctor. The doctor had recognised the hesitation of the patient and not avoided the important topic introduced, even though it was not pursued at this time.

At the next appointment the vaginal oestrogens and atrophic vaginitis were discussed. Although treatment had made physical intercourse easier, the lack of sensation was still present. 'Maybe it is normal for my age?' When the doctor asked when it had started, she described a very satisfying sexual life until her husband's retirement. What had changed then? A distinct tone changed in her voice – the rather timid, 'maybe I am too old for sex, lady became a strident, controlled matriarch.' 'He thinks he can tell me how to run the household, which I have done for the last 30 years with no complaints and tell me there is time after the washing up for an afternoon of sexual interlude as he feels too tired at night. I have far too many things to do in the afternoon and he really needs to get something else to fill his time.' The inability to communicate this to her rather forceful husband

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