Female sexual dysfunction

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Abstract

This contribution briefly illustrates the complexities of the field of female sexual dysfunction, both in terms of the circumstances in which the problems can arise and the multiplicity of causations. It is often hard for a woman to find the language to describe the nature of her difficulty, which means obtaining access to appropriate professional help can be problematic. The main causes of female sexual dysfunction are outlined here, as described by the Working Group for a New View of Women's Sexual Problems. These include social, political and economic factors, partner and relationship issues, psychological factors and medical factors. There are difficulties with the classification of female sexual dysfunction, as current attempts neither reflect the full complexity of female sexuality nor take account of the myriad possibilities of causation. The most commonly presenting sexual symptoms are described. These include desire and arousal problems, problems with orgasm, sexual aversion, phobia and 'sexual anorexia', sexual pain of non-medical origin, and vaginismus. Mention is made of life events that can trigger sexual dysfunction in women, making reference to physiological, emotional or relationship changes. The importance of careful assessment by a person skilled and trained in this field is stressed. A range of treatment options is covered, including psychological and physiological approaches, mechanical devices and pharmacological agents. The sex therapy programme, Sensate Focus, is included in table format. Possible referral routes are mentioned, and educational materials are listed.

Keywords anorgasmia; arousal disorder; female sexual dysfunction; painful sex; sensate focus; sexual aversion; vaginismus; vulvodynia; vulvovestibulitis

The field of female sexual dysfunction is complex, owing to the multiplicity of factors that have an impact on female sexuality.

There is general concern among clinicians about the over-involvement of mechanical devices and medication in the management of perceived female sexual dysfunction.[1] Critics are concerned that sexual function is increasingly seen in terms of performance, as measured by number and intensity of orgasms for example, rather than satisfaction generally. This viewpoint isolates any sexual concern from other important factors that might be contributing to any problem, such as underlying illness, emotional disturbance and relationship pressures. The fear is that these could pass undetected, leading to greater distress for the patient and risk to her health.

Because of shame about sex and a lack of appropriate language in which to express sexual matters, women may repeatedly complain of vague symptoms, described in unclear terms, bewildering to the clinician. Without sensitive yet direct questioning, sexual problems and concerns may not be revealed. The patient may need help to find the words to express what has previously been impossible to say.

Up to 10% of people attending psychiatric clinics have sexual problems, although this may not be the primary reason for presentation. The figure for general practice surgeries is higher, given the incidence of sexual problems within the general population.

Thus, the clinician presented with female sexual dysfunction may have a challenging task ahead, picking a way through different opinions, wrong assumptions, problems with language, the risk of over-medicalization and the risk of failure to identify organic illness.

Causes of female sexual dysfunction

The Working Group for a New View of Women's Sexual Problems has compiled a comprehensive guide to causes of female sexual dysfunction, which is summarized in Table 1.[2] The 'medical factors' manifest as pain or lack of physical response despite a good relationship, adequate knowledge and a positive attitude. Particular mention of oral contraceptives and other hormonal contraceptive preparations should be included as factors here, because of the effects they can have on sexual feelings and responsiveness.

Classifying female sexual dysfunction

DSM-IV and ICD-10 offer categories for the classification of female sexual dysfunction.[3,4] These are receiving criticism from a strong body of opposition, predominantly clinicians and researchers, spearheaded by the Working Group for a New View of Women's Sexual Problems.[2] The main concern is that both classifications follow the human sexual response cycle proposed by Masters and Johnson in 1970.[5] This describes desire, leading to arousal, leading to a plateau phase, then orgasm, followed by resolution. The classifications concentrate on the physiological aspects of heterosexual penetrative intercourse, and there is an implicit assumption that male and female sexualities are comparable in many ways. However, these classifications are restrictive for both men and women and do not encompass the complexity of sexual experience.

In evaluating sexual problems for women it is particularly important to include the woman's awareness of pleasure and satisfaction,[6] as well as the context of the sexual activity and the relationship between the partners,[7] since these can be the most relevant factors in female sexual response and satisfaction. This contribution describes the female dysfunctions as they are likely to be presented, offering a balance of both physiological and contextual perspectives.

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Causes of female sexual dysfunction

Sociocultural, political or economic factors

- Ignorance and anxiety due to inadequate sex education, poor access to health services and lack of language
- Sexual avoidance or distress due to perceived inability to meet cultural norms, shame about one's body, sexual attractiveness or sexual identity
- Inhibitions due to conflict between the sexual norms of one's subculture and those of the dominant culture
- Lack of interest, fatigue or lack of time due to family and work obligations

Partner and relationship factors

- Inhibition, avoidance or distress arising from betrayal, dislike or fear of partner, partner's abuse, power imbalance, poor communication
- Discrepancies in desire for sexual activity or preferences
- Difficulty in communicating preferences or initiating, pacing or shaping activities
- Loss of sexual interest as a result of conflicts or traumatic experiences (e.g. infertility or the death of a child)
- Inhibitions in arousal or spontaneity due to partner's health or sexual problems

Psychological factors

- Sexual aversion, mistrust or inhibition of sexual pleasure due to past abuse, problems with attachment, depression or anxiety
- Sexual inhibition due to fear of sexual acts or their consequences (e.g. pain during intercourse, pregnancy, STD, loss of partner, loss of reputation)

Medical factors

- Medical conditions affecting neurological, neurovascular, circulatory, endocrine or other systems of the body
- Pregnancy, STDs or other sex-related conditions
- Side effects of drugs, medications or medical treatments
- Iatrogenic conditions
- Oral contraceptives are often associated with changes in women's sexual responses, although the reasons for this are not always obvious

Source: Kashak and Tiefer, 2001.[2]

Table 1

Problems with desire and arousal

Desire has been described as the expression of sexual drive, as evoked by a stimulus. Recent research confirms that it is inextricably intertwined with physiological arousal, evidenced by changes, for example pelvic engorgement, vaginal lubrication, increased heart rate, etc. It has been demonstrated that whilst most women respond physiologically to sexual stimuli, they may have no awareness of this arousal. To a certain extent intermittent loss of sexual desire in women as a reaction to changing external or internal circumstances is a normal aspect of female sexuality. However, it can be perceived as a problem by the woman or by her partner, who may be troubled and pressurize for change. Therefore therapy needs to take account of the relationship, rather than focusing solely on the individual.

Problems with orgasm

A woman may be pre-orgasmic, in which case she will believe she has never experienced an orgasm or climax, or she may have ceased being orgasmic; this may occur for a number of reasons, medical illness among them. Some women develop orgasmic ability over time while others, (about 10%), even with experimentation, never do experience orgasm in any situation. Male partners are often more worried by a lack of orgasm in their partner than the woman herself, assuming close parallels between male and female sexualities. A man may see it as a failure or lack of prowess on his behalf, whilst the woman may well be satisfied with sex as it is.

A very few cases of hyper-orgasmia have been described, some of which respond to pharmacological treatment with bromocriptine, while others resolve over time.

Aversion, phobia, 'sexual anorexia'

Strong feelings of revulsion at the prospect of sexual activity are typical of sexual aversion, and may result from early childhood events or later problems, frequently with the theme of disgust, humiliation and shame.

Fear, or phobia, of sexual contact is a common response to earlier trauma, abuse or violation, or may have no obvious cause.

The 'sexual anorexic' may feel willing and want to be sexual but cannot allow herself to proceed when in the sexual encounter; she may have low self-esteem and family of origin issues are likely antecedents.

In all three presentations, the woman may be puzzled at her reactions and go to great lengths to avoid being in sexual situations. Some are able to overcome their reluctance from time to time, usually with the help of alcohol and other drugs. Many have family of origin and relationship disturbances underlying the sexual symptom.

Painful sex

Pain occurring in the absence of any infection or inflammation may indicate that there is insufficient vaginal lubrication for penetration to be comfortable, or that there is incomplete arousal, so that the inner part of the vagina does not expand to make space for penetration.

Deep dyspareunia, however, may be caused by this lack of arousal but can also be due to other pelvic conditions such as endometriosis, adhesions, salpingitis and others which might require gynaecological or other medical investigations.

However, vulvodynia, a persistent sensation of burning, tingling or aching in the vulval area not necessarily related to any sexual activity, is increasingly reported particularly from older women. Vestibulodynia (previously known as vestibultis) is a pain syndrome triggered by touch. The woman experiences exquisite pain to the touch, which may persist for some hours after it has arisen. The pain may be triggered simply by the experience of sexual arousal, and in general sexual activity is impossible.

Vulval pain syndromes are often exacerbated by stress and careful exploration of life events at or around the time of the commencement of symptoms could elucidate this. Vulvodynia