Psychosexual disorders

Claudine Domoney

Abstract

Consultations in the gynaecology clinic should seek to understand the patient's problem and the effect on their quality of life and physical and psychological health. All unexpected symptoms may be expressed in various ways, often not corresponding with the doctor's categorisation. Frequently psychosexual disorders are therefore not addressed. Understanding sexual problems by using psychosexual skills and understanding human sexuality, will help management, using a mind-body approach and combining treatment of the physical complaints and exploring psychological distress.

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

Introduction

Psychosexual 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 function of the pelvic organs with respect to both physical and psychological performance, the ability to engage with sexual difficulties is paramount. Training is recognised as poor in general medical education but many difficulties of both the healthcare professional and the patient are due to the awkwardness and sensitivities of expressing sexual pain and distress. Sharing these difficulties however, within the consultation and during examination, can be therapeutic. The interventions available to the gynaecologist will be physical in the form of medical and surgical interventions but will be maximised by including a psychotherapeutic approach to examination of the patient. This will improve understanding of the impact on their sexual health and acknowledgement can initiate recovery. The patient can be considered the 'expert' rather than the doctor who facilitates resolution in psychological terms.

Female sexual function

Comprehension of 'normality' facilitates better management of abnormality. Sexual function includes roles in reproduction, pleasure and affirmation of relationships in varying degrees over a lifetime. The categorisation of female sexual behaviour may be more qualitative than with men. Male sexual performance can be assessed using quantitative measures Eg erection and ejaculation. The models of female sexual behaviour, being less compatible with quantitative assessment, 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 pivotal perspectives 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.

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 innate female sexual drive (Figure 2). A female perspective, where an innate drive or libido may not be necessary for a healthy and satisfying sexual life, becomes normalised. This improves the understanding of true female psychosexual disorders that represent the reality of women's sexual lives. The context within which a sexual encounter occurs may be paramount. Sexual motivation in women may start from a position of sexual neutrality. Reasons for being sexual include the desire to reinforce the physical and, often more importantly, the 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 satisfaction, with or without orgasm. Desire and arousal may often occur simultaneously. However mental and physical pain may easily disrupt this cycle and the ability of the woman to focus on desire and arousal sensations.

Sexual satisfaction promotes further sexual activity. Breaking the cycle of negative feedback may include recognising the pressures from other influences, including the media, proposing alternative criteria for 'normal' sexual behaviour. These other factors can increase performance anxiety and dissatisfaction in women as well as men. Reinforcement or lack of recognition of the negative feedback cycle can then facilitate the development of an entrenched psychosexual disorder.

It is well recognised that the hormonal milieu may impact on sexual responsivity, accounting for changes throughout female lives. In addition, both physical and mental healthare important for maintaining a sexual life. The medical and/or surgical treatment of health issues have potential side effects that affect normal function. To recognise these sexual, physical and psychological health factors and manage the consequences is important to prevent behavioural changes that are much more difficult to disentangle and treat.

Case 1

A 42-year-old woman comes to the gynaecology clinic and is seen firstly by a male medical student who takes a medical history of her issues. When he comes to present this to the doctor he is confused and embarrassed. The patient also projects the same feelings to the doctor when trying to explain her symptoms further. The doctor is unclear what the problem is. She refers to the GP referral letter, which is similar in the themes of mixed symptoms – none of which may seem to be suitable for the gynaecology clinic. What do you think we can help you with here? Why have you come now? What is distressing you most?

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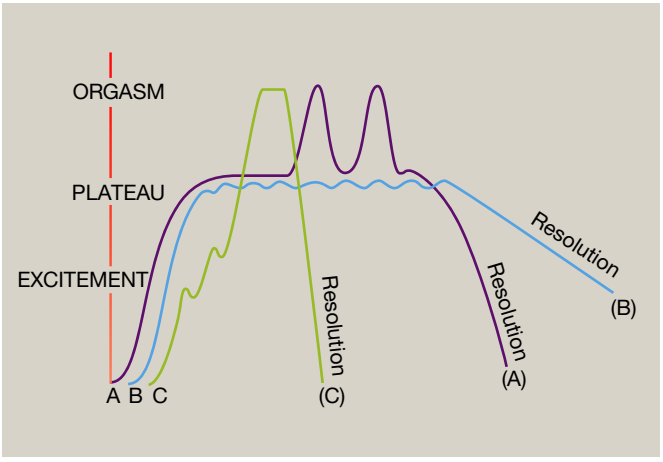

Figure 1 Masters and Johnson linear model of human sexual response.

Gentle open ended questions then opened the floodgates of rage towards her husband – his lack of understanding, his demands for sex, his inability to understand her pain. On asking 'What pain do you feel?' she becomes more reflective and starts to explore the changes in her body that have made her feel uncomfortable with sexual activity and herself as a sexual person. Previously they had enjoyed a good sex life that had seemed the envy of her friends when they discussed them together (that culturally she felt was more than he should expect). She had mixed urinary symptoms, vaginal dryness, some perimenopausal type symptoms. She also appeared to have a fear of further pregnancies but had had side effects with all hormonal contraception she had previously tried. She felt he was cavalier with the risks he took with unprotected sex that she would have to bear the consequences of. She had started to feel pain with sex but examination was remarkably normal. When it was reflected that the pain may be due to psychological factors in addition to the physical, she remarked 'the sooner I can divorce him the better … '.

The consultation ended with a summation of the issues that had presented – most of the physical could be treated: management of overactive bladder, alternative long acting contraception and consideration of hormone replacement if she was truly perimenopausal. Yet her understanding of the expression of her anger towards her husband needed acknowledgement. It would be necessary for the couple to address the shortcomings of their relationship and how they approach the changing years ahead of them that would determine success. When calmer, she volunteered she would very much like to preserve her marriage if he would contribute to saving it.

Female sexual disorders

Classification

As understanding of sexual function evolves, the definition of dysfunctions has changed. The Diagnostic and Statistical Manual of Mental Disorders (DSM) of the American Psychiatric Association published its fifth version of sexual dysfunctions in 2013. This combines the dysfunctions into three broad categories as opposed to five in the fourth version published in 1994. The symptoms now also need to be present for at least 6 months and occur with a frequency of 75%. This will therefore exclude transitional changes in sexual function that are

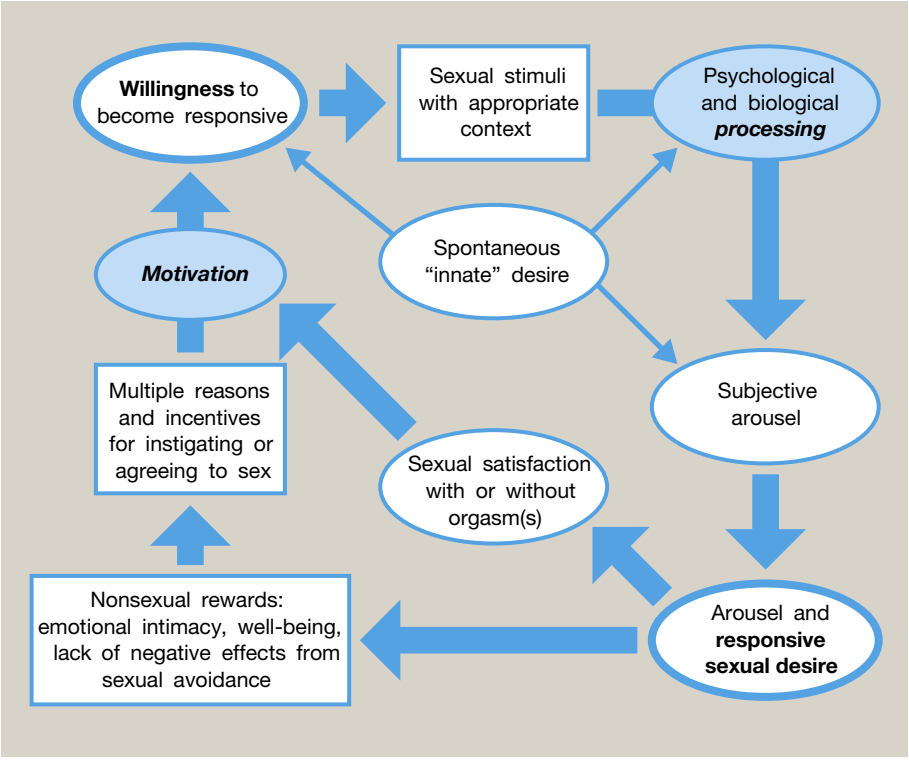

Figure 2 International Consensus model of female sexuality.