Female Sexual Dysfunction – without an organic cause

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Sexual Medicine Practitioner
How patients feel

- 85% adults are willing to speak about sexual concerns
- 71% felt their doctor would not be helpful
- 68% concerned it would make their doctor uncomfortable\(^1\)

- ‘Struggling in silence’
- No validation or normalisation
- Only 25% of physicians will discuss sexual issues, even if they believe that there is a problem\(^2\)
- Most rarely or never addressed sexual issues

1 Marwick et al
2 Sharon L Bober et al J Sex Med 2013
Percentage of individuals with Sexual Complaints

Lauman et al. JAMA. 1999;281:537-544
PLISSIT Model

A simple model that shows most people with sexual problems do not need an intensive course of therapy.

The acronym **PLISSIT** describes four basic forms of sex therapy:

- **P**ermission
- **L**imited **I**nformation
- **S**pecific **S**uggestions
- **I**ntensive **T**herapy

![PLISSIT Diagram](image)

The PLISSIT Model of Sex Therapy
(developed by Jack Annon)

- **P** = Permission
- **LI** = Limited Information
- **SS** = Specific Suggestions
- **IT** = Intensive Therapy

Magnus Hirschfeld Archive for Sexology
Biopsychosocial model of Sexuality

- Psychological factors
- Cultural factors
- Biological factors
- Interpersonal factors
What causes sexual problems?

**Predisposing Factors**: These include constitutional and prior life experiences that contribute to a person’s vulnerability for dysfunction. Usually not sufficient to create sexual dysfunction.

<table>
<thead>
<tr>
<th>Predisposing Factors (Adapted from Althof et al., 2010)[2]</th>
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<tbody>
<tr>
<td><strong>A. Constitutional Factors</strong></td>
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<tr>
<td>1. Anatomical deformities, e.g., intersex conditions</td>
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<tr>
<td>2. Hormonal irregularities</td>
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<tr>
<td>3. Temperament, e.g., shyness vs. impulsivity; inhibition/excitation</td>
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<tr>
<td>4. Physical resiliency (a lack of / low)</td>
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<tr>
<td>5. Personality traits, e.g., obsessive- compulsive vs. histrionic</td>
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<td><strong>B. Developmental Factors</strong></td>
</tr>
<tr>
<td>1. Problematical attachment/experiences with parents or parental surrogates</td>
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<tr>
<td>2. Exposure to physical, sexual coercion, violence</td>
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<tr>
<td>3. Surgical intervention/medical illness</td>
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<td>4. Event based or process-based trauma</td>
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<td>5. Early sexual experiences, e.g., first intercourse</td>
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<td>6. Sexual abuse</td>
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<td>7. Religious/cultural messages, expectations, constraints</td>
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</table>
What causes sexual problems?

**Precipitating Factors**: They include more immediate factors that propel a person from an adequate response to a dysfunctional response.

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<tr>
<td>1. Life-stage stressors such as divorce, separation, loss of partner, infidelity, menopausal complaints</td>
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<tr>
<td>2. Infertility or post-partum experiences</td>
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<tr>
<td>3. Humiliating sexual encounters/experiences</td>
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<td>4. Depression/anxiety</td>
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<tr>
<td>5. Relationship discord</td>
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<tr>
<td>6. Substance abuse</td>
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</table>
What causes sexual problems?

**Maintaining Factors**: may prolong and exacerbate problems irrespective of the original predisposing or precipitating conditions. They are responsible for transforming disappointing or episodic sexual failure into chronic conditions.

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<td>1. Ongoing interpersonal conflict</td>
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<tr>
<td>2. Stress- emotional, occupational, personal</td>
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<tr>
<td>3. Acute/chronic illness/health problems</td>
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<tr>
<td>4. Medications, substance abuse</td>
</tr>
<tr>
<td>5. Loss of sexual self-confidence, performance anxiety</td>
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<tr>
<td>6. Body image concerns</td>
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What causes sexual problems?

Contextual Factors: encompass every day stresses and demands that impinge on the individual or couple. They are usually temporary but can become chronic and impact on sexual function.

Contextual Factors (Adapted from Althof et al., 2010) [2]

1. Present day stresses and demands- financial burdens, unemployment, caretaking of parents, children or partner, fatigue from childrearing
2. Environmental constraints- lack of privacy, time, partners working different shifts
3. Repeated unsuccessful attempts to conceive children, artificially assisted attempts to conceive
Kaplan added the concept of desire to the Masters and Johnson model and condensed the response into three phases eliminating the plateau phase.
Sexual Dysfunction (DSM-IV-TR)
Primary / Secondary, Global / Situational

Female
- Desire disorders
  - hyper / hypoactive
  - inhibited, aversion
- Arousal disorders
  - Impaired lubrication
  - no subjective excitement
- Orgasmic disorders
  - rare or absent
- Pain disorders

Male
- Desire disorders
  - hyper / hypoactive
  - inhibited, aversion
- Arousal disorders
  - erectile dysfunction (ED)
- Orgasmic disorders
  - premature ejaculation (PE)
  - delayed ejaculation
- Pain disorders
Sexual Complaints

Women aged 18 to 59 years
N=1749

- Sexual desire disorder: 32%
- Sexual arousal disorder: 21%
- Orgasmic disorder: 26%
- Experienced pain during intercourse: 16%

Prevalence of FSD: low sexual function & distress

Dysfunctions were defined using the Sexual Function Questionnaire (SFQ) and the Female Sexual Distress Scale (FSDS)

N=356 Australian women aged 20 to 70 years
Overlap of Disorders

Sexual Desire Disorders

Sexual Arousal Disorders

Orgasmic Disorders

Sexual Pain Disorders

Contributors to Desire Problems

- Biological
  - Sex Hormones
  - Illness
  - Fatigue

- Expectation of Negative Outcome
  - Past history of disappointing sex

- Contextual
  - Lack of privacy
  - Safety
  - Emotional rapport
  - Cultural beliefs

- Interpersonal
  - Stimulation
  - Partner dysfunction

- Lack of Appropriate Stimuli
  - Relationship discord
  - Absence of emotional intimacy

- Intrapersonal Development History
  - Trauma (sexual, physical, medical)
  - Negative emotions (anxiety, fear, shame, guilt)

Created by: Sandra Leiblum, PhD
Sexual Response “at rest” is balanced within a normal range, which is subsequently influenced by numerous mental and physical factors, which may vary within and between experiences.

Perelman MA. J Sex Med 2006;3 1004-1012 (Adapted)
Rosemary Basson’s Circular Model

- Emotional intimacy
- Motivation or receptivity of the sexually neutral woman
- Spontaneous sexual drive
  - Sexual stimuli
  - Psychological and biological factors
  - More arousal and sexual desire
  - Sexual arousal
  - Physical and emotional satisfaction
Sexual Dysfunction (DSM-V)
Lifelong / Acquired, Generalised / Situational

Female
- Interest/arousal disorders
  - reduced interest/thoughts/initiation
  - impaired lubrication
  - no subjective excitement
- Orgasmic disorders
  - rare or absent
- Pain disorders

Male
- Desire disorders
  - hypo active
  - inhibited, aversion
- Arousal disorders
  - erectile dysfunction (ED)
- Orgasmic disorders
  - premature ejaculation (PE)
  - delayed ejaculation
- Pain disorders
Female Sexual Interest/Arousal Disorder (DSM-V)
Lack of, or significantly reduced, sexual interest/arousal as manifested by at least three of the following:

1. Absent/reduced interest in sexual activity.
2. Absent/reduced sexual/erotic thoughts or fantasies.
3. No/reduced initiation of sexual activity, and typically unreceptive to a partner’s attempts to initiate.
4. Absent/reduced sexual excitement/pleasure during sexual activity in almost all or all (approximately 75%–100%) sexual encounters (in identified situational contexts or, if generalized, in all contexts).
5. Absent/reduced sexual interest/arousal in response to any internal or external sexual/erotic cues (e.g., written, verbal, visual).
6. Absent/reduced genital or nongenital sensations during sexual activity in almost all or all (approximately 75%–100%) sexual encounters (in identified situational contexts or, if generalized, in all contexts).
• symptoms have persisted for a minimum duration of approximately 6 months.

• symptoms cause **clinically significant distress** in the individual.

• sexual dysfunction is not better explained by a **nonsexual mental disorder** or as a consequence of a **severe relationship distress** (e.g., partner violence) or **other significant stressors** and is not attributable to the effects of a **substance/medication** or **another medical condition**.
Clinical Assessment of FSD

History: open ended questions, a conversation

- lifelong or acquired, situational or generalised
- biopsychosocial approach
- predisposing, precipitating, maintaining factors
- problem: desire, arousal, orgasm or pain (or combination)
- distress
Clinical Assessment of FSD

Identification of psychosocial factors:

- individual factors: attitudes & beliefs about sex (e.g. negative first sexual experiences), lifestyle (e.g. sleep), negative self-image, stress, other precipitating factors (e.g. sexual abuse)
- relationship factors: quality, duration of relationship, conflict or trust issues, communication, routine
- partner: useful for both partners to be evaluated, partner’s health
Clinical Assessment of FSD

Identification biomedical factors:

- hypothyroidism
- menopause
- coronary artery disease, diabetes
- urinary incontinence
- neurological
- depression or anxiety
- cancer
- surgery
- side effects of any prescribed medications (e.g. SSRI’s, antipsychotics, oral contraceptives)
Anatomy

Female external genitalia and clitoris
Physiology

Female Arousal:

- During the arousal phase, vaginal walls and clitoris become engorged with blood, tumescent or swell.
- Most obvious sign of sexual excitement and tumescence is the lubrication of the vagina (transssudation).

“Sweating” (transssudation) of the vaginal walls. Vaginal blood vessels and clear fluid (A), muscular wall of the vagina (B), lubricating “sweat” (C).
Clinical Assessment of FSD

Physical examination: general examination recommended

• genital examination: good medical care, education, reassurance (normal examination may be informative)
• mandatory (lack of sexual interest/arousal, combination of dysfunctions, sexual pain)
• may be delayed, always with care
• inspection first

Look for

• pain mapping (q-tip testing)
• vulval atrophy, inflammation, infection, neoplasia, perineal scarring
• muscle strength, spasm or tenderness
• uterine or adnexal pain or masses

Investigations: FBC, Glucose, Thyroid Function, Prolactin and imaging
Management

Basic counselling
• permission to talk about sexuality
• patients feel accepted and understood
• emotional relief, gives information
• dispels myths and misinformation

Lifestyle modifications and education:
• education about sexual response (e.g. women in long-term relationships may not feel spontaneous desire)
• adequate sleep, exercise, diet
• locking the bedroom door if privacy is concern
• addressing sexual boredom, changing the sexual routine, spending time as a couple (e.g. date nights)
Management

General medical treatment
• optimise treatment of underlying conditions

Vaginal lubricants (to facilitate stimulation) and moisturizes

Hormone treatment
• Oestrogen: local or systemic benefits genito-urinary syndrome of menopause - vulvovaginal atrophy, vaginal dryness, dyspareunia
• Testosterone:
  • not approved for use in SA
  • testosterone (300mcg daily), transdermally has been shown to benefit sexual desire in oestrogen replete, naturally and surgically postmenopausal women1 (Davis 2013)
• Tibolone: beneficial effects desire and lubrication
• DHEA: side effects of chronic use unknown, vaginal DHEA further trials

Eros clitoral device: enhances clitoral engorgement and blood flow
Management

Centrally active agent: Flibanserin (Addyi)  FDA Approved

- postsynaptic agonist of serotonin receptor 1A and an antagonist of serotonin receptor 2A
- increased number of satisfying sexual events by 0.5 to one additional event per month (over placebo)
- increased the sexual desire score by 0.3 to 0.4 over placebo, and decreased the distress score related to sexual desire by 0.3 to 0.4 over placebo.
- can cause hypotension and syncope, with increased risk and greater severity when patients drink alcohol or take Addyi with certain medicines (CYP3A4 inhibitors) due to interference with breakdown
- only prescribed by certified practitioners
- requires daily dosing
- expensive
Psychosexual

- Cognitive Behavioural Therapy
  - Sexual abuse, relationship factors, poor body image

- Sex therapy
  - Includes sensate focus
    - exchanging physical touch, moving from non-sexual to sexual areas, with partners taking turns

- Mindfulness
  - Cognitive distraction prevalent among women with sexual dysfunction\(^1\)
  - Increase in metacognitive awareness (thoughts experienced as merely mental events)\(^2\)

1 Nobre and Pinto-Gouveia 2006
2 Teasdale et al 2012
Mindfulness

- Ancient Eastern practice with roots in Buddhist meditation
- Focuses on present moment, non-judgemental awareness
- Introduced by Kabat-Zinn to patients suffering from chronic pain in 1970s
- Evolved into 8 week MBSR/MBCT programmes
- Main stream: health, education, business, military
- Health benefits: depression, anxiety, stress, chronic pain, ADHD, substance use, chronic pelvic pain, sexual health
Management

Sexual Health

• Restoring mind-body connection, benefiting mood
• Attention to and acceptance of the present moment
• Allows for recognition and attention to sexual stimuli, less tendency to self-criticize, to follow distracting thoughts, evaluate one’s sexual responsiveness.
• Freedom from anxiety, guilt and shame which may inhibit arousal
• Improved concordance between genital and subjective arousal¹
• Awareness of genital responses improves sexual desire, arousal, orgasm, Improvements seen in sexual complaints due to gynaecological cancer, sexual desire/arousal disorder², provoked vestibulodynia³

¹ Brotto LA et al 2016
² Brotto LA et al Gynecol Oncol 2012; 125:320-5
³ Brotto, LA, Basson, R et al. 2015
Case Study