

Exploring Female Sexual Function ♀

Serena Cauchi

APN Case Presentation Series - 2016



Courtesy of Emily Nagoski

Outline

Talking about sex is often still 'taboo' and many clients find it difficult to raise their concerns with their GP or other health practitioner(s).

This presentation explores sexual functioning and common sexual concerns, including:

- desire discrepancy
- arousal problems
- dyspareunia
- vaginismus

Beliefs and expectations about sex

We are bombarded by social media advising us about sex and relationships:

- “How to tell if your partner is satisfied”
- “Multiple orgasms made easy”
- “How to perform fellatio without gagging”
- “Expert style foreplay”



But a lot of this is neither informative or helpful for women and instead, creates performance anxiety and low sexual self-esteem.

The media construct

“A hot and horny sex-starved nympho..”

Women are ‘brain-washed’ by these messages.

Some women may mis-diagnose ‘dysfunction’ rather than ***dissatisfaction*** or ***disappointment*** when failing to meet their or their partner’s unrealistic expectations.

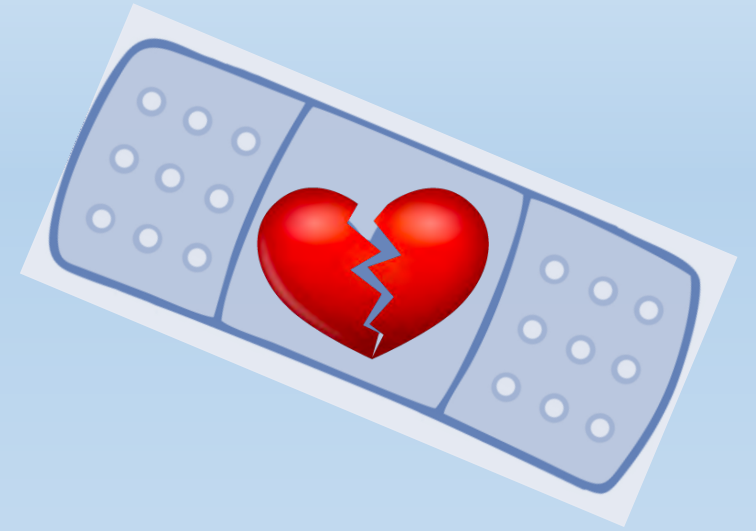


Female sexual dysfunction

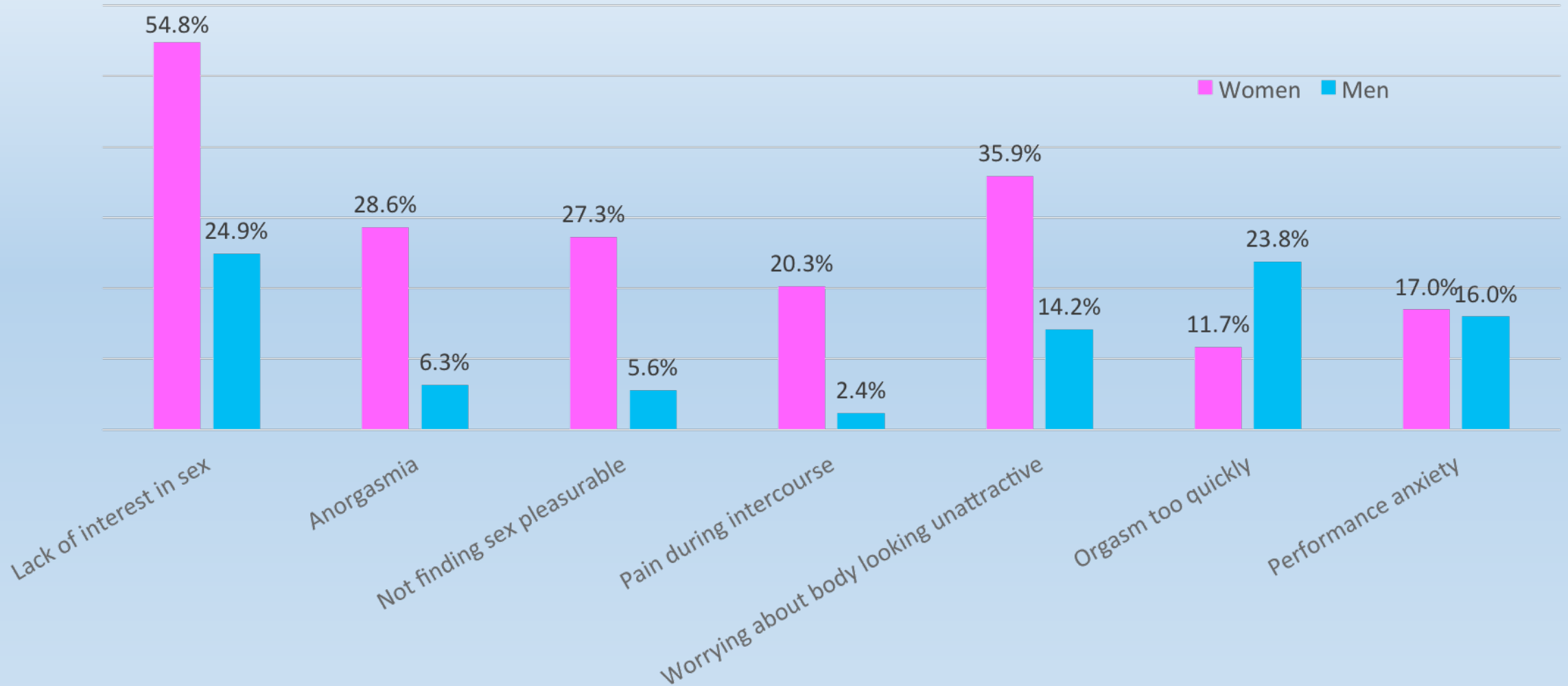
In a study of sexually active 18 to 59 year olds, sexual dysfunction was reported by

- 43% of women
- 31% of men

Only a minority seek help – under-treated.

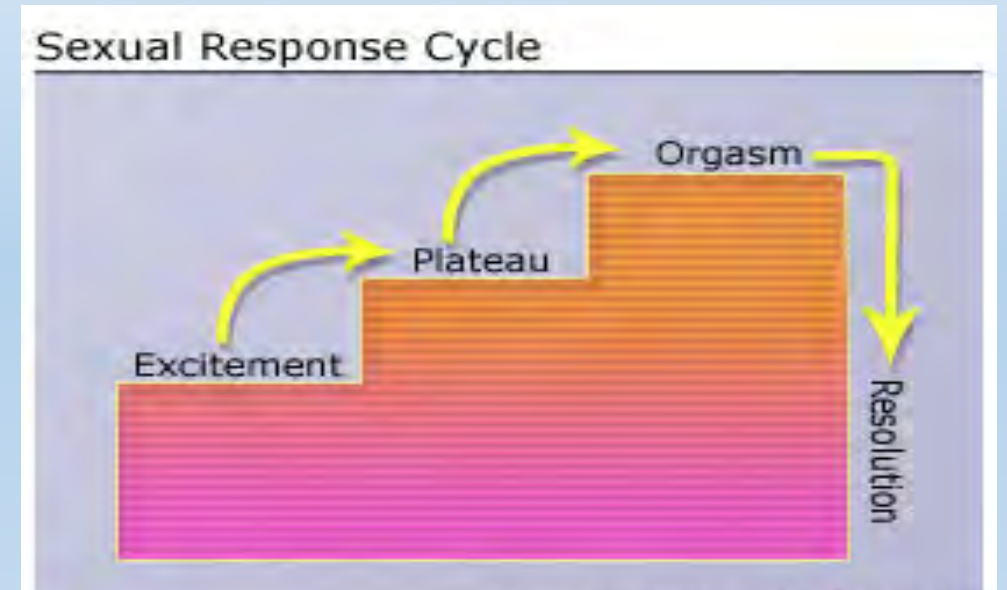


Sex in Australia

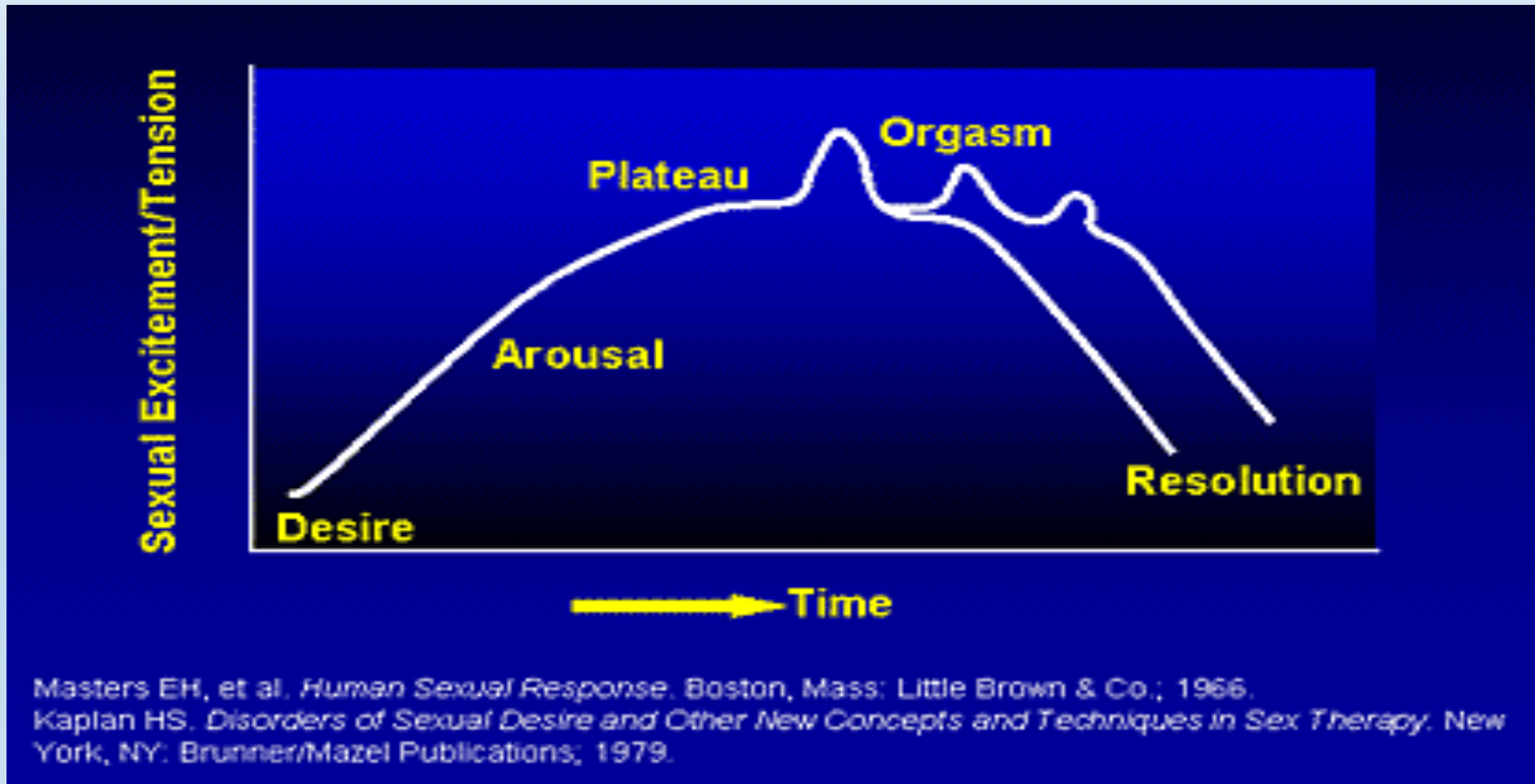


Chequered history of desire disorders

- In 1970s Masters and Johnson did not recognise desire disorders
 - Premature ejaculation
 - Impotence
 - Frigidity
 - Anorgasmia
 - Vaginismus
- Desire disorders only proposed as a specific disorder in 1977 (Singer Kaplan and Lief)



Traditional linear female sexual response cycle 1979



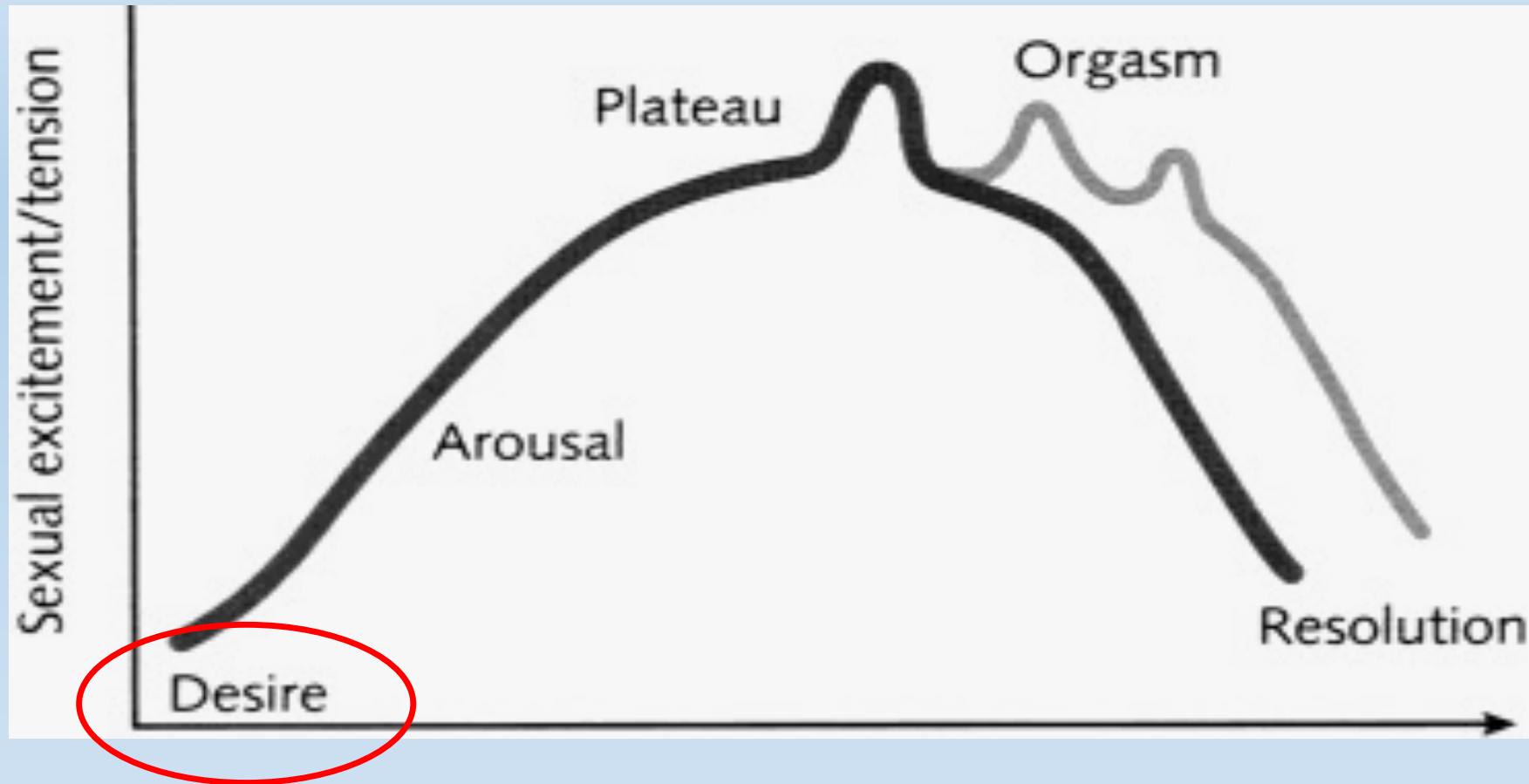
Sexual response cycle

- Sexual response cycle consists of 5 phases:
 - Sexual desire phase: can last for days
 - Arousal phase: 1-2 minutes to hours
 - Plateau phase: 30 seconds to 3 minutes
 - Orgasm phase: 3-15 seconds
 - Relaxation phase: 10-15 minutes
- Therein there are two basic physiologic processes:
 - Vasocongestion
 - Neuromuscular tension - myotonia
- Vasocongestion takes place in lower and upper genital organs and breasts, while myotonia takes place in the whole body

The DSM grapples with low desire

- First official recognition of desire disorder: DSM-III 1980 labeled the low sexual desire in women **'Inhibited Sexual Desire' (ISD)**
- DSM-III-R 1987 introduced the term **'Hypoactive Sexual Desire Disorder' (HSDD)**
- Further minor refinements in DSM-III-R, DSM-IV and the DSM-IV-TR

The traditional model of sexual response has created a widely held social construct: **spontaneous (initial) desire** is the norm for both genders – if you don't experience 'lust' you are dysfunctional



New insights into female sexual function

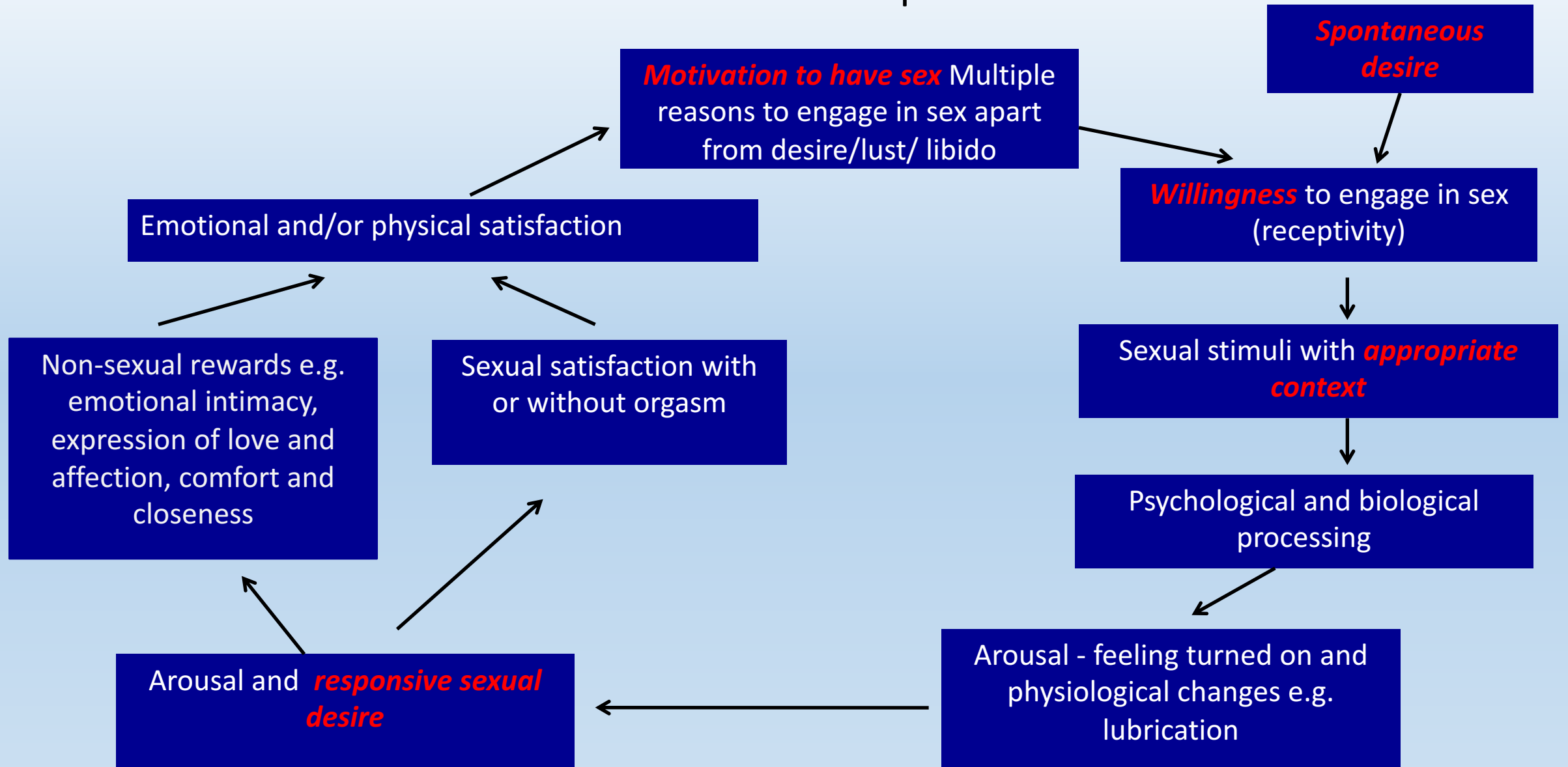
- Male spontaneous sexual desire in long term relationships
- spontaneous initial desire in women
- After the 'honeymoon' stage
- 'responsive desire'
- Context is crucial

The need for a new version of the female sexual response cycle



Time to update

Circular model of female sexual response



What is an erotic context? **Not this!**



DSM-V 2013

- The DSM-V aimed to incorporate these new theories about female sexual response by moving away from the linear model and making some subtle changes to their diagnostic criteria
- Merged 2 separate diagnoses
 - Female Hypoactive Sexual Desire Disorder (HSDD)
 - Female Sexual Arousal Disorder (FSAD)
- Now Female Sexual Interest/Arousal Disorder (FSIAD)

DSM-V

The DSM-V combines hypoactive sexual desire disorder and female sexual arousal disorder in a single disorder: “female sexual interest/arousal disorder”.

- Sexual desire is the motivation to have sex
- Sexual arousal refers to the physiological process of arousal, which includes: vaginal lubrication; genital warmth (related to blood flow)

Women commonly report experiencing these as part of the same process.

How is FSIAD diagnosed?

- Absence or significantly reduced sexual interest/arousal for at least 6 months (with at least 3 of the following symptoms):
 - Absent/reduced interest in sexual activity
 - Absent/reduced sexual/erotic thoughts or fantasies
 - No/reduced initiation of sexual activity; unresponsive to partner's attempt to initiate sexual activity

Diagnosis of FSIAD (cont)

- The problem causes clinically significant distress (bother)
- The sexual dysfunction is not better explained by:
 - Non-sexual mental disorder
 - Severe relationship distress (e.g., partner violence) or other stressors
 - Effects of a substance/medication or another medical condition

Symptoms of FSIAD (cont)

- Absent/reduced sexual interest/arousal in response to any internal or external cues (e.g., written, verbal, visual)
- Absent/reduced sexual excitement/pleasure during sexual activity in at least 75% of encounters (lack of subjective arousal)
- Absent/reduced genital or non-genital sensations during sexual activity in at least 75% of sexual encounters (lack of objective arousal)

To sum up

- This new condition of FSIAD is the inability to experience initial spontaneous or responsive desire and sexual arousal **in an appropriate erotic context**
- The key message is, that it is absolutely normal to only experience one type of desire or the other
- If you don't crave sex but you can get aroused and sex is pleasurable once you get going you do not have a sexual dysfunction

The questions to ask

- You say you do not desire sex but...
 - Do you find that once you get into sex you can get aroused and find it pleasurable most of the time?
 - How often do you have an orgasm during partner sexual activity? (only 29% of women have an orgasm every time they have sex with a partner)

Assessment

Biological Factors

Medications, hormonal status, neurobiology, physical health, aging

Psychological Factors

Depression, anxiety, self-image, substance abuse, history of sexual abuse or trauma

Socio-cultural Factors

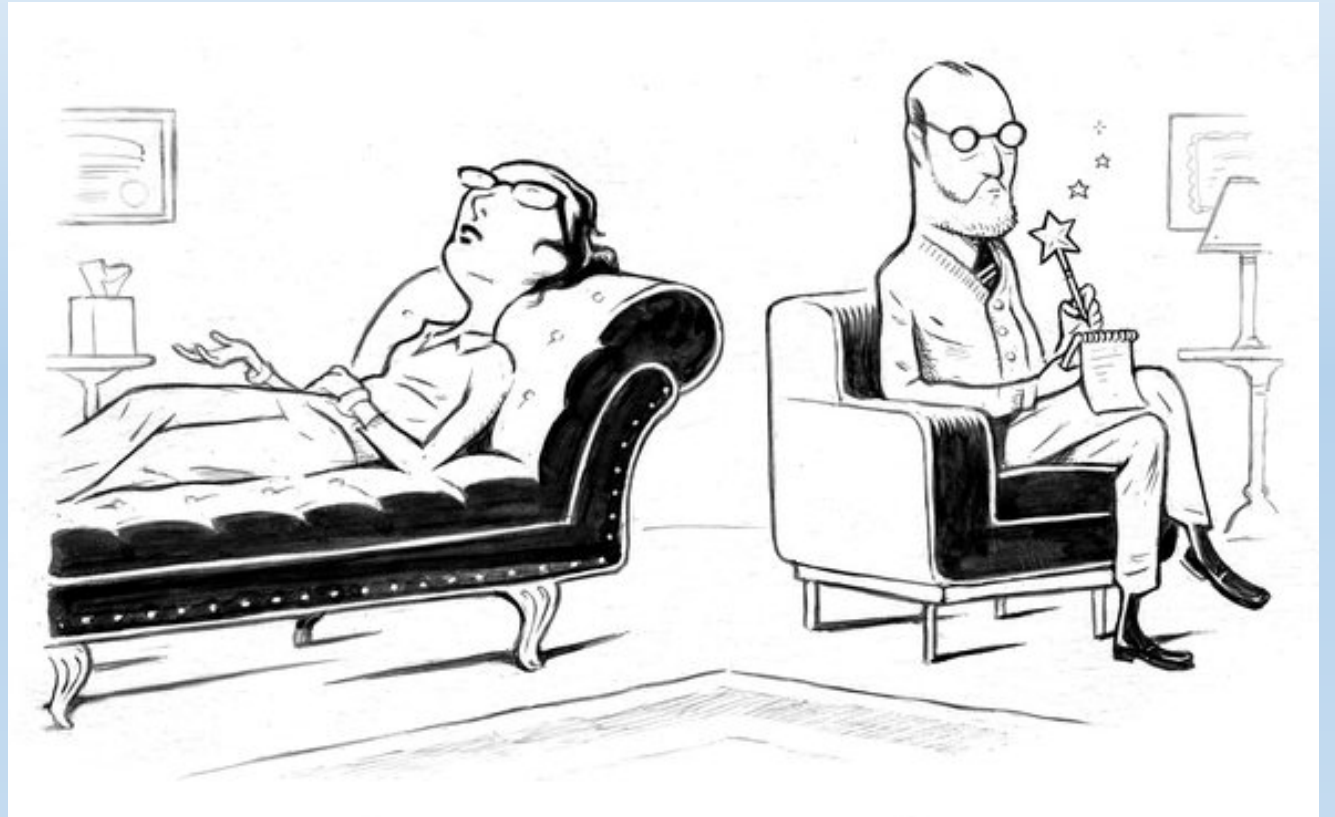
Upbringing, cultural norms and expectations, religious influences

Interpersonal Factors

Relationship status / quality, partner's sexual function, life stressors

Taking a sexual history

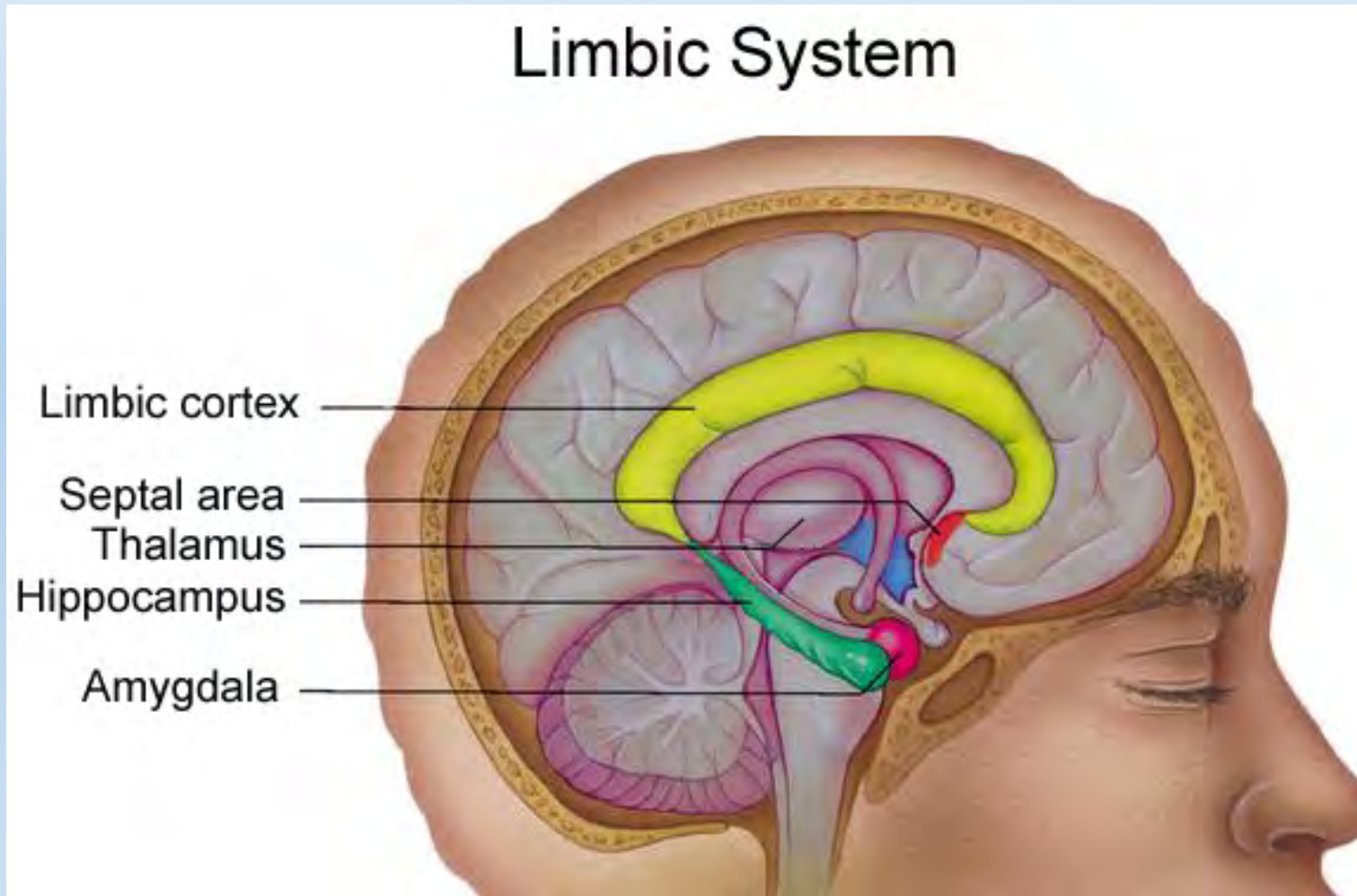
- Make no assumptions
- Orientation
- Experience of intercourse
- Other sexual activities



Taking a 'Desire' History

- Lifelong or acquired - ask about current and past sexual frequency – what about previous relationships?
- Ask when they last had sexual activity if at all
- Ask about both partners' preferred sexual frequency
- Total or situational – does she masturbate?

Desire discrepancy



- Desire originates in the limbic system of the brain
- Sexual desire = motivation to have sex

Desire discrepancy

- Physical
- Emotional
- Relationship
- Sexual



Typical female sexual enhancers

- Romantic gestures
- Communication
- Intimacy
- Affection - non demand
- Quality time with partner
- Low level of conflict



Female enhancers are highly prevalent during early courtship or 'limerence' period.

HOW TO IMPRESS A WOMAN: Love
and cherish her and be her best friend.

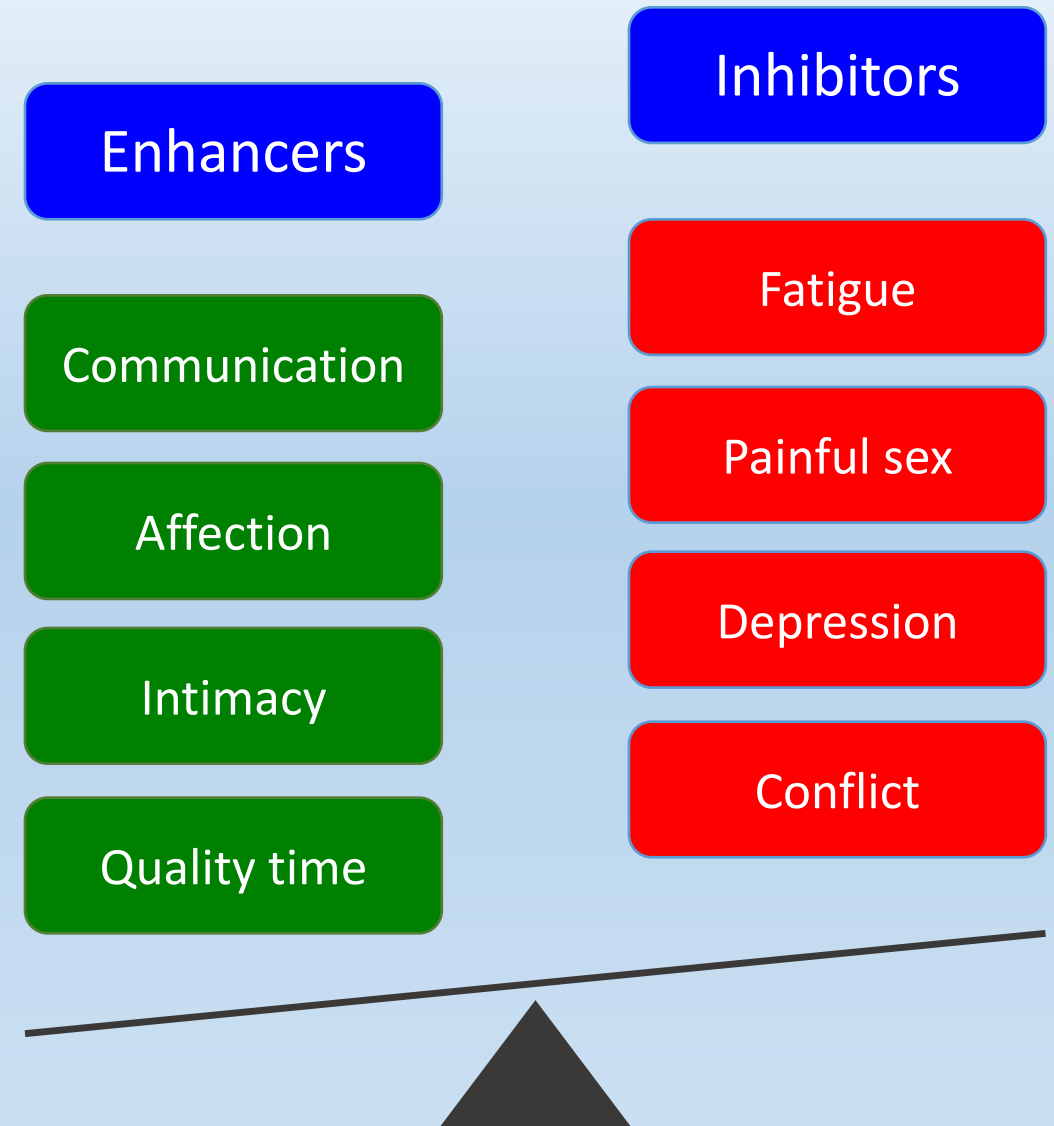
HOW TO
IMPRESS A MAN:
Show up naked.
Bring beer.



som^{ee}cards
user card

Desire discrepancy

- Libidos usually match during limerence
- After 6 – 18 months, female desire may diminish
- Causes conflict and unhappiness in the relationship
- Desire drops even further



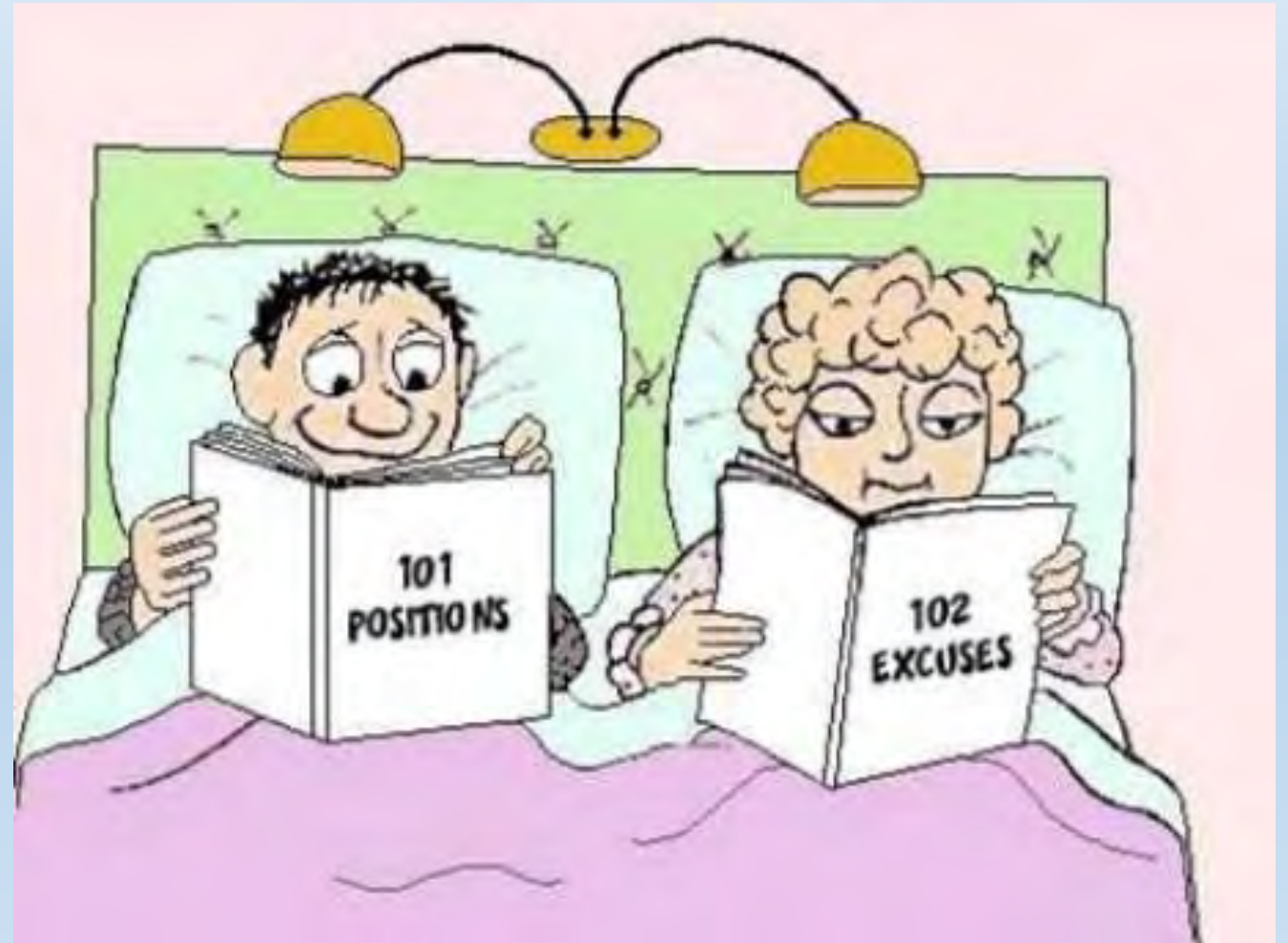
Desire discrepancy

- Male desire is stronger than female desire
- Less distractable due to 10-20 times more testosterone



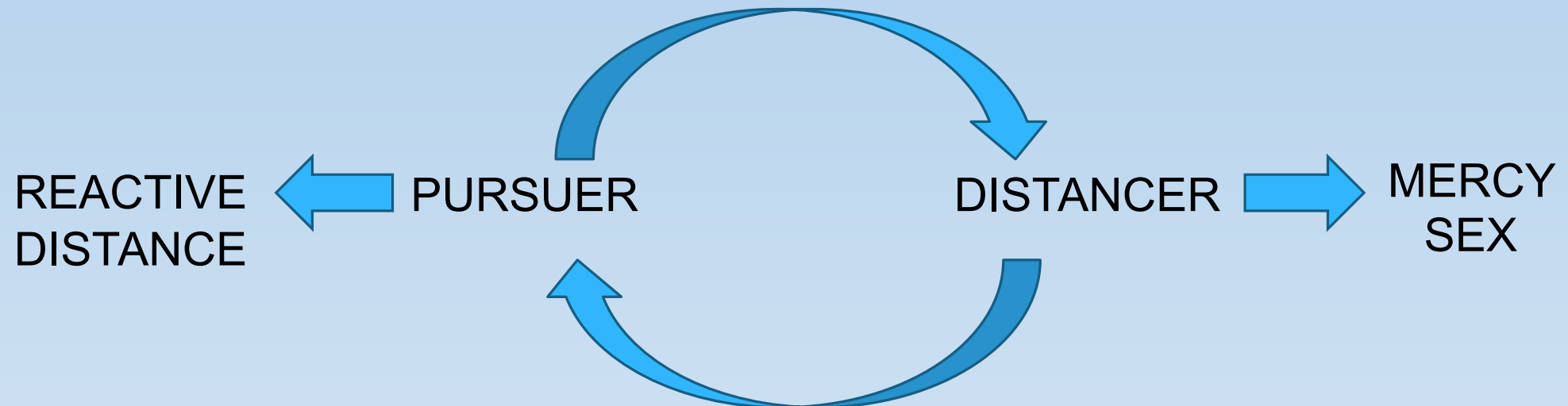
Desire discrepancy

*is
inevitable*



Desire discrepancy

- Creates a vicious cycle
- Higher drive partner = pursuer
- Lower drive partner = distancer
- Result – evermore decreasing desire in distancer



Getting your love life right in the groove, from
the bestselling author of *Where Did My Libido Go?*

GOOD LOVING, GREAT SEX



Dr ROSIE KING

Australia's leading sex expert

Getting your sex life back on track from
the best-selling author of *Good Loving, Great Sex*

WHERE DID MY LIBIDO GO?



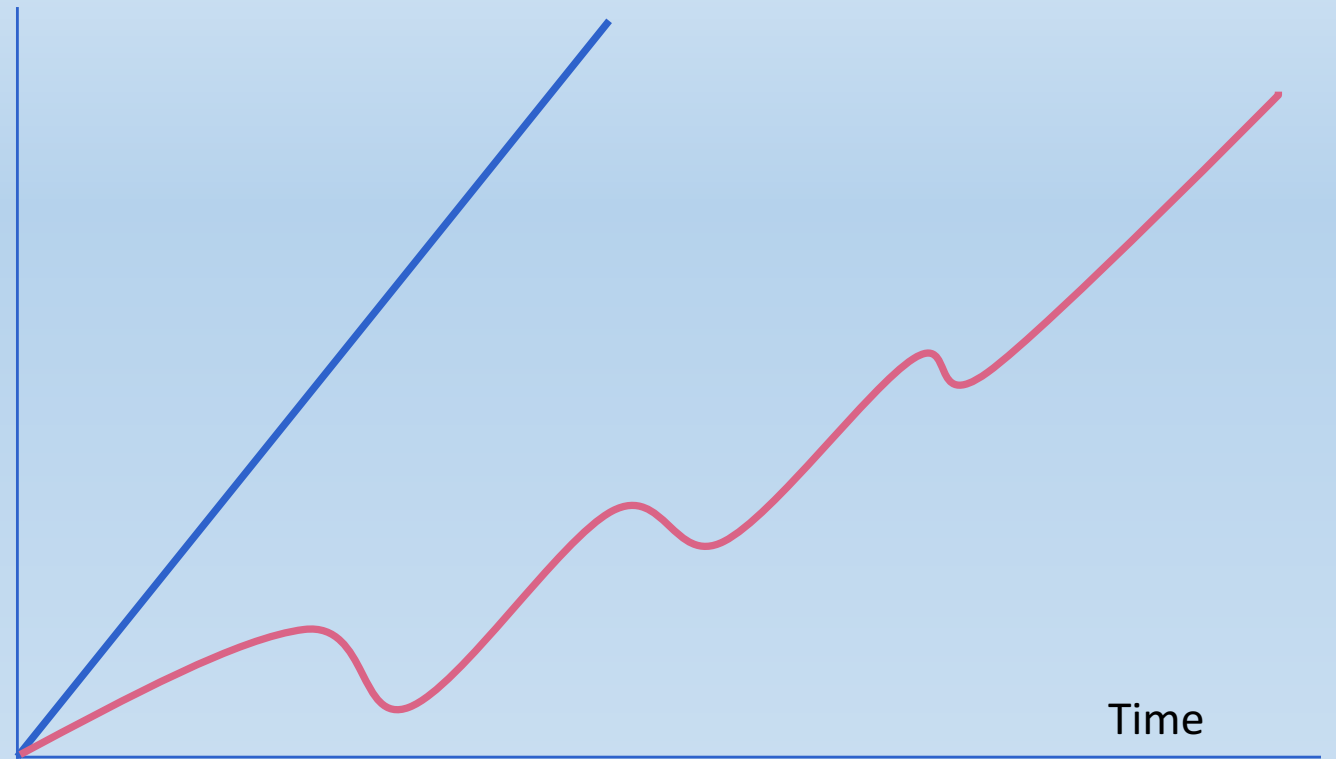
Dr ROSIE KING

Arousal problems

- Lack of arousal and pleasure
- Difficulty reaching orgasm
 - Primary or secondary
 - Total or situational
- Uncomfortable intercourse

Male v Female Arousal

Sexual arousal -
excitement

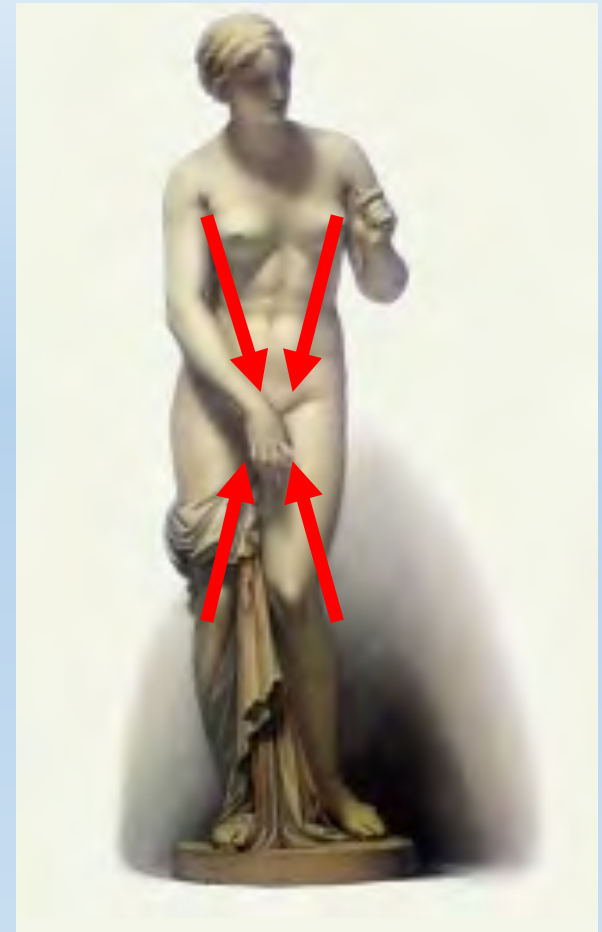


Factors affecting arousal

- Inadequate foreplay
- Relationship conflict
- Anticipating pain
- Previous trauma
- Pregnancy or STI concerns
- Not attracted to your partner
- Religious beliefs / guilt
- Domestic violence
- Trust
- Performance anxiety
- Anti-depressant medication
- Limited privacy

Maximising female arousal

- Adequate conditions for sex
- Women may need up to 15 to 20 minutes of foreplay to get adequately aroused for comfortable intercourse
- If tense or tired may take longer
- Arousal can slow with age



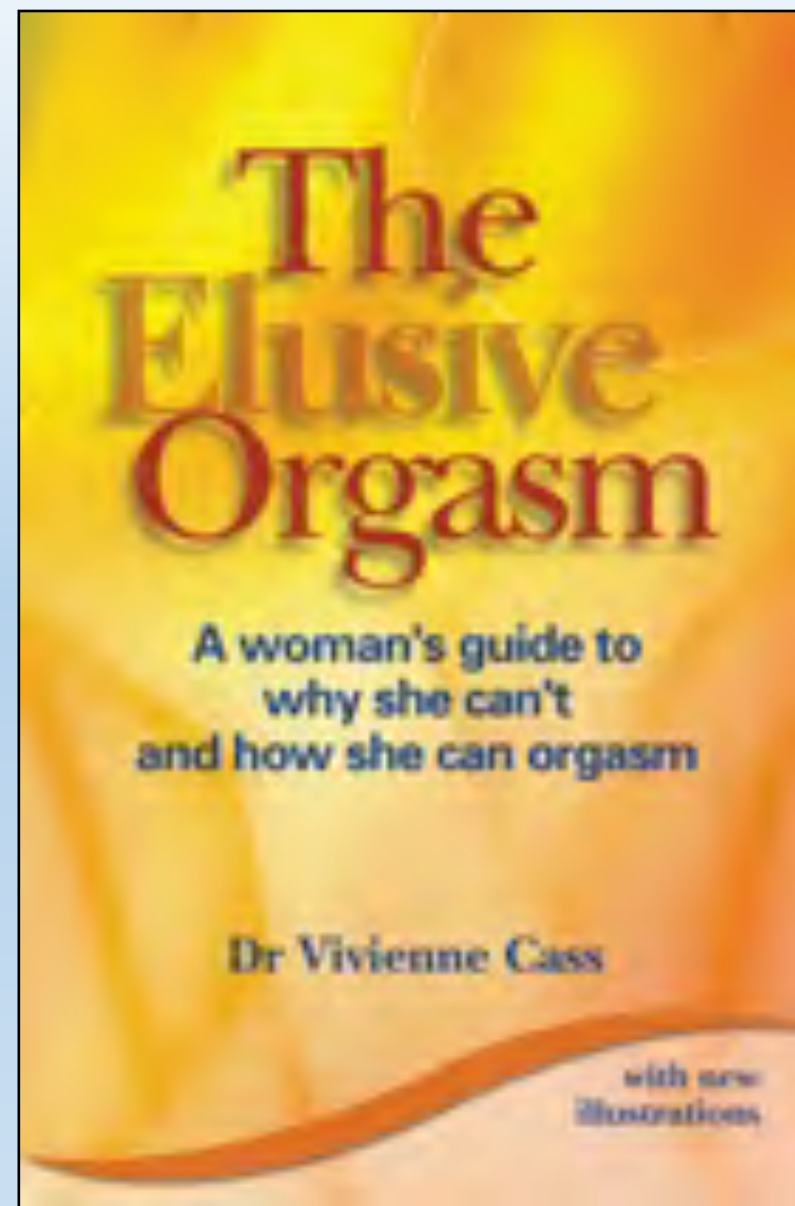
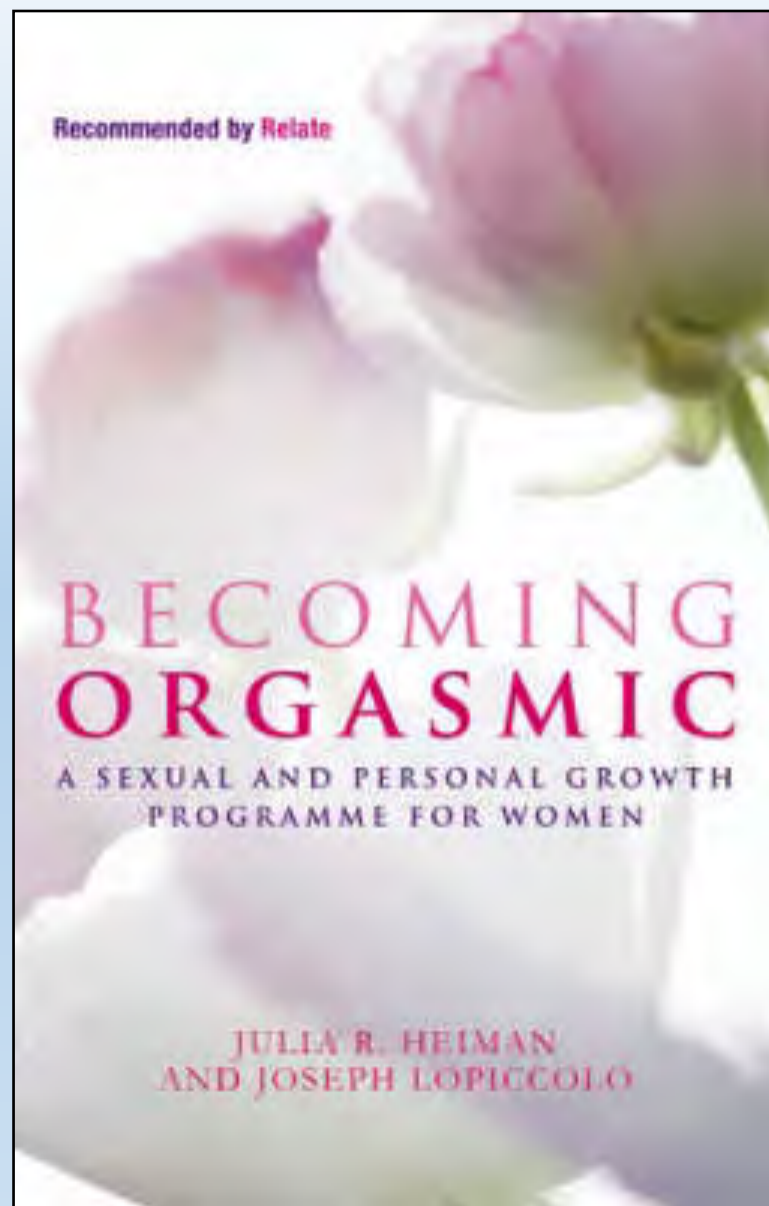
DSM-V

DSM-V criteria Female orgasmic disorder include

- Marked delay in, marked infrequency of, absence of orgasm
- Markedly reduced intensity of orgasmic sensations.
- Lasting at least 6 months in 75% - 100%
- Distress reported
- Life long anorgasmia or acquired
- Generalised or Situational
- Not better explained by other mental disorders or relationships difficulties.

Female orgasm

- 30% of women orgasmic through intercourse alone
- 40% require clitoral stimulation
- 30% rarely or never orgasm with a partner
- Peaking of sexual pleasure followed by release of tension
- 5 to 15 contractions of pelvic muscles (vagina, urethra, uterus, pelvic floor)
- Followed by decongestion and release of oxytocin and endorphins



DSM-V

Genito-Pelvic Pain/Penetration Disorder

Vaginismus & Dyspareunia

- Defined as fear or anxiety
- Marked tightening or tensing of abdominal & pelvic floor muscles, or actual pain with vaginal penetration
- Persistent or recurrent for at least 6 months
- Life long or acquired following no dysfunction

Dyspareunia

- Psychogenic or mixed
- Primary or secondary
- Superficial or deep
- Total or situational
- Acute or chronic



Impact of painful intercourse on sexual function

Woman

- Loss of desire for intercourse/ any sexual activity
- Difficulty becoming aroused and feeling pleasure
- Difficulty reaching orgasm

Male partner

- Can lead to sexual dysfunction in male partner e.g. ED or PE especially if woman insists on attempts at penetration despite pain

Assessment of dyspareunia

- In every woman you need to exclude organic causes
- Superficial – entry pain
 - Vulval inflammation, skin disorder or vaginal infection
 - Atrophic vaginitis
 - Episiotomy
 - Inflexible hymen

Deep dyspareunia

- Pain may be more pronounced in certain positions
 - endometriosis
 - pelvic inflammatory disease
 - uterine prolapse
 - retroverted uterus
 - uterine fibroids and ovarian cysts
 - cystitis, painful bladder syndrome
 - irritable bowel syndrome
 - haemorrhoids

Management of dyspareunia

- Treat underlying disorder
- Maximise arousal
- Use lubricant
- Avoid positions that cause pain
- Woman controls the 3 Ps
 - Position
 - Pace
 - Penetration
- Focus off intercourse onto 'outercourse'

Vaginismus

- Misnomer: spasm of pelvic floor muscles causes pain and prevents or impedes penetration by
 - Finger
 - Tampon
 - Speculum
 - Penis
- 'Reactive pelvic floor spasm' due to chronically shortened and contracted pelvic floor muscles
- Primary or secondary
- Total or situational

Physical contributors

- Dyspareunia from any cause
- Chronic candidiasis
- Endometriosis
- Urinary tract infections
- Childbirth pain
- Pelvic trauma or surgery
- Rape, sexual/physical abuse or assault

Psychological contributors

- Poor sex education
- Sex negative conditioning and attitudes - guilt
- Pressure to be a virgin at marriage
- Unrealistic vaginal fantasies
- Difficulty using tampons
- Fear of pregnancy and childbirth
- Untoward sexual experiences: sexual abuse or assault
- No obvious cause
- Negative accounts of others' experiences

Management of vaginismus

- Referral to Dr to exclude physiological causes
- Referral to Pelvic Floor Physiotherapist
- Graduated dilator exercises
- Sensate focus exercises prior to attempts at intercourse to improve communication about sexual likes and dislikes
- Adequate foreplay – reading or viewing erotic material may help
- Use lubricant
- Woman-on-top position controlling the 3 Ps
- Gradual penetration initially without movement

Vaginal dilators or trainers



Further

Serena Cauchi

Edgecliff Business Centre
203-233 New South Head Road
Edgecliff NSW 2027

E: serena@serenacauchi.com.au

M: 0418 663 603



Resources

Sex Therapist & Sexual Health Physician:

Dr Rosie King, 301A/282 Victoria Avenue, Chatswood 2067 | P: 0410 698 000

Male Sexual Health Physician:

Dr Michael Lowy, The Male Clinic, Suite 2, Level 6, 75 Crown Street, Woolloomooloo 2011

E: info@themaleclinic.com.au | P: 1300 002 111 | W: themaleclinic.com.au

Women's Health and Research Institute of Australia (WHRIA)

Level 12, 97-99 Bathurst Street, Sydney 2000 | E: info@whria.com.au | P: 1300 722 206

Gynaecologist & Pain Medicine Specialist: Dr Thierry Vancaillie, Dr Jason Chow

Gynaecologist & Menopause Specialist: A/Prof John Eden

Pelvic Floor Physiotherapists: Sherin Jarvis