Women's Sexual Problems

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Overview of women's sexual problems

- Sexual aversion disorder
- Hypoactive desire disorder
- Dyspareunia – vaginismus
- Arousal disorder
- Orgasmic disorder

Factors involved in sexual problems

- Physical: aging & menopause, pregnancy & lactation, infection, allergy, medical conditions e.g. diabetes, cancer, arthritis, incontinence, alcohol & drugs.

- Psychological: expectations, knowledge, attitudes, meanings, depression, anxiety, mental illness, previous abuse or neglect.

Love

“ Love is the triumph of imagination over intelligence”

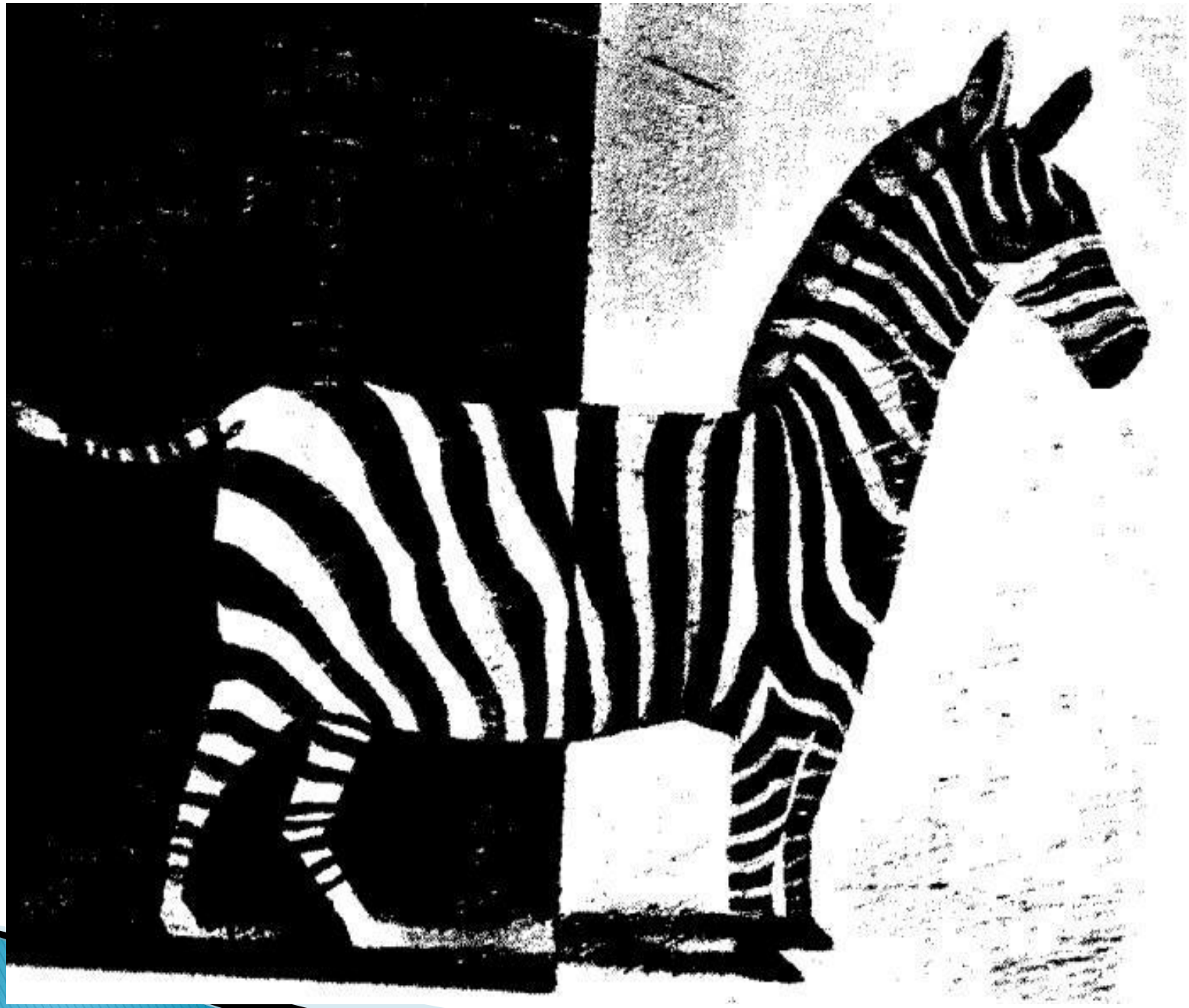
Henry Louis Mencken1880-1956

Sex is not simple

- Sexual problems are often complex.
- Late presentation is common
- Assessment requires medical, sexual, relationship, psychological & family emotional history, from both partners, as well as physical examination & pathology tests (if indicated)
- Sex is important – few people for whom it has not been important at some time.

Gender differences

- Male focus on physicality, penetration, orgasm
- Male focus on logicality, solution focused
- Female focus on emotionality
- Female focus on discussion
- Individual sexual meanings



- A great marriage is not when the “perfect couple” comes together. It is when an imperfect couple learns to enjoy their differences.

  Anne Morrow Lindbergh


Recycling!
Husbands
Lovers
Boyfriends

When to see women with sexual problems/ when to refer

- Time, knowledge and skills
- Time and interest – plenty of both
- Knowledge– human sexuality, effect of medical problems and their treatment, relationships therapy. Normality
- Skills– single and/or couple therapy
- Accepting attitude, ability to be confronted & survive

When not to see

- OK to say “ I don’t know” and refer on when you have no interest in that problem
- When you feel uncomfortable
- When you have no time
- When you do not like to see couples
- When you do not like people returning a number of times

Sexual aversion disorder – sexual anorexia

- Very hard to treat, Modest goals
- May have history of abuse
- May enter therapy to please partner
- Support is most essential requirement
- Progress at their own speed (usually very slowly)
- Desensitisation program – relaxation, self exploration, positive thinking, encourage partner to support.

Hypo-active desire disorder – low libido

- Women have 20X less testosterone than men
- Testosterone levels halve from 20-40yrs
- Testosterone levels fall with age
- 30% women have lost libido by menopause
- Women protective/ men adventurous in sex
- Pressure by partner &/or self leads to avoidance of sex

The Seven Dwarves of Menopause

Itchy, Bitchy, Sweaty, Sleepy, Bloated, Forgetful & Psycho

Disparate desire

- Man or woman may have higher desire
- Management of difference in relationship, no-one is right
- Analyse relationship system
- Encourage time together, fun, communication, decrease stress
- Medical check of one with low libido (exam & pathology tests)

Causes of low libido in women

- Pregnancy, birth, lactation, menopause
- Pain- endometriosis, birth trauma, vaginismus, lichen sclerosis, arthritis
- Previous/present abuse
- Lack of time with partner, relaxation, arousal. Sex as a duty
- Undercurrents
- Anxiety, depression, body image issues

Assessment of low libido

- Medical history and examination
- Relationship history and dynamics
- May never have had a libido
- Depression/ anxiety
- Emotional history ? Previous abuse, Family attitudes
- Examination, pathology tests
- OC – E2 & T levels are low SHBG high

Treatment low libido in women

- Understanding the problem (you and them)
- See both partners. Support & reassure
- Education: normality, fantasy model, gender differences
- Treat medical & genital conditions,
- HT for menopause: vaginal, oestrogen, combined, Tibolone. Weigh up benefits and risks
- Time together, fun, communication, problem solving.

Treatment low libido in women

- Dealing with abuse issues
- Relationship therapy
- " Where did my libido go" Rosie King,
- " Perfectly normal" Sandra Pertot
- Realistic goals
- Sensate focus


THE TIME
B. Cook

Testosterone therapy in women

- No consensus definition of androgen deficiency in women
- Testosterone assays issues
- Symptoms: tiredness, low libido, feel unwell, unmotivated, depression, loss vaginal sensation
- Treat only peri or menopausal women
- Essential after oophorectomy in young women
- Use oestrogen (& progestogen if uterus present) first, Then add testosterone

Testosterone therapy in women

- Check testosterone levels before, during and after 6 months
- Male gels and patches unsuitable for women.
- Testosterone always used with oestrogen
- Testosterone Implant 100 mg (S/C)- 6 monthly, stable blood levels, few side effects
- Androfeme cream 1 cm 0.5% testosterone applied daily to abdomen, buttocks or thighs.
- Lawler Pharmaceuticals Western Australia

Side effects of Testosterone

- Acne
- Hirsutism
- Voice change
- Enlarged clitoris
- Fluid retention
- Aggression
- Increase in LDL
- Hepatitis, polycythaemia
- ? Effect on breast cancer

Dyspareunia

- Common 1 in 20 women had pain for 1 month last year (Sex in Australia Study 2003)
- Suffer in silence & lose libido, arousal & orgasm
- Check for physical cause: menopausal atrophy, candidiasis, endometriosis etc.

Definition of dyspareunia

- DSM IV 1.) vaginismus and 2.) dyspareunia
- Vaginismus has been defined by Basson (2003)
- “The persistent or recurrent difficulties of the woman to allow vaginal entry of a penis, a finger or any object despite the woman’s expressed desire to do so. There is often phobic avoidance, involuntary muscle contraction and anticipation/ fear/ experience of pain. Structural or other physical difficulties must be ruled out/ addressed.”

Definition of dyspareunia (Basson 2003)

- “Persistent or recurrent pain with attempted or complete vaginal entry and/or penile vaginal intercourse.”

Classification of vulvar pain ISSVD (2003)

- Type A – pain related to a specific disorder (eg. Infectious, inflammatory, neoplastic, neurological)
- Type B – generalised or localised vulval pain either of which may be provoked (sexual, nonsexual or both), unprovoked, or a mixture of both.

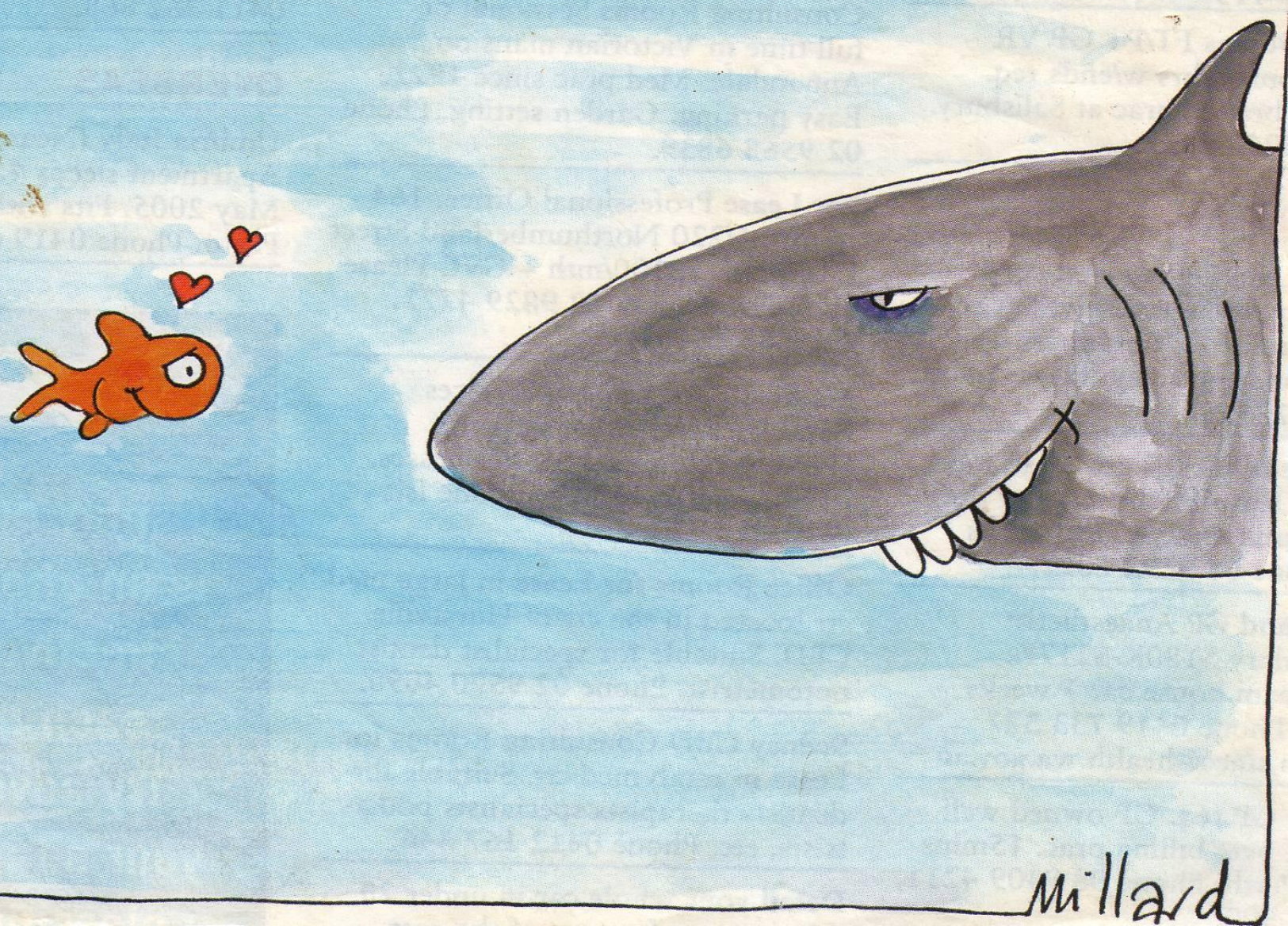
Localised pain – complex regional pain syndrome

- Vulvodynia burning pain, provoked or unprovoked, visual exam & swabs negative.
- ISSVD 2003 definition of vulvodynia
- “vulvar discomfort most often described as burning pain occurring in the absence of relevant visible findings or a specific clinically identifiable neurological disorder”

Complex regional pain syndrome (contd)

- Vestibulodynia (vulvar vestibulititis)
- Clitorodynia may be priapism with pain
  cancer, SSRI related
- Pain syndromes overlap with somatoform disorders, where stress and anxiety manifest as various physical symptoms, including pain. Not able to be diagnosed. May have bizarre features

Unsafe Sex



Millard

Presentation of vaginismus

- Affects 1-6% women any age
- Pain on penetration (primary or secondary)
- Unconsummated marriage / apareunia
- Infertility
- Lack of libido
- Sexual avoidance
- 2 people affected
- Time to seek treatment important

Partners reaction

- Male or female partner
- Withdrawal, be supportive or may be pushy
- May initiate the consultation
- Important to engage the partner
- Their role is a difficult one
- Provide support but not policeperson

Predisposing, precipitating and maintaining factors

- Predisposing:
- Previous pain eg: candida, painful Pap smear, trauma, surgery, sexual abuse
- Ignorance about sexuality/ partner too
- Anxiety disorder
- Precipitating: intercourse
- Maintaining: fear of pain

Psychological aspects

- Women with vaginismus have increased comorbid anxiety disorder
- No increased risk of depression
- Role of childhood sexual abuse unknown
- PTSD unknown incidence
- Emotionally charged issue

Education

- Anatomy of vulva, vagina, and pelvic floor
- Physiology of arousal
- Embryology of vagina & vaginal sensation
- Involve partner
- Bibliotherapy
- www.vaginismus.com

Self exploration and relaxation

- Step by step program
- Takes a few months
- Need ½ hour daily for exercises
- Learning to relax the pelvic floor
- General body relaxation at start of each session
- Putting one finger inside (short nails)

Self exploration and relaxation contd

- Kegals exercises
- Strain pushing downwards
- 2 fingers with Kegals
- Amielle Trainers 1-4 with Kegals
- Xylocaine gel 2%
- Partners fingers
- ? Sensate focus program with partner

Medications & other treatments

- IM Botulium toxin in levator ani
- Antidepressants
- Couple therapy
- Therapies to address self esteem, body image, anxiety and fear.

Arousal disorder

- Lack of focus
- Hurried sex
- Partner with premature ejaculation
- Lack of sensation
- Never learned arousal
- Lack of interest
- Fear and anxiety

Lack of orgasm

- Universal or situational
- Organic/ psychological/ relational
- Self/ partner driven
- Learning to orgasm; physical & psychic stimulation, or focus
- Attitude, understanding, relaxation
- “Becoming orgasmic: a sexual growth program for women” Lopiccolo & Heiman


"THE MOST wasted
OF ALL days IS THAT DURING
WHICH ONE HAS NOT laughed."
- NICOLAS DE CHAMFORT

Factors involved in sexual problems contd

- Relationship: developmental stage (visionary, adversarial, dormant, vital)

Communication: 1:5 negative to positive interactions

Negative aspects: contempt, stonewalling, criticism, defensiveness,

Control & abuse

Roles, resentments, closeness/ distance, management of difference

Infidelity: secret sex workers, affairs, Internet