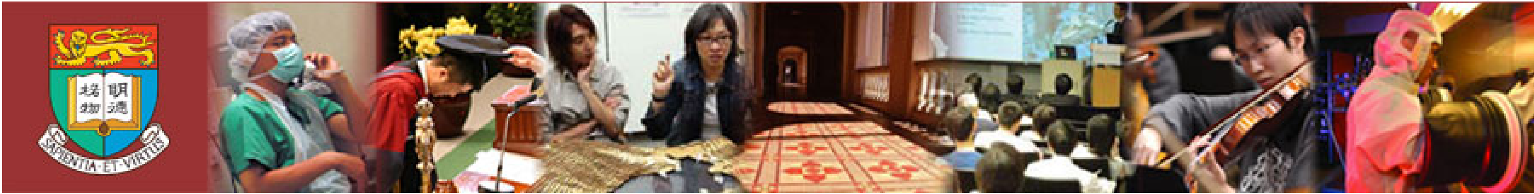
CORE
Metadata, citation and similar papers at core.ac.uk
Provided by HKU Scholars Hub



Title	Female sexual dysfunction
Author(s)	Ng, ML
Citation	Journal of Paediatrics, Obstetrics and Gynaecology (Hong Kong Edition), 2001, v. 27 n. 3, p. 45-48
Issued Date	2001
URL	http://hdl.handle.net/10722/53469
Rights	Creative Commons: Attribution 3.0 Hong Kong License

Female Sexual Dysfunction

Man-Lun Ng, MD(HK), FRCPsych(UK), FRANZCP, FHKAM(Psychiatry), Dip.Am.Board (Sexology), FAACS, DPM

Sexual dysfunction occurs when an individual is unable to participate in a sexual relationship as he or she would wish.[1] The diagnosis should always take into account both partners' feelings. This is particularly important for females since their sexual desire and psychophysiological responses are variable and more difficult to quantify than those of men.

TYPES AND INCIDENCE

Female sexual dysfunction includes inhibited sexual desire, sexual aversion, sexual arousal disorder, orgasmic dysfunction and sexual pain disorders. Sexual pain disorders include dyspareunia and vaginismus.

The rate of sexual dysfunction in women in the West has been estimated to range from 19 to 50% in outpatient populations, increasing to 68 to 75% if sexual dissatisfaction or problems not amounting to dysfunction are included in the definition.[2,3] In the East, no reliable data on female sexual dysfunction are available but recent surveys from China in 1987[4] and 1992[5] indicated that up to 40% of married subjects were sexually dissatisfied, wives slightly more so than husbands. In most clinic statistics, the most common female sexual dysfunctions are inhibited sexual desire and sexual aversion, followed by sexual arousal disorder, orgasmic dysfunction, dyspareunia and vaginismus.

PHYSICAL CAUSES

Physical illness can directly or indirectly cause sexual dysfunction. Problems relating to the genitalia are the most direct causes: trauma, tumor or infection of the urogenital tract or surrounding areas, diseases causing urinary frequency or incontinence, and dryness and lack of elasticity of the vagina following menopause.

Diseases of other bodily organs or systems can also have a direct effect. Cardiovascular diseases that impair perfusion of the genital organs may undermine sexual arousal and orgasmic responses. Endocrine diseases, notably hypothyroidism and pituitary diseases, inhibit sexual desire by upsetting hormonal balance, as does chronic renal failure, that is usually associated with an increased blood prolactin level. Neurological illnesses interfere with sexual function by distorting the sensation or motor control required for proper sexual arousal and responses.

Almost all types of physical illness can indirectly cause sexual dysfunction if they lower the patient's mood, create physical discomfort, or impair bodily appearance and self-image. A gynaecological operation or mastectomy can cause sexual dysfunction because it makes her feel as if she is no longer a woman. Autoimmune or skin diseases can shatter sexual confidence and inhibit sexual desire and responses. Chronic illnesses cause sexual dysfunction because of long term pain, life threats and psychosocial turmoil.

Medications constitute another important cause. Most drugs that cause sexual dysfunction in the male can likewise affect females.

Common culprit drugs include oral contraceptives, antihistamines, antidepressants, minor tranquilisers and hypnotics.

PSYCHOSOCIAL CAUSES

Psychosocial factors are another major cause of female sexual dysfunction. The male dominant culture that prevails in modern societies suppresses female sexuality in various ways, for example by teaching anti-sexual morals, or by perpetuating the female passive role in sexual relationships. There is a paucity of information and research on female sexuality. Such a culture also makes females more likely to be the victims of a sexual assault with its concomitant psychological harm, a consequence of which is sexual dysfunction.

Relationship conflicts are another common factor. There may be problems in communicating sexual needs; in relaxing during sexual intercourse or in initiating sexual interest. The conflicts can come from the woman's feelings of insecurity within the relationship, extramarital attractions, fear of pregnancy or other factors that generate hostility between a couple.

Other non-specific stresses can cause depression or anxiety in a woman. Common ones are heavy work, financial or job problems, tension in caring for children, loneliness and lack of recognition or identity within a family.

CLINICAL FEATURES

Inhibited sexual desire is the lack of interest in initiating sexual activity either with a partner or in isolation (masturbation or sexual fantasy). It manifests in the form of decreased sexual activity incompatible with age and context. The woman tends not to seek sexual cues or may actively avoid them.

Sexual aversion is the occurrence of fear or anxiety at the prospect of sexual interaction. If there is sexual activity, the woman will harbour strong negative feelings towards it and be unable to experience pleasure although she may show signs of sexual arousal or even orgasm during intercourse.

In *female sexual arousal disorder*, the main problem is the failure of vaginal lubrication to allow comfortable penile entry. The woman's sexual responses may be insufficient to initiate lubrication or maintain it at a sufficient level. Associated signs in the excitement phase include inadequate tumescence of the labia or erection of the nipples. The normal increase in blood pressure, heart rate and respiratory rate that usually occurs in a sexually excited person is lacking or minimal.

Orgasmic dysfunction refers to the absence or delayed occurrence of orgasmic response during sexual intercourse. The nature and pattern of orgasmic responses vary in women, but the common physiological pathway is a moment of sympathetic and parasympathetic release with involuntary muscle contractions at or around the genitalia or other parts of the body. Women with orgasmic dysfunction show varying degrees of impaired release.

The crucial diagnostic feature, however, is the subjective impairment of the ecstatic pleasure that should come along with the release.

Dyspareunia

Dyspareunia occurs when pain is felt on sexual intercourse. The pain can be anywhere in the body and of any type, but occurs most commonly in the lower abdomen, in the vagina or uterus.

Vaginismus

The symptoms of vaginismus are pain (or the fear of it) and involuntary contraction of the muscles of the outer vagina on anticipation of sexual intercourse. It differs from dyspareunia in two aspects. First, the patient may not actually have any pain, she may just fear having it. Second, the symptom occurs at the anticipation of sexual intercourse, even before any genital contact. In some patients, the involuntary contraction can spread to the adductor muscles of the thigh, causing the legs to be tightly and spastically closed together.

DIAGNOSIS AND INVESTIGATIONS

A history that can elicit accurately the type, onset and development of the sexual symptoms is usually sufficient to lead to a fairly confident diagnosis. To trace the aetiology, the doctor should gear further history taking, physical examination, psychological tests and laboratory investigations towards the identification or exclusion of probable physical or psychological factors. There are physiological tests to measure specific female sexual responses, but they are for research purposes only and are not recommended for routine clinical use.

TREATMENT

If dysfunction is a complication of underlying disease, the primary disease should first be treated. Even after full recovery, some specific sexual rehabilitative measures may be needed before dysfunction improves. For underlying disease for which there is no curative treatment, management of the dysfunction should be targeted at alleviating sexual symptoms or promoting sexual readjustment.

Drug Therapy

Oestrogen replacement is an effective treatment of inhibited sexual desire or dyspareunia associated with menopause or other oestrogen deficient conditions. It can be administered in tablet form or as a vaginal cream. For women with an intact uterus, the concomitant use of progesterone lowers the risk of cervical cancer but may also diminish treatment efficacy. For non-responsive patients, a combination of oestrogen with testosterone is an alternative, especially for oophorectomised women with sexual desire deficits. It is contraindicated in women with previous breast cancer, uncontrolled hyperlipidaemia, liver disease, acne or hirsutism.

Surgery

Surgical exposure of the clitoris may improve sexual arousal if stimulation problems arise from a clitoris covered by prepuce adhesions. Some women choose to undergo vaginoplasty to increase vaginal tone.

Psycho-behavioural Treatment

This is the mainstay of treatment, and often the only treatment required. It is also a common adjunct to medical or surgical treatment. It relates to four major areas.

Educational

The aim is to ensure that the patient and her partner have the necessary and accurate sexual knowledge to remove misunderstanding, uncertainties and fears that may contribute to or cause the sexual problem. Educational content may relate to sexual anatomy, physiology, psychology, sexual health or sexual techniques. For some women, instructions can also be given on how to improve the environment for sex, dispel myths or clarify the individual's sexual morals and beliefs.

Psychological

At the most superficial level, the patient is given the permission, courage and confidence to try out new adaptive behaviours or to remove any negative emotions, attitudes or reactions to sex or the dysfunction. In most cases, the partner will also need this type of support. The next deeper level relates to communication skills. The doctor provides the opportunities, vocabulary, training and skills for communicating sexual needs and responses. This may be given to the patient on an individual basis or in joint sessions with their partner. Psychological work at an even deeper level will be required for only a small number of patients whose dysfunction is caused by past psychological traumas or subconscious problems. There are many types of in-depth psychotherapy; the type depends on the cause of the problem, the patient's personality and the therapist's own training and theoretical orientation.

Behavioural

With the new knowledge, confidence

and insight obtained from educational and psychological treatment, the patient may still need to try out new sexual behaviour by herself or with her partner if the dysfunction is to be overcome. For best results, the trying-out should be in the form of graded behavioural exercises, designed and assigned by the therapist based on the patient's problem, capability and progress.

Generally, the exercises can involve the training in mental sets or imagery, in achieving relaxation, in creating and perceiving erotic stimuli of the patient's genital or non-genital areas of the body (genital or non-genital sensate focus) and in doing all these together with their partner. Some exercises are specific for particular types of dysfunction. For example, Kegal exercises, which aim to strengthen pubococcygeal tone, are useful for orgasmic disorders, while progressive vaginal dilatation is reserved almost exclusively for the treatment of vaginismus. In the clinic, the doctor gives the patient instructions for these exercises, with or without partner, to be practiced at home. In the next session, the patient or the couple reports back on how the exercise has been practiced. If it has been satisfactorily performed with target results achieved, another exercise of slightly greater difficulty is assigned and so on until the dysfunction is overcome. In the course of exercise training, new psychological problems may be identified that affect the patient or the couple, and that may require additional work in educational or psychological aspects.

Attitude Expansion

For many people, the sole aim of a sexual act is to achieve penile-vaginal penetration followed by intravaginal ejaculation. This restrictive aim will make sexual responses and pleasure difficult to achieve where a physical or psychiatric condition prevents coitus. Thus another important part of sex therapy is to help the patient accept and practice non-coital behaviour and to obtain pleasure from it, such as oral sex, mutual masturbation and fetishism. This may require prolonged attitude and behavioural training.

PROGNOSIS

The prognosis of female sexual dysfunction depends on the type and severity of the condition and the underlying cause. The prognosis for organically caused dysfunction depends on that of the organic problem, although sex therapy can usually achieve some improvement. Of the dysfunctions caused by entirely psychologically factors, vaginismus has the highest treatment success, approaching nearly 90%,[6] followed by orgasmic disorder, arousal disorder and others.

CONCLUSION

Most female sexual dysfunction can be diagnosed and treated by the primary care physician provided he/she has an open attitude and is receptive to sexual problems, is able to take a comprehensive sex history and can apply superficial psychological treatment. The treatment experience can be very rewarding for both the patient and the physician as well as strengthening the doctor-patient relationship. Only long-standing or multiple dysfunction with severe psychological components resistant to simple treatment require referral to a sex specialist.

REFERENCES

1. World Health Organization. The ICD-10 classification of mental and behavioral disorders. Clinical Description and Diagnostic Guidelines. Geneva:WHO, 1992.
2. Read S, King M, Watson J. Sexual dysfunction in primary medical care: prevalence, characteristics and detection by the general practitioner. J Public Health Med 1997;19:387-391.
3. Schein M, Zyzanski SJ, Levine S, Medalie JH, Dickman RL, Alemagno SA. The frequency of sexual problems among family practice patients. Fam Pract Res J 1998;7:122-134.
4. Xu AQ. On female sexual rights. Sociological Research 1990;3:103-104.
5. Liu DL, Ng ML, Zhou LP, Heaberle E. Sexual Behavior in Modern China. New York; Continuum, 1997;307.
6. Rosen RC, Leiblum SR. Treatment of sexual disorders in the 1990s: an integrated approach. J Consult Clin Psychol 1995;63:87-90.

About the Author

Dr Ng is Professor of Psychiatry at the Department of Psychiatry, University of Hong Kong, Hong Kong SAR, China.

Competing interests: None declared.