

FEMALE SEXUAL DYSFUNCTION

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Normal Female Sexual Response

Normal women experience a sequence of physiological responses to sexual stimulation. This process occurs in four phases: excitement, plateau, orgasm, and resolution.

Excitement is brought on by psychological stimulation (through either fantasy or the presence of a love object), and physiologic stimulation (caressing, kissing, visual, and/or olfactory (perfume) sensations). In women, vaginal lubrication begins 30 seconds after onset of arousal, clitoral erection increases its diameter twofold, venous engorgement of the labia minora increases it to two to three times normal size — becoming bright pink to burgundy red, and nipple erection (67 percent) characterize the excitement phase. This phase lasts several minutes to several hours.

Plateau occurs with continued psychological and physiologic stimulation. In women, constriction of the lower third of the vagina with elevation of the perineum (this creates up to 50 percent decrease in the diameter of the vaginal opening that functions to increase clitoral stimulation through coital traction on clitoral shaft — also known as the *orgasmic platform*), elevation and retraction of the clitoris behind the pubic bone, an increase in breast size — especially in breasts that have not nursed, increased breathing rate, sexual flushing (pink mottling on abdomen — often spreading to breasts, neck, face, arms, and thighs), and copious vaginal lubrication (increased only by prolonged pre-orgasmic stimulation, at maximum in week prior to menses) characterize the plateau phase. This phase lasts 30 seconds to several minutes.

Orgasm in women is characterized by 3 to 15 contractions of the muscles surrounding the lower third of the vagina, upper 1/3 of labia minora, perineum, anus, and orgasmic platform. These contractions occur at 0.8 second intervals, beginning two to four seconds after the onset of orgasm. The uterus may also contract throughout orgasm, especially with pregnancy and self-stimulation. This phase lasts 3 to 15 seconds. Many women who are orgasmic prefer to progress through orgasm prior to intercourse. Unlike men, who experience a refractory period after orgasm, and are unresponsive to sexual stimulation for a variable period of time, women are able to experience multiple orgasms before,

during, and after intercourse, provided that sufficient clitoral stimulation is present. Sexual gratification and orgasmic response are associated with nerve endings in the clitoris, mons pubis, labia, and possibly pressure receptors in the vagina and pelvis.

Resolution in women is the feeling of relaxation and well being that is experienced after the sudden release of sexual tension brought about by orgasm. The physiologic changes that occur during arousal are reversed. Resolution usually lasts five to ten minutes. If orgasm does not occur, resolution may take two to six hours, and may be associated with irritability and emotional discomfort.

Sexual response is a true psycho-physiologic experience. Psychosexual development, psychological attitudes toward sexuality, and attitudes toward one's sexual partner are directly involved with and affect the physiology of the human sexual response.

Love and Intimacy

Love is a sustained emotional response to a known source of pleasure. A desire to maintain closeness to the love object is described by the phrase "being in love." Intimacy occurs when a person is able to give and receive love without fear or conflict. Sex, love, and intimacy are reciprocally enhancing. In an intimate relationship one actively promotes the personal growth and happiness of the loved one. Quality intimacy in a mature sexual love relationship possesses the values of increased self-awareness, increased self-affirmation, and sometimes at the moment of orgasm, even the loss of feelings of separateness from the loved one.

The increasing equality of the sexes profoundly affects the choice of love object. Emotional reasons for choosing a love object reflect personality patterns. For example, one may choose a mate purely on physical attraction, which ordinarily establishes a transient relationship. There may be a magical desire for a perfect lover, with idealized qualities reflected in other past sources of affection. One may take a partner to protect pride, social position, or financial security, rather than to satisfy love needs. A woman who considers herself unattractive sexually may choose a mate who is passive and dependable yet sufficiently unattractive so that she does not have to compete with other women. Essentially undesirable themes such as these exist in all personalities, and probably in all matings. When these themes predominate the couple may function mainly to exchange patterns of exploitation. This interlocking fulfillment of needs may fail to bring sufficient love and intimacy to the relationship. This may lead to discomfort and anxiety, which may manifest as a breakdown in the relationship.

Sexual Dysfunction

Sexual dysfunction is experienced by 63 percent of American women at some time in life. Fifty percent of couples experience sexual dissatisfaction. Sexual dysfunction is not incompatible with a happy marriage. Sexual dysfunction can be reflective of biological, intra-psychic, interpersonal conflicts, or a combination of these factors. Sexual func-

tion can be adversely affected by stress of any kind, emotional disorders (like depression or anxiety disorder), or by lack of knowledge about the psycho-physiologic sexual response cycle. The dysfunction may be life-long, transient, generalized, or situational. It may be limited to a specific partner or situation. Sexual dysfunctions include sexual desire disorders (hypoactive or inhibited sexual desire and sexual aversion), sexual arousal disorders, orgasmic disorders, sexual pain disorders, and sexual disorders due to medical conditions or substance abuse.

Sexual Desire Disorders are the most common sexual dysfunction in both women (35 percent) and men (15 percent). In one study of relatively happily married couples, 33 percent of the women describe difficulty maintaining sexual excitement, in another 35 percent expressed disinterest in sex. This disorder usually develops in adulthood, often after a period of normal functioning. These individuals often retain the ability to become aroused and experience orgasm. In women, this disorder may be associated with other sexual dysfunctions like painful intercourse, or anorgasmia (lack of orgasm). Physiologic causes of decreased sexual desire include medications (blood pressure medications, thiazide diuretics (fluid pills), antidepressants (Prozac, Zoloft, Paxil), antipsychotics, anticholinergics (Detrol, Ditropan), antihistamines (Allegra, Benadryl, Claritin), barbiturates, narcotics (Percocet, Vicodin), benzodiazepines (Zanax, Klonopin), birth control pills, cocaine, marijuana, and alcohol), chronic medical illness, depression, stress, and hormonal alterations. Elevated prolactin levels (a hormone responsible for milk production) or depressed testosterone levels (which occurs in the peri-menopause, or with surgical removal of the ovaries) may affect sexual desire. Cessation of breastfeeding will bring resolution of symptoms in nursing mothers. Testosterone supplementation or DHEA 50 mg per day has been proposed to help some peri-menopausal women, however this has not been proven beneficial in well designed medical studies even when testosterone levels were monitored. Treatment of women with inhibited sexual desire may require individual and relationship counseling. This may allow her to identify negative feelings that inhibit her sexual responses. Loss of desire may also be an expression of hostility, or the sign of a deteriorating love relationship. In one study, women were influenced by their perceptions about dominance, decision-making, affection, and their partner's threats to leave. *Marital discord was the most frequent reason for inhibition of sexual desire and activity in women.* At times the problem may be merely a failure to set aside appropriate time for intimacy. Time for intimacy and sexual activity should receive high priority within the relationship.

Orgasmic Dysfunction. Lifelong anorgasmia affects up to 15 percent of women. 45 percent of women experience inhibited orgasm at some time during life. Some women have orgasmic contractions, and yet are unaware that they are orgasmic. Surveys of sexual behavior demonstrate that most couples do not experience orgasm simultaneously, that many women achieve sexual satisfaction without orgasm, and that

many women are more likely to be orgasmic during foreplay, when they receive more direct and intense clitoral stimulation, than during intercourse. The most common cause of anorgasmia is excessive self-observation during arousal, often accompanied by anxiety, negative feelings toward sexuality, relationship problems, low self-esteem, poor body image, or fear of losing control.

Sexual Pain Disorders. Vaginismus is a medical condition that causes painful intercourse secondary to involuntary spasm of muscles surrounding the vaginal opening. This may occur secondary to vaginal pain (after episiotomy repairs or severe yeast vaginitis), a history of sexual abuse, or cultural or familial teaching that sex is evil, painful, or undesirable. Once the cause is understood, biofeedback techniques are extremely successful.

Dyspareunia (painful intercourse) is a sexual dysfunction that frequently has an organic, rather than psycho-physiologic, basis. Organic causes include: poor lubrication, urethritis, cystitis (bladder infection), trigonitis (bladder inflammation), poorly healed vaginal lacerations or episiotomies, pelvic inflammatory disease, or endometriosis. These conditions should be treated. At times, dyspareunia may be relieved by coital position changes like female-dominant, or side-by-side.

Female Homosexuality (Lesbianism)

Little usable data are available in the medical literature concerning sexual dysfunction in female couples. In 1994, the National Lesbian Health Care Survey was done. 60 percent were involved in a primary love relationship with another woman, 20 percent were single, and 2 percent were married to men. Only 28 percent were open about their sexuality with family or heterosexual friends. 88 percent were open about their sexuality with other lesbians. 57 percent had entertained thoughts of suicide, and 18 percent had attempted suicide. 55 percent had either suffered with depression or anxiety, received treatment for depression, or were currently depressed. 40 percent gave a history of physical abuse. 40 percent had been raped, 25 percent as a child, and 15 percent as an adult. 19 percent had been victims of incest. With these social disadvantages, it would be reasonable to expect that sexual dysfunction in the lesbian population was at least as prevalent as in the heterosexual female population.

References

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