Sexual disorders (female)

Sexual disorders (female) - F52 (Clinical term: Sexual dysfunction, not caused by organic disorder or disease Eu52)

Clinical judgements about sexual dysfunction should take into account the individual's ethnic, cultural, religious and social background, which may influence sexual desire, expectations and attitudes about performance.

Presenting complaints

- Patients may be reluctant to discuss sexual matters. They may instead complain of physical symptoms, depressed mood or relationship problems. It is important to be aware that patients with sexual problems may have a history of sexual abuse/assault (in childhood or later).
- Patients may present sexual problems during a routine cervical-smear test, well-woman clinic or when discussing contraception.

Diagnostic features

Sexual dysfunction can cause marked distress and interpersonal difficulty. Common sexual disorders presenting in women are:

- lack or loss of sexual desire, sexual aversion
- sexual arousal disorder (inability to attain/maintain an adequate physiological response to sexual excitement)

- sexual pain disorders:
  - vaginismus (involuntary spasm of vaginal muscles on attempted penetration accompanied by a fear or phobia the phobia can rarely occur without the spasm)
  - dyspareunia (recurrent genital pain associated with sexual intercourse - superficial vulval, vaginal or deep pelvic)

- orgasmic disorder (delay in, or absence of, orgasm or climax).

Distinguish between lifelong versus acquired, generalized versus situational, psychological versus combined factors.

When the sexual dysfunction can be better accounted for by another axis 1 disorder, or is due to the direct physiological effects of a substance/medication, or a general medical condition; that is:

- If low or sad mood is prominent, see Depression - F32#. Depression may cause low desire, or may result from sexual and relationship problems.
- Relationship problems. If persistent discord in the relationship is the primary problem, relationship counselling should precede specific psychosexual treatment of the sexual dysfunction.
- Gynaecological disorders (vulval pain disorders [eg vulval vestibulitis], vaginal infections, pelvic infections [salpingitis] and other pelvic lesions [eg tumours or cysts]), although vaginismus rarely has a physical cause.

- Side-effects of medication, alcohol or drugs (eg SSRI antidepressants, oral contraceptives and beta-blockers).
- Physical illnesses that affect the sexual physiology - vascular, neurological or endocrine systems - might contribute (eg atherosclerosis, multiple sclerosis, diabetes).
- Note that more than one sexual dysfunction can co-exist.

Lack or loss of sexual desire

Essential information for patient and partner

Sexual desire varies at differing times in an individual's life and varies widely between individuals. Research shows that at any one time 30-40% of women will claim low sexual desire. Loss of or low sexual desire has many causes, including relationship problems, earlier traumas (eg sexual abuse/assault), fear of pregnancy, postnatal problems, loss and bereavement, physical and psychiatric illnesses, stress (including long working hours) and many more. Women with low/no libido do not usually initiate sexual activity or may only engage in it reluctantly when it is initiated by a partner.

General management and advice to patient and partner

Discuss patient's beliefs about sexual relations. Check whether the patient and/or the partner have unreasonable expectations. Ask the patient about traumatic sexual and relationship experiences and negative attitudes to sex. Accept that this may take more than one appointment.

If possible, see partners together as well as individually. Try to find out if this is a problem for the woman or the relationship. If the latter, consider a difference in sexual need rather than dysfunction. Suggest development of an understanding and acceptance of what each partner wants during intimacy and help them to communicate these wants. Suggest introducing this communication into intimacy in a planned way (ie 'I would like this…').

Over several weeks, encourage patient and partner to practise pleasurable physical contact without intercourse, commencing with non-genital touching and moving through mutual genital stimulation to a gradual return to full intercourse. Partners must take it in turns to be active and passive in terms of touching and to initiate/go second ('sensate focus' therapy).

Consider ways of building self-esteem (eg exercise, education) and advise time and space to herself.

Sexual arousal disorder

Essential information for patient and partner

The essential feature is an inability to achieve or maintain an adequate lubrication-swelling response of sexual excitement. It is often accompanied by sexual desire disorder and orgasmic disorder. Women may have little or no subjective sense of sexual arousal. Resulting problems include painful intercourse, sexual avoidance and relationship discord.

General management and advice to patient and partner

Advise similar strategies as in management of low sexual desire ('sensate focus' therapy) and anorgasmia, including self-pleasuring manually/with a vibrator and the use of sexual fantasy.

Vaginismus

Essential information for patient and partner

Vaginismus is an involuntary spasm of the pubococcygeal muscles, accompanied by intense fear of penetration and anticipation of pain. Sexual responses (eg desire, pleasure) may not be impaired unless penetration is attempted or anticipated. It is found more often in younger women than older ones, in women with negative attitudes to sex, and those with a history of previous sexual abuse/assault. Once vaginismus is established, it is usually chronic but it can be overcome with specific psychosexual therapy.

General management and advice to patient and partner

The patient needs to gain confidence and control over vaginal muscle spasm. Exercises (systematic desensitization) involving vaginal muscle relaxation (reverse Kegels) and the systematic introduction of graded trainers (fingers, tampons or vaginal dilators) are successful if coupled with addressing the fear or phobia. Control can then be shared with a partner. Treatment often requires long-term therapy but has a promising outcome. Avoidance of practice and low motivation are common problems.

Dyspareunia

Essential information for patient and partner

There are many physical causes, both of deep and superficial dyspareunia. Women typically seek treatment in general medical settings. Genital abnormalities are rarely found on examination. Exclude treatable causes. Pain can occur before, during and after intercourse. In some cases, however, anticipation, poor lubrication and muscle tension are significant factors. Even where there has been a physical cause and it has resolved, anticipation of pain may frequently maintain the dyspareunia. The use and understanding of pain cycles is very helpful and often the secret to success.

General management and advice to patient and partner

Treat any physical cause. Check if patient experiences desire/arousal/lubrication. Relaxation, good arousal, prolonged foreplay and careful penetration may overcome psychogenic problems. Referral to a gynaecologist or GUM clinic or psychosexual service is advisable if simple measures are unsuccessful.

Anorgasmia

Essential information for patient and partner

Previous trauma, restrictive upbringing and negative attitudes to sex may have led to an inhibition of the normal sexual response. Many women are unable to experience orgasm during intercourse but can often achieve it by clitoral stimulation. Women may achieve sexual satisfaction without an orgasm.

General management and advice to patient and partner

Discuss the couple's beliefs and attitudes. Encourage self-pleasuring, manually or using a vibrator, and the use of sexual fantasy. The couple should be helped to communicate openly and to reduce any unrealistic expectations. Self-help books, leaflets or educational videos may be useful (see Resources for patients and families).

Referral

Patients can refer themselves to:

- Relate
- BASRT (British Association for Sexual and Relationship Therapy) - registered psychosexual therapists
- Brook Advisory Centres
- Family planning clinics
- Genito-urinary medicine (GUM) clinics.

Consider referral to a psychosexual specialist if patient and doctor are unable to enter into a programme of treatment or if primary care treatment has failed.

Resources for patients and families

Relate 0845 1304 010/4561 310 (helpline)
Website: http://www.relate.org.uk
Counselling for adults with relationship difficulties, whether married or not.

BASRT (British Association for Sexual and Relationship Therapy) 020 8543 2707
Email: info@basrt.org.uk; website: http://www.basrt.org.uk
Registered therapists are multidisciplinary, and work in the NHS as well as privately.

Brook Advisory Centres 020 7617 8000 (24-hour helpline)
Email: admin@brookcentres.org.uk; website: http://www.brook.org.uk
Free counselling and confidential advice on contraception and sexual matters, especially for young people (under 25).

AVERT http://www.avert.org.uk
Includes useful lesbian and young people's sections, which give basic information on homosexuality and sexual health.

Lovelife http://www.lovelife.uk.com
Designed for 16–24-year-olds, includes a list of GUM and family planning clinics around the country.

Dr Miriam Stoppard's Everywoman's Life Guide by Miriam Stoppard. Profile Pursuit Ltd, 2002

Embarrassing Problems: Straight-Talking Good Advice by M Stern. Health Press, 1995

Painful Sex: A Guide to Causes, Treatment and Prevention by M Goldsmith. Thorsons, 1995

Becoming Orgasmic: A Sexual Growth Program for Women by JR Heiman and J LoPiccolo, Prentice-Hall, 1988. Self-help exercises for anorgasmia.

A Woman's Guide to Overcoming Sexual Fear and Pain by Aurelie Jones Goodwin, New Harbinger Publications, 1997