Essentials of Female Sexual Dysfunction from a Sex Therapy Perspective

Linda E. Ohl

Discussing sexual issues with a clinician should be easy and natural for patients. However, data suggest that this is not the case. Clinicians are not talking about sex with their patients. In a recent poll of adult patients in the United States, only 9% of those aged 40 to 80 years of age were asked about sexual concerns by their physicians in the last 3 years (Moreira et al., 2005).

Furthermore, when sexual dysfunction is present, patients will not broach the topic with their clinicians. In another study, reasons for men not bringing the topic to the forefront during their medical encounters were examined. Fifty-one percent were fearful that the clinician would dismiss their concerns, 46% fear the clinician would be uncomfortable, and 46% were concerned there would be no medical treatment available (Marwick, 1999).

In the current environment, with constraints on the amount of time that can be spent with each patient, coupled with the discomforts previously mentioned, it is highly likely that individuals will not have their sexual dysfunction addressed during a standard medical encounter. Nurses, nurse practitioners, and physician assistants are in a position to help fill this gap in the total care of the patient by initiating conversation with patients.

The purpose of this article is to review the basics of normal and abnormal female sexual function, and provide a set of tools with which to approach women suffering from sexual dysfunction, including guidelines on when to refer to a sex therapist.

Normal Female Sexual Function

Developing a basic understanding of what is considered “normal” is important in helping to determine at what stage a patient may be experiencing difficulties within the sexual response cycle.

What does the sexual response cycle look like in the healthy female? Masters and Johnson developed a model for normal sexual function in the 1960s, in their landmark publication, Human Sexual Response (Masters & Johnson, 1966), and that model is still in use to this day. In their system, there are four phases that women experience during a complete sexual encounter: excitement, plateau, orgasm, and resolution. There have been some modifications to the cycle suggested by others. Helen Singer Kaplan, for instance, introduced the concept of “desire” into the response cycle (Kaplan, 1995), and Basson emphasized the importance of desire (Basson, 2001), but even in these modified systems, the basic Masters and Johnson system remains widely used.

The initial phase of the normal sexual response cycle is the excitement phase. During this time, a woman experiences physiological changes in her body, such as swelling of the nipples and of the breasts. During this stage, she will have an increased respiratory rate, elevation of blood pressure, and vasocongestion of the pelvic organs. The woman may experience a skin flush due to increased blood flow to the skin, and may even note a rash on the chest, breasts, and face. Other signs that signify the excitement phase are increased size of the clitoral shaft and labia separation as blood flow increases. The labia may also have notable physical changes. The labia majora become flatter, thinner,
and raise upward and outward. The labia minora may increase in size and may protrude from the labia majora, as blood flow increases.

The second stage in Masters and Johnson’s sexual model is the plateau phase. This is a continuation of the excitement phase, although more intense at its peak. During the excitement phase, events are happening very fast, but during plateau, these changes are continuing to increase, although at a slower rate, until maximum excitement is reached. The plateau concept describes the woman reaching her peak level of physical excitement prior to orgasm occurring. The vasocongestive response is at its highest. There is continued myotonia, increased heart rate and blood pressure, and the clitoris retracts under its hood. It is at this point in time that many women need extensive clitoral stimulation in order to continue into the orgasmic phase.

This phase lasts anywhere from a few seconds to several minutes and is many times reported as the most intense. Feelings of desire are described as a sense of warmth and tingling in sexual regions, and a desire for further arousal is common.

During the orgasm phase, a several-second time period of very significant myotonia occurs, followed by an abrupt release, and rhythmic contractions of the perineal, bulbocavernous, and pubococcygeus muscles (Bohlen, Held, Sanderson, & Ahlgren, 1982). The uterus contracts, as blood flow increases. The labia minora may increase in size and may protrude from the labia majora, as blood flow increases.

The last phase of the sexual response cycle is the resolution phase. During resolution, there is a return of all the physiologic changes described previously to their normal basal state. Heart rate, blood pressure, and respiration return to normal minutes after orgasm. Muscles that were in a state of contraction become very relaxed, and many women describe their bodies as “limp.” Women may describe their relaxation as a time of complete calm. Feeling of closeness to the partner may be at the maximum during resolution.

There is variation in an individual’s sexual response cycle. Some women do not feel fully satisfied if all phases of sexual response are not experienced, while others may typically bypass phases. For instance, a woman who is highly orgasmic may pass very quickly from excitement to orgasm, without a discernible plateau phase. Some women with medical problems that limit lubrication may be able to proceed to orgasm without notable physical changes of the excitement and plateau phases. Many women who suffer from anorgasmsa never reach the orgasm phase, but may still be quite satisfied with the total sexual experience. Sexual satisfaction is a subjective term and is solely determined by each individual. For many, feelings of closeness, bonding, touching, and intimacy are enough.

Women may also focus on their partners’ needs, at the expense of their own sexual experience. This is partly due to the higher relative importance placed on achieving orgasm by men. A woman may choose to quietly wait for the partner to reach orgasm and abandon her own sexual needs.

Overview of Female Sexual Dysfunction

Female sexual dysfunction (FSD) may be psychogenic or organic. However, unlike male sexual dysfunction, where the vast majority of cases are thought to be predominantly organic, current thought indicates a reverse situation in women. The majority of sexual dysfunctions in women are thought to be nonphysical.

However, recent research has associated medical conditions more frequently with sexual issues. Female sexual dysfunction has been linked to hypertension and its treatment (Burchardt et al., 2002), coronary artery disease (Salonia, Briganti, & Montorsi, 2002), and diabetes mellitus (Enzlin et al., 2002). The same vascular aberrations that cause erectile dysfunction in men associated with cardiovascular risk factors can cause arousal stage difficulties in women.

Effects of pelvic surgery and hormonal changes associated with menopause are known. Perhaps this issue may be viewed differently in the future, but currently FSD is diagnosed and treated primarily by therapists.

It remains important during the woman’s initial evaluation to determine if there is evidence for the presence of an organic condition or if it seems psychogenic. While screening for organic causes, one should look for neurologic issues, cardiovascular disease, cancer, urogenital disorders, medications, fatigue, and hormonal loss or abnormalities. Psychogenic causes include depression/anxiety, prior physical or sexual abuse, stress, drug or alcohol abuse, interpersonal relationship issues, such as partner performance and technique, or lack of partnership quality.

Social and cultural issues may also be contributing factors to FSD. Some cultures teach young women that sex is only for procreation, that sex is not to be enjoyed, or that the most important thing in a sexual encounter is pleasing the partner at her expense. Such issues are para-
mount in male-centric cultures. Religious upbringing may also influence attitudes toward sex and possibly lead to a psychogenic problem or other issues, such as lack of use of birth control measures by Catholics. Guilt related to diversion from literal religious teachings can exacerbate sexual dysfunctions. Evaluating a woman’s sexual education, religious beliefs, family values, and societal taboos can help determine the root of the dysfunction.

Certain aspects of the onset and the particulars of the FSD may be helpful in determining whether it is organic or psychogenic. For example, acquired disorders, those appearing after a period of normal sexual functioning, may be associated with progression of medical diseases that contribute to the problem. Acute onset of a new dysfunction after a psychological stress is most likely psychogenic. Situational conditions (occurring only under some conditions, such as with a certain partner, but not others) are most likely psychogenic, whereas those that are persistent under all conditions are more likely organic. Younger women will most likely suffer a psychogenic problem, and older women with medical conditions and post-menopausal women are more likely to have an organic component.

It is also possible to have combined psychologic and organic disturbances. Even in the case where a medical condition is the primary cause of the problem, psychologic factors are often a secondary reaction to the primary cause. Patients may experience frustration or anxiety in approaching sexual activity, and this may further inhibit the sexual response via subconscious suppression. For example, a woman who has an organic cause of lack of lubrication may have pain during intercourse from dryness, leading to her frustration. Her partner becomes angry, and then she develops a fear that he may leave. During the next sexual encounter, her anxiety and fear is at the forefront of her thinking and the subsequent physical response to this further inhibits the ability to lubricate.

Classifications of Female Sexual Dysfunction

There has been controversy in the world of psychotherapy as to whether or not a diagnosis of a psychosocial cause, thereby pathologizing it, is really necessary. The question arises as to whether labeling causes more harm than good. However, if there is to be progress in the development and testing of treatment methods for psychogenic and organic FSD, a classification system is needed to assure that uniform criteria are used to evaluate and diagnose subjects.

For the purpose of this article, the specific criteria and definitions for women with sexual dysfunction put forth by the American Psychiatric Association (APA, 1994) in the Diagnostic and Statistical Manual, 4th Edition (DSM-IV) are used to help understand the differing presentations of FSD. At the beginning of each category’s discussion, the DSM-IV diagnostic code is listed in parentheses.

A sexual dysfunction is characterized by a disturbance in the processes of the normal sexual response cycle or by pain associated with sexual intercourse. According to the APA (1994), there are four classifications of sexual dysfunction (see Table 1). Each of these conditions will be discussed in detail. Note that most definitions of a sexual dysfunction require that the condition causes distress for the patient. Women who have a condition but do not suffer distress can be argued to not have a clinically significant malady.

**Sexual Desire Disorders**

- **Hypoactive Sexual Desire Disorder (302.71, DSM-IV)**. Hypoactive sexual desire disorder (HSDD) is defined as a persistent or recurrent deficiency (or absence) of sexual fantasies and or desire for, or receptivity to, sexual activity that causes personal distress. Age and context of a person’s life are taken into consideration. The lack of sexual desire must cause distress, and there are no other medical conditions or drugs involved as causative agents.

  Paik and Laumann (2006) surveyed the American literature published since 1970 to summarize the incidence of various sexual dysfunctions. In their analysis, the lifetime incidence of HSDD ranged from 7% to 31%. Short duration problems were less common, indicating that some women may suffer from lack of desire for temporary time periods. Most of the studies were survey-based epidemiologic studies, begging the question about whether the studied populations represent the type of individuals seeking medical attention. One “real-life” gynecology clinic-based study, however, gave a similar lifetime incidence of desire disorder of 29% (Nusbaum, Gamble, Skinner, & Heiman, 2000).

  **Sexual Aversion Disorder (302.79, DSM-IV)**. The difference between HSDD and sexual aversion is that with sexual aversion, the female will do almost any-
thing to disengage from all sexual contact with a sexual partner. The woman experiences anxiety, fear, or disgust when confronted with sexual advances. She may at times feel terror, faintness, nausea, and heart palpitations. It is not uncommon for a woman to experience marital discord due to avoidance of sexual situations. She may go out of her way to avoid sexual situations by traveling, going to sleep early, overextending herself in social or work situations, and not caring for her personal appearance.

**Female Sexual Arousal Disorder**

Female Sexual Arousal Disorder (302.72, DSM-IV) is the inability to attain or maintain sufficient sexual excitement, which may be expressed as a lack of subjective excitement, or lack of genital lubrication/swelling or other somatic responses. It should cause marked distress or interpersonal difficulty. It cannot be accounted for by another major mental disorder and is not exclusively due to medications. The woman experiencing sexual arousal disorder looks much different. She enjoys sexual encounters and finds herself frustrated due to the inability to attain, or to maintain sufficient lubrication for penetration during a sexual encounter, or at least until completion of the sexual activity.

Paik and Laumann (2006) reported the incidence of current problems with lack of feeling of excitement or pleasure as low as 2%, with lifetime incidence of 20%. Difficulties with peripheral manifestations of FSAD, such as vaginal dryness or lack of lubrication, had a lifetime prevalence of 13% to 31%. However, when considering all symptomatology related to problems with sexual arousal, clinic-based lifetime incidence is 12% to 50%.

**Female Orgasmic Disorder**

Female Orgasmic Disorder (302.73, DSM-IV) (formerly known “inhibited female orgasm”) is characterized by the persistent or recurrent, delay in, or absence of, orgasm following a normal sexual excitement phase. To be considered a significant condition, this should cause distress for the patient, and not be caused by another medical condition or use of drugs (such as serotonin reuptake inhibitors). Because women experience different variability in the type and intensity of stimulation that triggers orgasm, the diagnosis should be based on what would be reasonable for their age, sexual experience, and the adequacy of sexual stimulation.

Many women with orgasmic disorders have experienced this problem their entire lives. New-onset problems should make the clinician probe for new medical issues (neurologic signs or recent initiation of antidepressant therapy), or new psychosocial stressors, such as relationship issues, abuse, and depression.

In the National Health and Social Life Survey, 1,749 women ages 18 to 59 were surveyed about their sexual function (Laumann, Paik, & Rosen, 1999). Persistent or recurrent inability to achieve orgasm over the last year was reported in 25%. Unmarried women and those without a college degree were more likely to have problems with orgasm (Laumann et al., 1999). Recent studies report a lifetime incidence of total or partial orgasm difficulties of between 16% to 30% (Paik & Laumann, 2006). Approximately 5% of women have never achieved an orgasm (Klassen & Wilsnack, 1986).

**Sexual Pain Disorders**

Dyspareunia (302.76, DSM-IV). This condition is characterized by recurrent or persistent genital pain associated with sexual activity. It should cause distress, and must not be due exclusively to vaginismus, or lack of lubrication (which would be FSAD). It cannot be accounted for by another psychiatric condition or use of drugs or medications.

The entire vaginal area can be painful to touch. Dull, aching, or even sharp sensations are reported by many women when seeing their physician. Pain may be detected when penetration of a penis, tampon, finger, or another object is inserted into the vagina. Women may even feel discomfort when wearing tight pants or nylons.

There are many reasons for sexual pain including anatomic abnormalities. Post-surgical changes are a common reason for internal pain during intercourse. Allergic reaction to hygiene products can cause burning, itching, and swelling of the vaginal tissue. Discomfort may be due to bacterial or yeast infections. Lack of estrogen may cause thinning of the vaginal walls, leading to lack of lubrication, which can create burning and sting when penetration is attempted.

The lifetime prevalence of sexual pain disorders ranges from 17% to 19% from population-based survey studies (Paik & Laumann, 2006). Interestingly, despite the fact that clinical stud-
ies report a similar lifetime incidence of 10% to 20%, when queried about current problems, women in clinic-based studies report a much higher incidence of problems (21%-48%) than population studies (3%-13%) (Paik & Laumann, 2006). It is interesting that “current” incidences are reported to be higher than lifetime incidences, leading one to suppose that women forget episodes of acute problems seen in a medical setting after a period of time.

Obtaining a Sexual History

When obtaining a sexual history, depending on the environment and time constraints, it is important to collect relevant information in a timely manner. If the patient has seen a clinician prior to the appointment, and the clinician seems concerned about the patient’s sexual wellness, has a professional demeanor, and seems comfortable and understanding, it will make the sexual interview much more relaxing, honest, and helpful.

Make sure the patient is in a comfortable position (for example, is not disrobed for an examination), relaxed, face-to-face to the clinician, and in a private setting. There should be no desk between patient and clinician, as this may create a feeling of a boundary to the discussion. The practitioner should feel comfortable using sexual terminology, and be ready to listen actively. The use of eye contact is vital in gaining the woman’s trust and confidence. The interview environment is crucial in making a comfortable exchange of information, as the patient is being asked the most intimate, detailed questions of private life.

While speaking, it is best to mirror the patient’s sexual vocabulary so she can relate and understand the discussion. If possible, let the patient set the pace and the tone of conversation. Often, a question may need to be asked several times, in different ways, to get an accurate answer.

It is important to ask the patient if she would like to speak with the clinician about these issues. For some women this is not a concern, and for others it is a major life event. Giving the patient permission to discuss the issues is the first step in problem solving. Some general leading questions may be necessary to initiate the conversation, such as:

- “Are you having any sexual difficulties at this time?”
- “Are you having difficulties with desire for sex?”
- “Do you feel a sense of arousal when engaging in sexual behavior or when thinking about sexual matters?”
- “Do you have difficulties with lubrication, either before or after sex?”
- “Do you have problems when your partner attempts penetration?”
- “It is not uncommon for women with hypertension, diabetes, or heart disease to experience difficulty with sexual functioning. Is this a problem for you?”

More specific questions can follow, once the conversation is initiated.

For professionals working in a clinical environment, time is of the essence. There may not be time to practically include sexual function in a clinical encounter. To help with the time issue, some clinicians use validated research instruments designed to define the degree of sexual dysfunction. One such vehicle is the Female Sexual Function Index (FSFI), a five-page questionnaire asking about sexual feelings and responses (Rosen et. al., 2000). The use of screening surveys may assist in finding individuals in whom further questioning is necessary.

When to Refer to a Therapist

What should the clinician do if it is concluded there are no medical causes to better explain the woman’s sexual dysfunction? If the clinician has interest, therapy can be initiated in the medical office. Ask the patient her thoughts as to why she may be experiencing this problem. Spend a few moments educating her about sex and correcting any myths or misconceptions she may have.

Helping the patient find credible resources is very important (see Table 2). Direct her to the health section in the bookstore, library, or online. Handing out a list of books and Web addresses

Table 2.
Resources for Female Sexual Dysfunction Information

| The American Association of Sexuality Educators, Counselors and Therapists | www.aasect.org |
| The VP (Vulvar Pain) Foundation | www.vulvarpainfoundation.org |
| Women’s Health America | www.womenshealth.com |

Books
while sex therapists can provide initial three steps (P-LI-SS), have been trained to apply the specific needs. Sex counselors necessary to address the patient’s more intensive techniques as which applies progressively PLISSIT model (see Table 3), One of the most popular is the therapy used in treating FSD. "sex therapist" is used, ranging from having to perform sexually "homework" assignments are given at the end of a therapy session in order for the couple, or individual, to practice what was discussed in session. Assignments are geared towards teaching patients new skills. Some exam-

**Table 3. The PLISSIT Model for Sex Therapy**

<table>
<thead>
<tr>
<th>P = Permission</th>
<th>L = Limited Information</th>
<th>S = Specific Suggestions</th>
<th>I = Intensive Therapy</th>
</tr>
</thead>
</table>

**Source:** Annon, 1976.

with credible resources will help your patient make informed choices. You may wish to stock books in your office or clinic, for loan or purchase as a courtesy to the patient.

If these suggestions do not correct the situation, the issues may be more deeply rooted, or combined with other psychopathology, and may not be treated easily in the medical office setting. In this case, it is appropriate to refer the patient to a sex therapist or other clinician that specializes in FSD.

**What Can Your Patient Expect from a Sex Therapist Referral?**

There are many misconceptions in society when the term “sex therapist” is used, ranging from having to perform sexually in front of the therapist to arranging sexual surrogacy. Prior to a referral to a therapist, the clinician should reassure the patient that the therapist is a professional who will be dealing with the psychological issues having to do with FSD. There may be uncomfortable discussions in the office, but it should be clear that this will be a very professional psychotherapy encounter.

There are many models for therapy used in treating FSD. One of the most popular is the PLISSIT model (see Table 3), which applies progressively more intensive techniques as necessary to address the patient’s specific needs. Sex counselors have been trained to apply the initial three steps (P-LI-SS), while sex therapists can provide all four levels of intervention (P-LI-SS-IT).

**The P-LI-SS-IT Model for Sexual Counseling**

*Permission (P).* The practitioner creates a climate of comfort and gives *permission* to clients to discuss sexual concerns, often introducing the topic of sexuality, thereby validating sexuality as a legitimate health issue (Annon, 1976).

*Limited information (LI).* The practitioner addresses specific sexual concerns and attempts to correct myths and misinformation. This is reserved for relatively straightforward, noncomplex problems (Annon, 1976).

*Specific suggestions (SS).* The practitioner compiles a sexual history or profile of the client. Subsequently, after definition of the issues and how they have evolved over time, the therapist will assist the patient with very specific directions on how to address the problem. The patient is an active participant in the process, many times given the responsibility, with the therapist’s guidance, of finding a solution that becomes internalized.

The suggestions from the therapist may be very specific, such as activities to incorporate or to avoid in the bedroom that may lead to desensitization of the problem. These suggestions may include focusing on sexual sensations, recording negative thoughts and analyzing them, using music, candles and incense to enhance the sexual experience, employing mutually agreed upon fantasies, and using stimulating devices (Annon, 1976).

*Intensive therapy (IT).* The therapist provides specialized treatment in cases that are complicated by the coexistence of other complex life issues that may also include psychiatric diagnoses such as depression, anxiety disorders, obsessive-compulsive disorder, personality disorders, or substance abuse, or by interpersonal or intrapersonal conflict (Annon, 1976).

Sex therapists are trained to identify situations that require intensive therapy and to make appropriate medical referrals when necessary. On the first visit, a comprehensive interview will be conducted. An extensive history is recorded, with questions about upbringing and memories of family and social life. Because religious beliefs are connected closely with sexual attitudes, religious beliefs will be discussed. Questions regarding overall health, medications, and past medical history will also be included. Social issues, in reference to relationships, self-esteem, history of sexual abuse and trauma will be discussed. A comprehensive psychiatric history and assessment are conducted to help determine if psychiatric issues need to be addressed.

After the evaluation is completed, the therapist will suggest what might be contributing to the problem and suggest a treatment plan. The treatment plan can be altered on a regular basis, depending on what is happening in treatment. Usually treatment is conducted with the partner unless circumstances dictate differently. Treatment focuses on identification and examination of feelings, both from past and present experiences. The goal is to gain insight into maladaptive behaviors, improving communication between partners, and teaching new ways to deal with issues.

Because most sexual dysfunctions are regarded as a couple’s issue, the therapist might focus on the couple’s strengths rather than weakness. If the patient is not in a current relationship, the therapist may work on individual strengths.

“Homework” assignments are given at the end of a therapy session in order for the couple, or individual, to practice what was discussed in session. Assignments are geared towards teaching patients new skills. Some exam-
amples of these may be teaching the art of giving and receiving pleasure, extending mutual pleasuring (abandoning self-to-self pleasure), turning the idea of sexual obligation into pleasure, learning to focus on sensations rather than anxieties and fears, discovering harmful patterns in sexual relationships, and encouraging the patient to be open and honest about needs and frustrations in the relationship. Couples may even be asked to deliberately avoid orgasm, penetration, or even touching sexual organs for a period of time.

The cost and length of therapy can vary. Usually sex therapy duration is on the shorter side, when compared to standard psychotherapy. Fees can range from $80 to $150 or more per session. Some insurance companies may cover a portion or all of the fees. Many therapists will extend a sliding scale for charges if affordability is an issue.

Conclusion

Female sexual dysfunction is a common problem. Most dysfunctions are thought to be psychogenic, but our understanding increases as more studies are completed, providing new outlook on the etiologies of FSD. The initial discussion with the patient is of utmost importance, as some problems can be handled without referral. With more complex issues, referral to a qualified sex therapist can help the problem heal.

References


Statements of Disclosure

Urologic Nursing Editorial Board

Christine Bradway, PhD, RN, disclosed that she is on the Consulting Board for Boehringer Ingelheim Pharmaceuticals, Inc.

Kaye K. Gaines, MS, ARNP, CUNP, disclosed that she is on the Speakers’ Bureau for Pfizer, Inc., and Novartis Oncology.

Sally S. Russell, MN, CMSRN, disclosed that she is on the Advisory Board for Roche/Abbott Labs.

All other Urologic Nursing Editorial Board members reported no actual or potential conflict of interest in relations to the continuing nursing education articles that appear in this issue.

Urologic Nursing Manuscript Review Panel

Jeanne Held-Warmkessel, MSN, RN, APRN, BC, AORN(R), disclosed that she is on the Speakers’ Bureau for Pfizer, Inc. and Hana Biosciences, and on the Advisory Board for Pfizer, Inc.

Marta Krissovich, MS, RN, NP, CNS, disclosed that she is on the Speakers’ Bureau and Advisory Board for the National Association for Continence (NAFC).

Karen Sasso, MSN, RN, CCCN, disclosed that she is on the Speakers’ Bureau and Advisory Board for Adamed, Inc.

All other Urologic Nursing Manuscript Review Panel members reported no actual or potential conflict of interest in relations to the continuing nursing education articles that appear in this issue.