FEMALE

SEXUAL

DYSFUNCTION
FEMALE SEXUAL DYSFUNCTION: What women want?

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Bizarre workplace charges
Kashika Saxena | Sep 16, 2011, 12.00AM IST

If you think that you have the weirdest colleagues and the most bizarre boss, you’re in for a hilarious surprise. Read on to find out why you should be thanking your stars that you don’t work in an office where such extraordinary things happen.

36-year-old accountant Ana Catarian Bezerra took her employer to court last year. She claimed to suffer from a chemical imbalance which causes hypersexuality and she has to masturbate to release that tension. She wanted to be allowed to masturbate during work hours. She won. A Brazilian judge allowed her to legally watch porn at work and masturbate. Before she got professional help, she had to masturbate 47 times a day, now it’s down to ‘only’ 18 times daily.
Why talk about FSD???
Goals of Life

Hinduism has 4 *purushartha*s, the goals of life....

- **Dharma**: Duty
- **Artha**: Worldly status
- **Kāma**: Aesthetic and erotic pleasure
- **Moksha**: Salvation
Normal sexual response in women: What is it?

• Highly challenging

• Controversial

• Little consensus

• Normal defined by the absence of abnormal, i.e., absence of overt sexual dysfunction
A TEXTBOOK ON UNDERSTANDING WOMEN

(VOL-1)
DEMONS
STEP IN
WHERE
ANGELS
FEAR TO
TREAD
How important sex is?

• Almost 60% women feel adequate sex life as integral to their physical and emotional satisfaction

• Cultural differences
Malleability of Female sexuality

• Universal: Vaginal lubrication and orgasmic contractions
• Individual: Subjective and emotional aspects

• Cultural factors
• Individual experience
• Learning factors
The Masters and Johnson model

[Diagram showing the stages of sexual response: Desire, Arousal, Plateau, Orgasm, Resolution]
Playboy 1968
TIME 1970

Sex Education for Adults

RESEARCHERS MASTERS AND JOHNSON
The Masters and Johnson model

• Four-stage

• **First phase:** Excitement
  
  – Genital: Pelvic vaso-engorgement and vaginal lubrication
  
  – Extra-genital: Flushing, nipple engorgement, muscle tension, changes in HR, BP & RR

The Masters and Johnson model

- **Second phase**: Plateau
  - High level of sexual excitement is maintained

- **Third phase**: Orgasm

- **Last phase**: Resolution
  - After one or multiple orgasms, return to the pre-stimulated state

Orgasm....

- Increasing vaso-congestion & muscle tension in outer third of vagina
- Rhythmic, involuntary contractions
- Intense subjective feelings
- ‘petit mort’: a brief loss of consciousness
Kaplan’s three-stage model

- Desire
- Excitement
- Orgasm

Helen Singer Kaplan

Kaplan’s Desire…..

• Stage of sexual desire: physiologic and psychological components of sexual desire or libido

• Mediated by brain centres

• Also influenced by hormonal and psychosocial influences

• Necessary precursor to the development of adequate excitement and subsequent orgasm

What it achieved

Became the basis for classification of female sexual dysfunction in the third and fourth editions of the Diagnostic and Statistical Manual of Mental Disorders (DSM-III, DSM-IV)
Circular model of female sexual response

- Whipple and Brash-McGreer

- Phase of seduction: desire
- Phase of sensation: excitement and plateau
- Phase of surrender: orgasm
- Phase of reflection: resolution
Basson’s model of female sexuality

• Intimacy-based model

• Conceptualizes female sexual response as cyclic in nature

• Departs from the traditional elements

• Phases of sexual response are overlapping & non-sequential
Basson’s model of female sexuality

Basson’s: What’s new

• Woman may instigate physical contact or be receptive to sexual initiation for various reasons [1]

• Sexual desire viewed as one potential component of the sexual response cycle, but not necessary for sexual excitement or orgasm to occur

Women! and.......Men!

• Women can experience extragenital responses without the subjective perception or experience of sexual excitement or vice versa [1]

• In men, subjective excitement and increases in penile engorgement are highly correlated [1]

• **Men:** physiologic arousal concordant with subjective ratings while, **women:** discordance between subjective and physiologic arousal [2]

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Factors influencing female sexual response

Biologic & physiologic factors:

• Neurologic disease

• Cancer

• Urologic or gynaecologic disorders

• Medications

• Endocrine abnormality
Factors influencing female sexual response

Psychological factors:

• Depression/anxiety

• Prior sexual or physical abuse

• Substance abuse
Factors influencing female sexual response

Interpersonal factors:

• Relationship quality and conflict
• Lack of privacy
• Partner performance and technique
• Lack of partner
Factors influencing female sexual response

Socio-cultural factors:

- Inadequate education
- Conflict with religious, personal, or family values
- Societal taboos
FSD: Definition

Disorder of sexual desire, arousal, orgasm or sexual pain that results in significant personal distress.

DSM-IV TR classification of FSD

Sexual desire disorders

Sexual arousal disorders
• Genital arousal disorder
• Subjective arousal disorder
• Combined arousal disorder

Orgasmic disorder

Dyspareunia and vaginismus

Persistent sexual arousal disorder

AFUD classification of FSD

Hypoactive sexual desire disorder
Sexual aversion disorder
Arousal disorder
  • Subjective arousal disorder
  • Genital arousal disorder
  • Combined arousal disorder
Orgasmic disorder
  • Sexual pain disorders
  • Vaginismus
  • Dyspareunia

Screening questions to establish FSD

• Are you currently in a sexual relationship?

• Do you have any problems with desire, arousal or orgasm?

• If you are not currently sexually active, are there any particular problems contributing to you lack of sexual activity?

• Do you have any concerns or questions about your sex life?

• Please feel free to ask in future!
Sexual Desire Disorders

• *Hypoactive sexual desire disorder*: persistent or recurrent deficiency or absence of sexual desire or receptivity to sexual activity that causes marked distress or interpersonal difficulty

• *Sexual aversion disorder*: persistent or recurrent aversive response to genital contact with a sexual partner that causes distress or interpersonal difficulty

Desire (iccha): How to ask?

Over the past month:

– How often did you feel sexual desire?

– How would you rate your level of sexual desire?

• Sexual desire or interest is a feeling that includes wanting to have a sexual experience, feeling receptive to a partner's sexual initiation, and thinking or fantasizing about having sex

Sexual Arousal Disorder

Inability to complete sexual activity with adequate lubrication that causes marked distress or interpersonal difficulty

- Subjective sexual arousal disorder
- Combined genital and subjective arousal disorder
- Genital sexual arousal disorder

Sexual Arousal Disorder

• **Subjective**: Absence of feelings of sexual arousal from any type of sexual stimulation. Vaginal lubrication or other physical response still occurs.

• **Combined genital and subjective**: Absence of feelings as well as complaints of absent or impaired genital sexual arousal.

• **Genital**: Complaints of absent or impaired genital sexual arousal. Subjective sexual excitement still occurs from non-genital stimuli.
Arousal (uttéjna, josh): How to ask?

Over the past month:

- How often did you feel sexually aroused ("turned on") during sexual activity?
- How would you rate your level of sexual arousal during sexual activity?
- How confident were you about becoming sexually aroused during sexual activity?
- How often have you been satisfied with your arousal during sexual activity?

• Sexual arousal is a feeling that includes both physical and mental aspects of sexual excitement. It may include feelings of warmth or tingling in the genitals, lubrication (wetness), or muscle contractions.

Lubrication (*chiknapan*) : How to ask?

*Over the past month:*

- **How often did you:**
  - become lubricated ("wet") during sexual activity or intercourse?
  - maintain your lubrication ("wetness") until completion of sexual activity or intercourse?

- **How difficult was it to**
  - become lubricated during sexual activity or intercourse?
  - maintain your lubrication until completion of sexual activity or intercourse?

Orgasmic Disorder

Persistent or recurrent delay in or absence of orgasm after a normal excitement phase, causing marked distress or interpersonal difficulty

• Primary orgasmic disorder
• Secondary orgasmic disorder
Orgasm: How to ask?

(sukoon, tripti, nasha, pani chootna)

Over the past month:

• When you had sexual stimulation or intercourse
  – how often did you reach orgasm (climax)?
  – how difficult was it for you to reach orgasm?

• How satisfied were you with your ability to reach orgasm during sexual activity or intercourse?
Sexual Pain Disorders

• **Dyspareunia**: Recurrent or persistent genital pain associated with sexual intercourse that is not caused exclusively by lack of lubrication or by vaginismus and causes marked distress or interpersonal difficulty

• **Vaginismus**: Recurrent or persistent involuntary spasm of the musculature of the outer third of the vagina that interferes with sexual intercourse, causing marked distress or interpersonal difficulty

Pain (dard) : How to ask?

Over the past month:

• How **often** did you experience discomfort or pain
  – **during** vaginal penetration?
  – **following** vaginal penetration?

• How would you rate your **level** (degree) of discomfort or pain during or following vaginal penetration?

# Sexual Pain: Associated Conditions

<table>
<thead>
<tr>
<th>Superficial</th>
<th>Deep</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provoked vestibulodynia</td>
<td>Endometriosis</td>
</tr>
<tr>
<td>Vulvodynia</td>
<td>Pelvic congestion syndrome</td>
</tr>
<tr>
<td>Chronic vulvar dermatoses</td>
<td>Interstitial cystitis</td>
</tr>
<tr>
<td>Vulvitis or vulvovaginitis</td>
<td>Uterine retroversion</td>
</tr>
<tr>
<td>Condylomas</td>
<td>Uterine leiomyomas</td>
</tr>
<tr>
<td>Dermatologic disease (infectious or noninfectious)</td>
<td>Adenomyosis</td>
</tr>
<tr>
<td></td>
<td>Pelvic inflammatory disease</td>
</tr>
<tr>
<td></td>
<td>Pelvic adhesive disease</td>
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<tr>
<td></td>
<td>Ovarian remnant syndrome</td>
</tr>
<tr>
<td></td>
<td>Irritable bowel syndrome</td>
</tr>
<tr>
<td></td>
<td>History of sexual abuse</td>
</tr>
</tbody>
</table>
Persistent sexual arousal disorder

Spontaneous intrusive and unwanted genital arousal in the absence of sexual interest and desire. The arousal is unrelieved by one or more orgasms and the feelings of arousal persist for hours or days.
Satisfaction (*mazaa,* *santushti*) : How to ask?

*Over the past month:*

- *How satisfied have you been with:*
  - the amount of emotional closeness during sexual activity between you and your partner?
  - your sexual relationship with your partner?
  - your overall sexual life?

Incidence

• 43% of women [1] ......

• More common in women who have a history of sexual abuse or coercion [2]

• 60% of women aged less than 60 have some degree of sexual dysfunction [3]

It is unbelievable….but true!

- 1500 women attending a gynaecology clinic
- 98% respondents: one or more sexual concerns
  - Sexual desire: 87%
  - Orgasmic disorders: 83%
  - Dyspareunia: 72%
  - Inadequate lubrication: 5%

FSD prevalence as one ages

Filled circle: desire; open triangle: arousal; filled square: orgasm; open diamond: any.

FSD: Indian Scenario

• Joint family
• Extramarital relationship
• Polyandry
• Polygamy
• Taboos
What we do?

• WHO calls for physicians to take lead in addressing the sexual health concerns

• 14% of Americans aged 40 to 80 years reported that a physician had inquired about sexual concerns within the past 3 years

• In India: ?

The Pfizer Global Study of Sexual Attitudes and Behaviors. Available at: http://www.pfizerglobalstudy.com/
Barriers to discussing sexual health

• Insufficient medical education or training

• In USA: only 10 hours during the entire undergraduate curriculum to sexual health education [1]

• In India: ?

• Underestimation of sexual dysfunction prevalence

Barriers to discussing sexual health

• Time pressure

• Few perceived treatment options

• Patient discomfort

• Lack of confidence
LET YOUR ABILITIES BE KNOWN. PUT UP A BOARD IN YOUR OPD STATING...

A FRANK TALK ABOUT YOUR SEXUAL PROBLEMS IS WELCOME!

‘MAY BE THE DOCTOR CAN HELP’
If this is so, then why should ‘I’ talk about FSD???
Sexual History

• When to take

• How to take

• How to assess current sexual function
Opportunities: Sexual health screening

- Prior to gynaecologic surgery
- Menopause-related visit
- Antenatal visits
- Postpartum visits
- Routine gynaecologic examination
- Infertility assessment and treatment
- Management of chronic illness
- Depression
Making the environment conducive

• How, when, and where to address the topic

• Establish rapport

• Put patients at ease

• Set the tone for conversation
Quickie!

• Brief assessment: just 2–3 minutes

• Sexual history ideally taken within a review of systems

• Private setting

• Confidentiality

• Patient clothed to eliminate the anxiety, discomfort & vulnerability
Hierarchy......

- From general to specific
- From non-threatening to threatening
- From non-genital to genital
- From non-penetrative to penetrative
- From adolescence to pre- to post-marital
- From fantasy to reality
- From desire to orgasm
My favorite question

“Peri-menopausal women or women who have recently had a baby or say, pregnant women often notice problems with decreased lubrication, discomfort with sexual intercourse, or decreased sexual desire. Have you noticed any such changes?”
Sexual complaint identified: What to do next?

Determine whether:

• Concern can be addressed during the current appointment

• A follow-up visit is needed

• Sexual concern or complaint is beyond the scope of training or comfort of the physician and the patient needs referral

Complete sexual history

• Past medical history

• Current health status

• Reproductive history and current status

• Endocrine system e.g. diabetes: impaired arousal & orgasm, androgen insufficiency: hypoactive desire, estrogen deficiency: vaginal atrophy and arousal problems, thyroid: impaired sexual desire
Complete sexual history

• Neurologic diseases e.g. multiple sclerosis and spinal cord injuries can impair arousal and orgasm

• CVS disease: can cause arousal disorder [1]

• Psychiatric illness e.g. depression can impair desire, so can medications to treat psychiatric conditions, such as SSRIs

Medications with sexual side effects

**Psychotropic medications**
- Antidepressants (SSRIs, serotonin-norepinephrine reuptake inhibitors [SNRAs], tricyclic anti-depressants, monoamine oxidase inhibitors [MAOIs])
- Antipsychotics
- Benzodiazepines
- Mood stabilizers

**Antihypertensives**
- Beta-blockers
- Alpha-blockers
- Diuretics

**Cardiovascular agents**
- Lipid-lowering agents
- Digoxin

**Histamine H2-receptor blockers**

**Hormones**
- Oral contraceptives, estrogens, progestins, antiandrogens, GnRH agonists
- Narcotics
- Amphetamines
- Anticonvulsants
- Steroids

### Gynaecologic examination

<table>
<thead>
<tr>
<th>Examination</th>
<th>Condition to consider</th>
</tr>
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<tbody>
<tr>
<td><strong>Inspection of external genitalia</strong></td>
<td></td>
</tr>
<tr>
<td>Muscle tone, skin color/texture, skin turgor</td>
<td>Vaginismus, vulvar atrophy, vulvar dystrophy</td>
</tr>
<tr>
<td>and thickness, pubic hair amount, vaginal</td>
<td></td>
</tr>
<tr>
<td>pH</td>
<td></td>
</tr>
<tr>
<td>Cotton swab test of vulva, vestibule, hymenal</td>
<td>Vulvar vestibulitis</td>
</tr>
<tr>
<td>ring, Bartholin and Skene glands (pain</td>
<td></td>
</tr>
<tr>
<td>mapping)</td>
<td></td>
</tr>
<tr>
<td>Expose clitoris</td>
<td>Adhesions</td>
</tr>
<tr>
<td>Examine posterior forchette and hymenal ring</td>
<td>Episiotomy scars, strictures</td>
</tr>
<tr>
<td><strong>Monomanual examination</strong></td>
<td></td>
</tr>
<tr>
<td>Palpate rectovaginal surface, levator muscles</td>
<td>Rectal disease, vaginismus, levator ani myalgia, interstitial cystitis, urinary tract infection</td>
</tr>
<tr>
<td>bladder/urethra</td>
<td></td>
</tr>
<tr>
<td>Evaluate vaginal depth</td>
<td>Postoperative or postradiation changes, stricture</td>
</tr>
<tr>
<td><strong>Bimanual examination</strong></td>
<td></td>
</tr>
<tr>
<td>Palpate uterus and adnexa and perform</td>
<td>Fibroids, endometriosis, masses, cysts</td>
</tr>
<tr>
<td>rectovaginal examination</td>
<td></td>
</tr>
<tr>
<td>Speculum examination and papanicolaou smear</td>
<td>Atrophy, human papilloma virus infection, cancer, cystocele, rectocele, uterine prolapse</td>
</tr>
</tbody>
</table>
Scales, questionnaires, and checklists....

- Brief Index of Sexual Functioning for Women (BISF-W)
- Changes in Sexual Functioning Questionnaire (CSFQ)
- Derogatis Interview for Sexual Functioning (DISF/DISF-SR)
- Female Sexual Function Index (FSFI)
- Golombok-Rust Inventory of Sexual Satisfaction (GRISS)
- McCoy Female Sexuality Questionnaire (MFSQ)
- Sexual Interest and Desire Inventory—Female (SIDI-F)
- Sexual Quality of Life—Female (SQOL-F)
- Hypoactive Sexual Desire Disorder Screener (HSSD Screener)
FSD: Management issues

• Counselling
  - Cognitive behavioural therapy
  - Brief interventional therapy

• Relationship therapy

• Intensive sex therapy: effective in sexual aversion and arousal disorders, but less so in HSDD
M&J: Sensate focus

Ground rules
1. Agree on a ban on intercourse throughout therapy and genital touching for the first 4 sessions or 2 weeks.
2. Set up twice-weekly times to spend on this task, increasing from 20 to 60 minutes over 4 weeks.
3. Speak during these times only if the touch of the partner is painful or unacceptable, otherwise it is assumed that what is being done is OK.
4. Emphasis is given to the importance of focusing the concentration on personal experience, not on pleasing or arousing the partner; this is a learning exercise above all.

Stage 1
a. Taking plenty of time, each person explores the other’s naked (if possible) body, avoiding breasts and genitals, avoiding trying to arouse the other, and concentrating on the feelings experienced in both ‘active’ and ‘passive’ roles.
b. After 2 weeks, or 4 sessions, of this some familiarity and trust should allow the inclusion of breasts, and experimentation with a range of touches (e.g. body oils, talcum powder, fabrics).
c. As above, adding the making of specific requests for types of touch preferred, and the optional use of a ‘back to front’ position to enable the person being touched to guide the hand of the person touching.

Stage 2
a. Maintain the ban on intercourse. Include genital touching to explore and familiarize as part of the exercise already established, so there are no ‘no go’ areas.
b. While continuing the above, concentrate more on the genitals to discover the sensations resulting from different pressures and strokes in the different areas of the genitals.
c. This is an optional stage of mutual masturbation to orgasm.

Stage 3
a. Maintaining the ban on intercourse until 3c below, continue as before, and modify the process according to the wishes and pacing of each couple, to include genital contact. For heterosexual couples this is the experience of containment – allowing the penis to rest in the vagina.
b. Include genital contact with movement, gently thrusting or rotating.
c. This is thrusting to orgasm or full sexual intercourse.
Sensate focus exercises

• Reduce anxiety
• Improve sexual technique
• Reawake natural sensuality
• Eliminate goal-oriented approach
• Eliminate spectatoring
Cognitive behavioural therapy: The ABC Approach

- Antecedents lead to behaviour
- Behaviour leads to consequences
- Consequences here is FSD
- For consequence to be corrected, preceding antecedents and behaviours are to be analysed, identified, and corrected
CBT

- *It is a way of talking about:*
  - how you think about yourself, the world and other people
  - how what you do affects your thoughts and feelings

- Helps you change how you think (*Cognitive*) and what you do (*Behaviour*)
Gods come to rescue.....

• Goddesses of fertility
• Well-endowed bosoms
• Lord Krishna and gopis
• Draupadi
• Kama Sutra
• Dushyant & Shakuntala
• Shrgngara ras
Management issues: Orgasmic disorders

- Directed masturbation
- Erotic fantasization
- Mechanical aids
- Manual clitoral stimulation with partner
- Sesame oil with camphor
Mechanical aids

• Vibrators

• Clitoral therapy device

• Orgasm enhancers [1]

Management issues: Vaginismus

- Vaginal trainers
- Propranolol
- Anti-anxiety drugs
- Kegel’s exercises with dilators in-situ
- Coconut oil
Vaginal trainers
Management issues: Dyspareunia

• Diagnose stage:
  – Pain at external genitalia stimulation
  – Penile entry
  – Mid-vaginal pain
  – Deep vaginal stimulation

• Physical examination

• Treatment of cause
Management issues: Dyspareunia

• Antibiotics
• KY jelly
• Benzocaine gel
• Estrogen gel
• NSAIDs
FSD: Pharmacologic therapy

- Estrogen

- Transdermal testosterone (Intrinsa): 300 mg/d increases sexual desire, pleasure & orgasm

- L-arginine gel 5% (Wamup)

- PDE 5 inhibitors: Sildenafil ???
FSD: Pharmacologic therapy

- Antidepressants: Bupropion (? antidote for SSRI induced FSD)
- Apomorphine
- Yohimbine
- Tibolone
Never forget the partner

• Male sexuality is equally important

• Ensure that the partner is healthy

• Ensure financial, emotional, social health
Women’s sexual problems may be viewed as women not getting what they want........
What women want?

- Women want consensual & mutually satisfying sex
- Women want relationships
- Women want self love
- Women want time
- Women want sexual health and liberation
Best aphrodisiac?
How babies will be born in future
She is a Woman...
She is Life...
Our role

Ask!!!

Help

women realize
what they want......
Thank you

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