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Overview of Sexual Dysfunction in Women

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Sexual dysfunction includes painful intercourse, painful contraction (spasm) of the vaginal muscles, and problems with sexual desire, arousal, or orgasm that cause distress.

Depression or anxiety, other psychologic factors, disorders, and drugs can contribute to sexual dysfunction, as can the woman's situation, including relationship difficulties.

To identify a problem, doctors often talk to both partners separately and together, and a pelvic examination is often necessary when the woman has pain or problems with orgasm.

Improving the relationship, communicating more clearly and openly, and arranging the best circumstances for sexual activities can often help, regardless of the cause of sexual dysfunction.

Cognitive-behavioral therapy, mindfulness, or a combination of the two, can also help, as can psychotherapy.

About 30 to 50% of women have sexual problems at some time during their life. If the problems are severe enough to cause distress, they may be considered sexual dysfunction. Sexual dysfunction can be described and diagnosed in terms of specific problems, such as lack of interest or desire, difficulty becoming aroused or reaching orgasm, pain during sexual activity, involuntary tightening of the muscles around the vagina, or persistent and unwanted physical (genital) arousal. However, these distinctions are not always useful. Almost all women with sexual dysfunction have features of more than one such specific problem. For example, women who have difficulty becoming aroused may enjoy sex less, have difficulty reaching orgasm, or even find sex painful. These women and most women who have pain during sexual activity often understandably lose their interest in and desire for sex.

Normal Sexual Function

Sexual function and responses involve mind (thoughts and emotions) and body (including the nervous, circulatory, and endocrine systems). Sexual response includes the following:

Motivation is the wish to engage in or continue sexual activity. There are many reasons for wanting sexual activity, including sexual desire. Desire may be triggered by thoughts, words, sights, smells, or touch. Desire may be obvious at the outset or may build once the woman is aroused.

Arousal has a subjective element—sexual excitement that is felt and thought about. It also has a physical element—an increase in blood flow to the genital area. In women, the increased blood flow causes the clitoris (which corresponds to the penis in men) and vaginal walls to swell (a process called engorgement). The increased blood flow also causes vaginal secretions (which provide lubrication) to increase. Blood flow also may increase without the woman being aware of it and without her feeling aroused.

Orgasm is the peak or climax of sexual excitement. Just before orgasm, muscle tension throughout the body increases. As orgasm begins, the muscles around the vagina contract rhythmically. Women may have several orgasms.

Resolution is a sense of well-being and widespread muscular relaxation. Resolution typically follows orgasm. However, resolution can occur slowly after highly arousing sexual activity without orgasm. Some women can respond to additional stimulation almost immediately after resolution.

Most people—men and women—engage in sexual activity for several reasons. For example, they may be attracted to a person or desire physical pleasure, affection, love, romance, or intimacy. However, women are more likely to have emotional motivations, such as

To experience and enhance emotional intimacy

To increase their sense of well-being

To confirm their desirability

To please or placate a partner

Especially after a relationship has lasted a long time, women often have little or no desire for sex before sexual activity (initial desire), but desire can develop once sexual activity and stimulation begin. Desire before sexual activity typically lessens as women age but temporarily increases when women, regardless of their age, have a new partner. Some women may feel sexually satisfied whether they have an orgasm or not. Other women have much more sexual satisfaction with an orgasm.

Did You Know...

After women have been in a relationship a long time, they often have little or no desire for sex until sexual activity and stimulation begin.

Causes

Many factors cause or contribute to various types of sexual dysfunction. Traditionally, causes are considered physical or psychologic. However, this distinction is not strictly accurate. Psychologic factors can cause physical changes in the brain, nerves, hormones, and, eventually, the genital organs. Physical changes can have psychologic effects, which, in turn, have more physical effects. Some factors are related more to the situation than to the woman.

Psychologic factors

Depression and anxiety commonly contribute.

What Affects Sexual Function in Women?

Type	Factor
Psychologic factors	Abuse (emotional, physical, or sexual) during childhood or adolescence
	Anxiety
	Depression
	Fear of intimacy
	Fear of losing control
	Fear of losing the partner
	Low self-esteem
	Worry about inability to have an orgasm or about sexual performance in a partner
	Worry about unwanted consequences of sex (such as unwanted pregnancy or sexually transmitted diseases)
Situational factors	Cultural background that restricts sexual expression or activity
	Distractions
	Relationship problems
	Surroundings that are not conducive to sexual activity
Physical factors	Abnormalities in genital organs (such as scarring after surgery or radiation therapy)
	Atrophic vaginitis (thinning of tissues of the vagina)
	Changes in the skin around the opening of the vagina area (such as lichen sclerosus)
	Infections of the genital area (such as genital herpes) or of the vagina
	Fatigue
	Hyperprolactinemia (high levels of prolactin, a hormone produced by the pituitary gland)
	Poor health
	Surgical removal of both ovaries in premenopausal women
	Thyroid disorders
	Some nerve disorders, such as multiple sclerosis
Drugs	Alcohol
	Anticonvulsants
	Beta-blockers (used to treat hypertension or heart disorders)
	Certain antidepressants, particularly selective serotonin reuptake inhibitors
	Opioids

Previous experiences can affect a woman's psychologic and sexual development, causing problems, as in the following:

Harsh sexual or other experiences may lead to low self-esteem, shame, or guilt.

Emotional, physical, or sexual abuse during childhood or adolescence can teach children to control and hide emotions—a useful defense mechanism. However, women who control and hide emotions may have difficulty expressing sexual feelings.

If women lose a parent or another loved one during childhood, they may have difficulty becoming intimate with a sex partner because they are afraid of a similar loss—sometimes without being aware of it.

Various sexual worries can impair sexual function. For example, women may be worried about unwanted consequences of sex or about their or their partner's sexual performance.

Situational factors

Factors related to the situation may involve the following:

The woman's own situation: For example, women may have a low sexual self-image if they are having fertility problems or have had surgery to remove a breast, the uterus, or another body part associated with sex.

The relationship: Women may not trust or have negative feelings about their sex partner. They may feel less attracted to their partner than earlier in their relationship.

The surroundings: The setting may not be erotic, private, or safe enough for uninhibited sexual expression.

The culture: Women may come from a culture that restricts sexual expression or activity. Cultures sometimes make women feel ashamed or guilty about sexuality. Women and their partners may come from cultures that view certain sexual practices differently.

Distractions: Family, work, finances, or other things can preoccupy women and thus interfere with sexual arousal.

Physical factors

Various physical conditions and drugs may lead or contribute to sexual dysfunction. Hormonal changes, which may occur with aging or result from a disorder, can interfere. For example, the tissues of the vagina can become thin, dry, and inelastic after menopause because estrogen levels decrease. This condition, called atrophic vaginitis, can make intercourse painful. Removal of both ovaries can also have this effect.

Selective serotonin reuptake inhibitors, a type of antidepressant, commonly cause problems with sexual function.

Estrogen therapy, if taken by mouth, is sometimes used to control symptoms associated with menopause and may enhance sexual function in postmenopausal women by helping relieve atrophic vaginitis (see Menopause : Treatment). However, estrogen that is inserted into the vagina (vaginal estrogen) can be just as effective for treating atrophic vaginitis. Vaginal estrogen can be inserted as a cream (with a plastic applicator), as a tablet, or in a ring (similar to a diaphragm).

Did You Know...

Taking a selective serotonin reuptake inhibitor (a type of antidepressant) can interfere with sexual function, but so can depression.

Diagnosis

Diagnosis often involves detailed questioning of both sex partners, alone and together. Doctors ask about symptoms, other disorders, drug use, the relationship between the partners, mood, self-esteem, childhood relationships, past sexual experiences, and personality traits.

If women are experiencing pain, doctors do a pelvic examination. Doctors try to do this examination as gently as possible. They move slowly and often explain the examination procedures in detail. If the woman wishes, they may give her a mirror to observe her genitals, which may help her feel more in control. If she is fearful of anything entering her vagina, she can

place her hand on the doctor's to control the internal examination. To diagnose sexual problems, doctors usually do not need to use an instrument, such as a speculum, to do the internal examination.

However, if doctors suspect a sexually transmitted disease, they insert a speculum into the vagina to spread the walls of the vagina apart (as done during a Papanicolaou, or Pap, test) and take a sample of fluids from the vagina. They examine the sample for organisms that can cause sexually transmitted diseases and may send a sample to a laboratory, where the organisms are grown (cultured) to make identification easier.

Treatment

Certain treatments depend on the cause of dysfunction. However, some general measures can help regardless of the cause:

- Making time for sexual activity: Women, who are used to multitasking, may be preoccupied with or distracted by other activities (involving work, household chores, children, and community). Making sexual activity a priority and recognizing how counterproductive distractions are may help.
- Practicing mindfulness: Mindfulness involves learning to focus on what is happening in the moment, without making judgments about or monitoring what is happening. Being mindful helps free women from distractions and enables them to pay attention to sensations during sexual activity by staying in the moment. Resources for learning how to practice mindfulness are available on the Internet.
- Improving communication, including about sex, between the woman and her partner
- Choosing a good time and place for sexual activity: For example, late at night—when a woman is ready for sleep—is not a good time. Making sure the place is private can help if the woman is afraid of discovery or interruption. Enough time should be allowed, and a setting that encourages sexual feelings may help.
- Engaging in many types of sexual activities: For example, stroking and kissing responsive parts of the body and touching each other's genitals enough before initiating intercourse may enhance intimacy and lessen anxiety.
- Setting aside time together that does not involve sexual activity: Couples who talk to each other regularly are more likely to want and enjoy sexual activity together.
- Encouraging trust, respect, and emotional intimacy between partners: These qualities should be cultivated with or without professional help. Women need these qualities to respond sexually. Couples may need help learning to resolve conflicts, which can interfere with their relationship.
- Taking steps to prevent unwanted consequences: Such measures are particularly useful when fear of pregnancy or sexually transmitted diseases inhibits desire.

Just becoming aware of what is required for a healthy sexual response may be enough to help women change their thinking and behavior. However, more than one treatment is often required because many women have more than one type of sexual dysfunction.

Psychologic therapies help many women. For example, cognitive-behavioral therapy can help women recognize a negative self-view that results from illness or infertility. Mindfulness-based cognitive therapy (MBCT) combines cognitive-behavioral therapy with the practice of mindfulness. As in cognitive-behavioral therapy, women are encouraged to identify negative thoughts. Women are then encouraged to simply observe these thoughts and to recognize that they are just thoughts and may not reflect reality. This approach can make such thoughts less distracting and disruptive. More in-depth psychotherapy may be needed when issues from childhood are interfering with sexual function.

Because selective serotonin reuptake inhibitors (SSRIs) may contribute to several types of sexual dysfunction, substituting another antidepressant that impairs sexual response less may help. Such drugs may include bupropion, moclobemide, mirtazapine, and duloxetine. Also, taking bupropion with an SSRI may be better for sexual response than taking the SSRI alone. Some evidence suggests that if women stopped having orgasms when they started taking SSRIs, sildenafil may help them have orgasms again.