

Women's Sexual Response and Dysfunction: A Reappraisal

By moving away from the concept that conscious sexual desire (neediness or hunger) needs to be present to allow rewarding sexual experiences, an alternative model of women's sexual response allows clarification of the common complaint of low desire.

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The traditional model of human sexual response, based on the research of Masters, Johnson and Kaplan, depicts sexual desire as initiating a linear sequence of events: arousal (erection/lubrication), a plateau of arousal, orgasm(s) and resolution.

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When women are asked why they are sexual, however, many reasons over and beyond the relief of sexual hunger or need emerge:¹⁻³ They include:

- To feel emotionally closer, more committed and bonded;
- To feel loved, wanted and attractive;
- To share the sexual feelings mostly for the sake of the sharing;
- To show affection, caring and attraction;
- To give and show the partner has been missed; and
- To show an argument is over.

These intimacy-based reasons are particularly prominent for women in longer-term relationships.

Case Study

Jenny is 41 years old, and complains of having low sexual desire since the birth of her children, who are now eight and 10. She describes her marriage as “fine.” The children are not causing problems, and her husband, Bob, is a good father and a considerate person. Jenny is not clinically depressed, has no history of depression and takes no medications. Her general health is fine, with regular periods. She has a busy part-time job which she enjoys.

Jenny denies any spontaneous sexual thinking, need to masturbate or having anything other than the very occasional sexual dream. None of this has changed throughout her adult life. She does not fantasize about anything — sexual or otherwise. She confirms she does not have spontaneous sexual wanting, which is the reason she is asking for help. Jenny states she does not get aroused, but is not aware of any need to add extra lubrication when she has intercourse. Orgasm is usually not experienced, but when you suggest that not being able to achieve orgasm may be a reason she has lost desire, Jenny corrects you. She feels she probably could reach orgasm, but usually does not put in the necessary focusing and effort required to reach that point. She reminds you she does not have the desire. Jenny confirms there has been no dyspareunia.

Her history is familiar, but difficult to manage. She is not speaking about loss of the traditional markers of sexual desire, such as sexual thinking, fantasizing or masturbating, which dominate the definition of hypoactive sexual desire disorder in the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV). She is speaking of little desire to be sexually active with her partner ever since the birth of her children and also of low sexual arousal and not experiencing orgasms. Even her diagnosis is uncertain.

Other more problematic reasons may include trying to keep a relationship, to comply with peer pressure, to do what is expected, to “keep the peace” or to provide a service. These less healthy reasons typically are associated with minimal arousal and satisfaction for women.

Community studies suggest over 40% of women have problematic sexual function, with 30% to 39% complaining of low sexual desire.^{4,5} While it would be incorrect to state that 40% of women have any “disorder,” the figures of self-diagnosed dysfunction are both remarkable and puzzling. If almost 50% of women feel substandard/abnormal, how accurate is the perception of “normal” female sexual response? To help our patients with perceived low desire and

lack of arousal, we need to understand the experience of desire and arousal in women who are satisfied with their sexual lives.

Alternative Sex Response Cycle

How does the sexual response unfold if, initially, there is little or no specifically sexual hunger? How does the woman become aroused? Sexual stimuli within the appropriate context/atmosphere are integral to the response cycle (Figure 1). For the previously listed intimacy-based reasons the woman is willing to find or be receptive to sexual stimuli that can potentially arouse her mind and body. Many psychologic and a few biologic factors may pre-

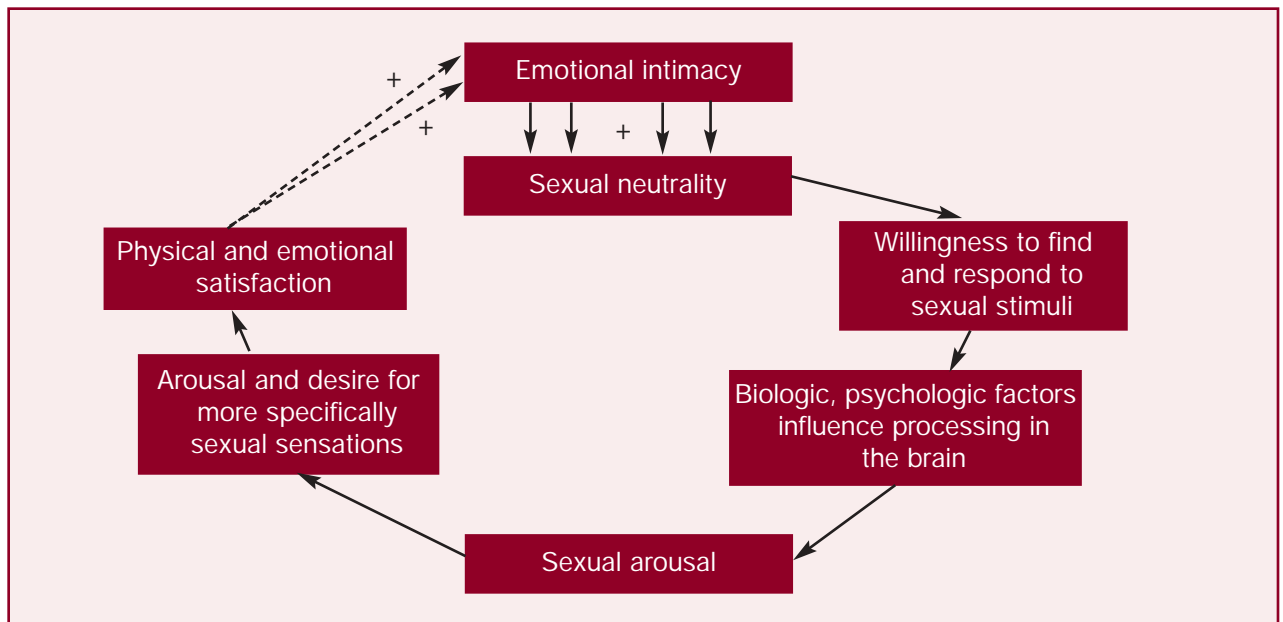


Figure 1. Intimacy-based cycle: desire is accessed during the experience.

clude that arousal.

Psychologic factors include: a large number of non-sexual distractions; negative sexual self-image; past negative experiences (*e.g.*, abuse); tendency to be self-critical and monitor one's own performance; tendency not to experience emotions of any sort, often stemming from childhood losses and traumas; fear of pain; fear of infertility; and a perceived lack of safety (*e.g.*, physical, emotional, safety from sexually transmitted diseases, unwanted pregnancy).

Biologic factors that may preclude arousal include: depression; side effects of medication; fatigue from poor sleep or chronic illness; and occasionally, a loss of all ovarian androgen; hypopituitary disorders with loss of ovarian and adrenal androgen; hyperprolactinemia; and hypothyroidism.

Sexual Arousal and Accessed Sexual Desire

Providing biologic and psychologic factors per-

mit, sexual arousal will be accessed. If it is enjoyed, and if the stimulation continues and the woman remains focused, further arousal will follow. This may be accompanied by sexual desire to continue these opacifically sexual feelings and experience arousal more intensely.

Outcome

Providing the outcome is positive (no dyspareunia, no criticism, no partner dysfunction), the woman's original goal to be emotionally closer and her acquired goal to experience more sexual sensations will both be achieved. She may or may not experience one or multiple orgasms.

Is the Model Accurate?

Many of the author's colleagues, using this model over the past few years, find it does reflect women's experiences. Many women, while sexually healthy and satisfied, agree they frequently begin a sexual experience sexually neutral. There



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are not discreet phases occurring in a linear sequence. Sexual desire and arousal do occur together. Women (and their doctors) find it very difficult to distinguish between hypoactive sexual desire and arousal disorder. Similarly, female arousal disorder usually (but not always — witness the typical side effects of selective serotonin reuptake inhibitors), accompanies female orgasmic disorder. Women agree that, especially in longer-term relationships, emotional intimacy is vital to their ongoing sexual desire.

Where Does Spontaneous Desire/Innate Sexual Hunger Fit In?

An apparent spontaneous sexual neediness is experienced, typically, early in relationships, or perhaps mid-cycle, or when the partners have been separated, or, quite irregularly, without any pattern. This is sometimes more noticeable if the woman is single. Likely, this can augment an intimacy-based cycle, as shown in Figure 2. This apparently spontaneous desire reinforces the woman's motivation to find and be receptive to stimuli, facilitates her eliciting arousal and can lead directly to the state of arousal.

Is The Model Useful For Managing Common Sexual Problems?

Chronic dyspareunia

This condition can lead to many breaks in a woman's sex response cycle. A common scenario is that the original problem, namely the pain experienced when attempting intercourse, is superseded by the patient's subsequent distress about her current lack of desire and difficulty getting aroused. By clarifying the effects of a painful outcome on the various components of her intimacy-based cycle, the patient will not only see the logic to her current situation, but also accept the need to address entities over and beyond the relief of her pain.

Both partners often will admit their emotional intimacy has been progressively diminished because of each painful sexual experience. Subsequently, the patient avoids any sexual stimuli. Sadly, it is rare for a couple to actually avoid all pain and omit intercourse from their experiences, even though this is the logical adaptation.

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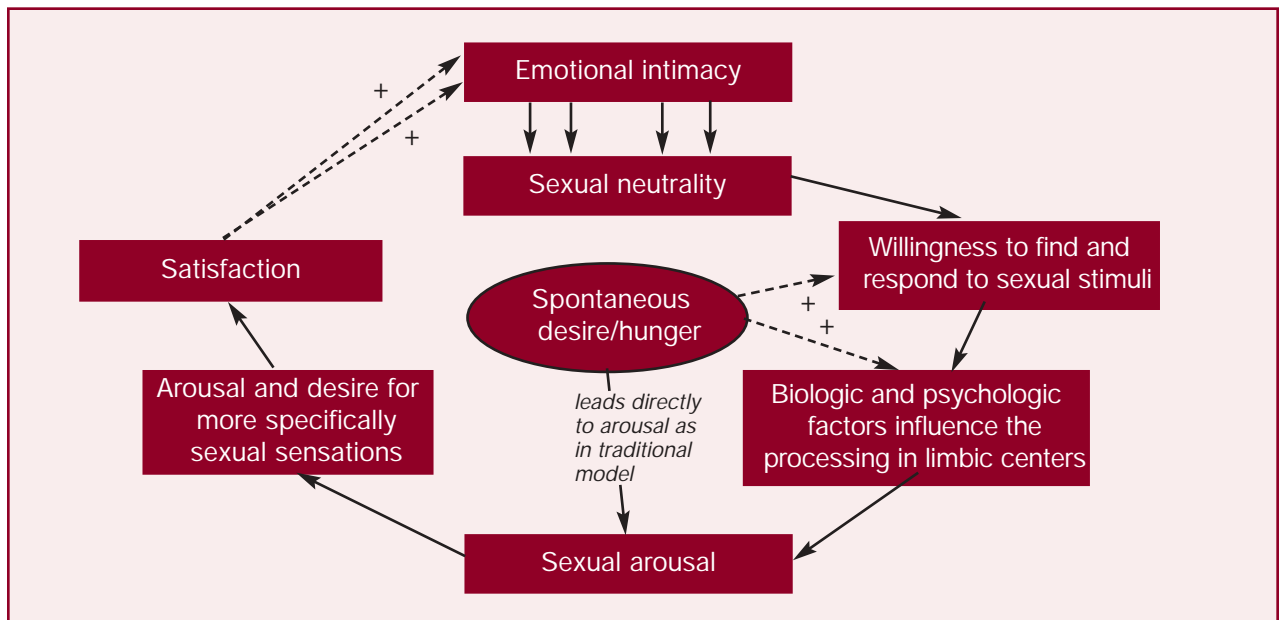


Figure 2. Blended intimacy-based and sexual desire-based cycles. Note that any spontaneous desire can augment the intimacy-based cycle.

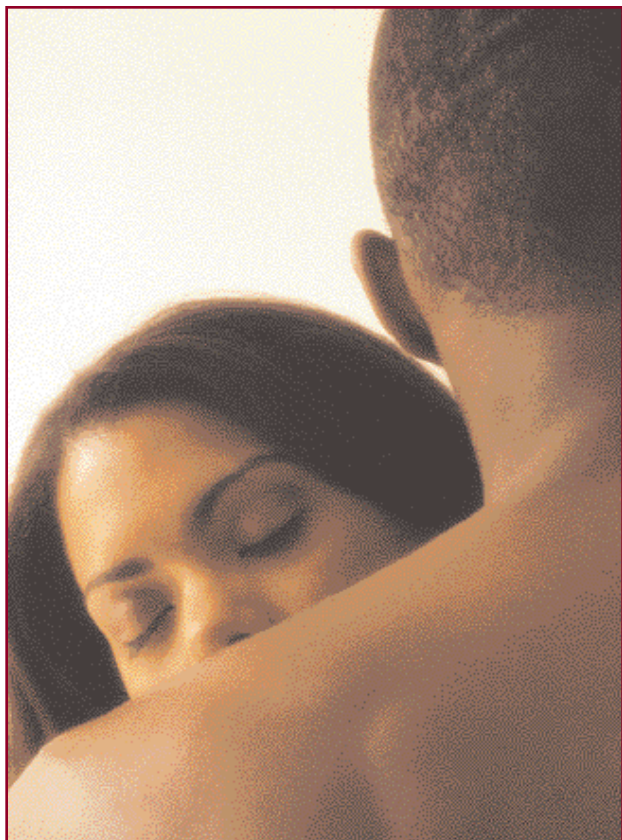
issues, including her fractured emotional intimacy with her partner, her learned avoidance of sexual stimuli and the need to entirely remove the possibility of pain by temporarily excluding intercourse from her sexual experiences. It is reintroduced only when the underlying condition (*e.g.*, vestibulitis, estrogen deficiency, endometriosis) has been addressed.

Sudden loss of ovarian androgen

Such a loss can lead to many breaks in the patient's cycle. Not only does testosterone nurture any spontaneous desire, but it influences the processing of the stimuli in the mind. It also is involved in the genital smooth muscle relaxation needed for vasocongestion. After a sudden, premature, surgical or chemotherapy-induced menopause, experiences may become unrewarding. This leads to a distancing of the two partners and avoidance of the very stimuli the woman needs, given that she now has very little spontaneous desire.

A recent study of transdermal testosterone replacement in women with lack of sexual desire and sexual response in association with a previous bilateral oophorectomy showed benefit only in the subgroup of women who were both older and achieved high-normal (as opposed to mid-normal) premenopausal testosterone levels.⁶ The management of these women's fractured cycles was limited to testosterone replacement only.

Negative repercussions for the emotional intimacy of couples going through lengthy fertility testing is clear to clinicians working in that area. Fears of irreversible infertility, personal contribution to that infertility, stress from the many investigations and the waiting and disappointment of each menstrual period (proving failure of the past month's conception attempt) all take their toll. Sexual contact for the sake of pleasure and intimacy often stops, the focus being on intercourse for reproductive reasons. Unfortunately, these patterns of intercourse-focused sex, with min-



Many times, there is nothing innately dysfunctional about a patient, but there may be problems with the context within which she attempts to be sexual.

imal pleasure for either partner, often continue even after the attempts of conception are over. Addressing low desire (in either partner) will require attention to all sites in the responsive cycle. The focus of therapy often is the woman's self-image, which may become extremely vulnerable during the investigations and subsequent fact of infertility.

Does The Model Provide The Framework For Assessing

Complaints of Low Desire?

The model allows the following clinical inquiries:

- The adequacy of sexual stimuli and sexual context;
- The ability to respond to sexual cues and sexual context — psychologic factors precluding processing stimuli into arousal and biologic factors precluding processing stimuli into arousal;
- The motivation: state of emotional intimacy and the presence of other motivations;
- Outcome of the sexual experience; is there a negative outcome despite arousal (*e.g.*, dyspareunia, partner dysfunction, medication effect); and
- Change in any apparent “spontaneous” desire over and beyond a normal, gradual decrease in desire with relationship duration.

What Do Women Mean By Sexual Arousal?

Typically, physicians equate women's sexual arousal with vaginal wetness. Yet, they know postmenopausal women not receiving estrogen supplementation can be perfectly aroused, but experience no lubrication at all. Women's sexual arousal is quite complex and includes the following:

- Subjective sexual arousal (composite);
- Genital throbbing, tingling and fullness;
- Increasing pleasure from direct stimulation of engorging genital structures;
- Increasing pleasure from direct stimulation of engorging breasts;
- Vaginal lubrication and vaginal tenting; and
- Changes of muscle tension, blood pressure, heart rate and respiratory rate.

It is important to note that, especially at fairly low levels of arousal, the subjective experience correlates poorly with direct measurement of genital congestion. Typically, women com-

plaining of arousal disorder claim no subjective arousal while viewing an erotic video, however, their genital response appears to be healthy. The latter can be detected by means of a vaginal plethysmograph, which measures the accumulation of blood in the vagina. These women's responses are identical to those of sexually healthy women who are subjectively aroused by the erotic video.⁷ Researchers can augment the physiologic congestion, for instance, with a sympathomimetic drug, but this does not augment the subjective experience of arousal.⁸

Women seem to determine subjective arousal mainly by how exciting they find the stimulus. So when patients are complaining of a lack of arousal, the physician must distinguish those who are speaking about a lack of subjective arousal and not finding the stimulus mentally exciting from those who are mentally excited, but who mourn the fact the vulva does not swell and vulval stimulation no longer feels pleasurable. Only the latter subgroup could potentially be helped by future vasoactive medications.

Conclusion

By moving away from the concept that conscious sexual desire (neediness or hunger) needs to be present to allow rewarding sexual experiences, and that its absence or rarity in women constitutes a disorder, we allow the development of a model that appears to accurately reflect women's sexual experiences (especially when they have been with the same partner for many years). Sharing this model with the patient allows for clarification of a complaint of low desire. She then can see the sites of weakness and may choose to address them. The logic of the situation itself is therapeutic. With relief, the patient realizes that another woman with the same somewhat tenuous emotional intimacy, a similar

number of non-sexual distractions on her mind and the same tendency to focus on her partner's pleasure rather than her own, would also likely complain of low sexual desire. There is nothing innately dysfunctional about such a patient, but there are many problems with the context within which she attempts to be sexual.

CME

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