Treatment Of Female Sexal Dysfunction By A Clinical Sexologist

By Deborah Caust, Ph.D., LMFT

In any given week, only about 5-10% of patients seen in my office are single or married women who are either self- or physician-referred for treatment of sexual dysfunction. This is surprising, given that my practice has been devoted solely to the treatment of sexual dysfunction and intimacy concerns for over twenty years. Is it possible that women are satisfied with their sex lives?

Not likely. According to a University of Chicago study, 43% of women report that they suffered from a sexual dysfunction within the previous twelve months. If roughly half of women are experiencing a problem, why are they not seeking sex therapy? Perhaps the answer lies in women's tendency to perceive sexual problems differently from men. Whereas men are likely to seek out medical or psychological help when their body does not "perform" as expected sexually, women seem to accept sexual problems as a natural consequence of their lives. They rarely expect to have a satisfying sex life and are unsure how to define one for themselves.

What Sexual Dysfunctions Affect Women?

According to Dr. Tom Lue, co-chair of the Sexual Health Council of the American Foundation for Urologic Disease, there are roughly four categories of women's sexual dysfunctions. They are: lack of sexual desire or interest, the inability to become sexually aroused, difficulty reaching orgasm, and painful intercourse or dyspareunia.

Unfortunately, sexual dysfunctions are rarely constructed so discretely in women. Typically, women present with a variety of interconnected sexual concerns superimposed on complex social and emotional relationships.

Three Cases: A Brief Synopsis

Vicky, 28, and Tom, 35, have been married less than a year. Vicky is unable to have an orgasm under any circumstances; in fact, she reports that she has never enjoyed sex with Tom, or anyone else, because of vaginal pain. Vicky is extremely shy about her slim body and feels inhibited at Tom's touch. She desperately wants to enjoy sex with her husband.

Together for ten years, Patty, 45, and Robert, 60, were referred by Robert's physician for treatment of erectile difficulty. During assessment, it was learned that Patty has never had an orgasm with Robert but can on her own. She thinks she could reach an orgasm manually with Robert if she felt comfortable expressing to him how to touch her effectively, however, Patty is rarely assertive.

Hilda, a single woman of 34, suffers from vaginismus (involuntary tightening of the external vaginal musculature) making intercourse impossible. Her gynecologist referred her for sex therapy after a difficult pelvic exam. Hilda believes that her issues are a result of sexual abuse, which she is unable to recall. She reports that she feels very sexual and achieves orgasm easily through masturbation.

Making an Assessment

In the first session with a new client, an assessment is made to determine probable diagnoses. Sexual symptoms are assessed for initial occurrence, nature and course of the problem over time, circumstances under which symptoms occur, client's concept of the problem and theoretical explanation of etiology, and previously sought medical and psychological treatment. An in-depth sociosexual history follows to determine other factors which may play a part in the presenting problem. Special attention is given to psychogenic issues such as fear of abandonment or rejection, lack of trust, inability to communicate openly with one's partner, difficulty relaxing, underlying or significant depression or anxiety, commitment concerns, fear of intimacy, etc. Developmental issues such as age and life stage (ex. newly married, retired, pregnant) must also be considered.

It is usually necessary to refer the patient to a physician as part of diagnostication, especially if there is suspected physiogenic etiology. Such concerns as depression or anxiety; medical type (i.e.. Anti-depressants, anti-hypertensives) and dosage; alcohol and other recreational drug use; gynecologic or urologic difficulties; medical conditions such as diabetes, hypo or hyperthyroidism; hormonal imbalances; and over-the-counter medicines (especially those used for stomach, allergy and eye disorders) usually signal referral to a physician who is specifically trained in sexual health. It is also necessary to assess for overuse of cigarettes or caffeinated drinks as these may also directly affect sexual functioning.

Sex Therapy

Diagnoses form the basis for setting concrete goals. For example, in the first case study above, preliminary diagnoses of inorgasmia and dyspareunia were determined for Vicky. These diagnoses were considered within the context of young newlyweds with inhibited communication. As a result, sex therapy was utilized in conjunction with psychotherapy to work on relationship issues.

Effective treatment is usually short term and problem focused. Typically, clients are assigned a series of exercises to do at home in addition to psychotherapy in the office. These may be standardized, such as Masters and Johnson's famous sensate focus exercises (for loss of sexual desire or difficulty getting aroused) or tailor made for the couple.

In the second case study, Robert's erectile dysfunction was treated with "get it and lose it" a standard exercise created by Bernie Zilbergeld. Two programs were selected and combined to help Patty become more reliably orgasmic. A bridging maneuver was designed to help Robert touch Patty more effectively. The turning point, however, was teaching Patty to assert herself interpersonally.

Regarding a Woman's Sexual Self

To work with a woman, it is necessary to consider her whole person. A woman's sexuality lies within her concept as a woman and in her relationship to her partner. How does she feel about herself as a sexual person? Does she have good self esteem; does she feel she deserves a satisfying sex life? How and when did she develop her erotic sensibilities?

Men and women develop gender-based differences in their sexual selves. As Jessie Potter, DHS, a well known sexologist, used to say: "Women have privates, men have publics." Men are bombarded with sexual information and acceptance from birth. Their sexuality may have to do with the public nature of their genitalia as well as society's view that men are, by nature, sexual. This is in contrast with a woman's sense of herself in which her sexuality is usually kept private, even from her partner. For most women, letting a partner know how to touch them, much less that they are sexual, remains taboo unless special care is given early in a woman's life to let her know this information is important and desirable.

Sadly, it has been estimated that one in every three to four women has been the victim/survivor of some form of unwanted sexual contact before the age of 18. Such difficult experiences may determine a woman's lifelong sexual values and beliefs and the selective lens through which she perceives her sexual partner. This may have been the case with Hilda, who has become physically incapable of being penetrated. Treatment with Hilda was slow and methodical. Much care was taken to help Hilda develop positive feelings about her sexuality as she learned to relax her vaginal musculature. She was eventually able to achieve and enjoy penetration.

Clinical experience shows that there are other concerns that effect women more than men. These include concerns about physical appearance, body self-consciousness, ability to maintain differentiation from a sexual partner, presumptions and expectations about the "right" things to do sexually, being able to say yes when something is wanted or no when it's not, communicating needs in the moment, fear of being perceived as too sexual, or not enough, being able to fully relax, and loving oneself.

Working with a Sex Therapist

Nearly all of my female clients report that they have not been able to tell their physician or psychotherapist about their sexual concerns. How can you, as a physician help these women? Presume that roughly fifty percent of the women you see in your practice have a problem. Rather than asking *if* there is a problem, ask presumptively what they would like to improve in their sex life.

If you need to refer, work with a qualified sex therapist. Look for a professional with a specific certification such as those provided by AASECT, The American Association of Sex Educators, Counselors, and Therapists, or AACS, the American Association of Clinical Sexologists. Here in the Bay Area, we have resources such as San Francisco Sex Information or the Institute for Advanced Study of Human Sexuality which maintain resource lists for referral. Meet with the therapist to see how comfortable you are and ask for a resume.

Ask whatever questions necessary to feel confidence in the sex therapist. Follow up with your patients to make sure that they are satisfied. Most importantly, extend yourself to the therapist so he or she knows that you are available for consultation and support.

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