# Female Sexual Dysfunctions 10

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## 10.1 Introduction

Female sexual health and female sexual dysfunctions have specific characteristics, which have to be taken into account when it comes to counseling and therapy:

- Sexual dysfunctions are intimately linked to the life phase of the woman. Adolescence, pregnancy, postpartum, and peri- and postmenopause have specific somatic and psychosocial challenges and demands regarding adaptation to these changes.
- Sexual dysfunctions of women are typically not distinct entities affecting only one part of the sexual response cycle, but rather there is a considerable degree of overlap and interrelation, which contributes to vicious circles and feedback effects intensifying the symptoms.
- Sexual function in women is highly context sensitive and thus vulnerable to relationship and sociocultural inhibiting factors.
- Sexual health of women is highly vulnerable to psychiatric disorders such as affective disorders like depression and anxiety. Women are more affected by these disorders compared to men.

These characteristics have implications for diagnosis and therapy of the different dysfunctions described below [1].

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## 10.2 Female Sexual Interest/Arousal Disorder

### 10.2.1 Definitions and Epidemiology

What is sexual desire and arousal—and what our patients perceive as sexual desire and arousal—often requires clarification. For many years, scientists described sexual desire as an innate urge that *triggers* sexual activity. This urge or drive was indicated by sexual thoughts and fantasies. This view, which is depicted in the previous DSM-IV definition of hypoactive sexual desire disorder, largely determined relevant clinical diagnosis and research. This view however was challenged when Rosemary Basson, a Canadian psychiatrist, presented data suggesting that sexual desire can be experienced at the beginning of the sexual response, but it can also be experienced *during* sexual activity *as the result* of *pleasurable* sexual *stimulation* [2]. This was termed "responsive desire," and today there is plenty of data showing that a considerable number of women from the general population agree to engage in sexual activity without necessarily feeling spontaneous desire [3, 4]. However, they may experience responsive desire *after* they start feeling pleasure/arousal from the available stimulation. A question that attracted research attention and is clinically relevant is the following: What is it that makes some women agree to engage in sexual activity when sexual desire is not the trigger? The role of *motivation* to engage in sexual activity has been emphasized. Data have shown that some women's motivation for sexual activity varies largely; it is often non-sexual in nature; it may be positive (to gain something) or negative (to avoid a negative experience) [5]. From the above, it is evident that our perception of sexual desire as a *state* experienced at the initial phase of the sexual response has shifted to a perception of desire as a *dynamic experience*, closely related to the appraisal of the available sexual stimuli, to the experience of sexual pleasure, and to one's motivation to engage in sexual activity [6]. In clinical practice, it is useful to think of desire as consisting of three components: drive, expectations/wishes, and motivation [7]. Drive refers to the biological component of sexual desire. Expectations/wishes refer to the cultural component of desire that is shaped by beliefs and values about sex. Motivation refers to the willingness to have sex and is shaped by psychological and relational factors.

Sexual arousal refers to a woman's experience of genital arousal: i.e., genital vasocongestion, lubrication, and tingling. A woman's feeling of genital and emotional arousal is self-reported and usually termed subjective sexual arousal [8]. It is not clear how much of one's perceived emotional arousal is explained by perceived genital arousal and vice versa, but these have been found to be positively correlated [9]. However, a woman's subjective sexual arousal does not always coincide with genital arousal as measured by objective measures, such as the vaginal photoplethesmography [8].

A broader view of desire, referring not only to sexual thoughts and fantasies but also to "interest in sexual activity," "receptivity to partner's attempts to initiate sexual activity," and *responsive sexual desire*, i.e., interest in response to sexual cues (internal or external), is reflected in the new criteria of the DSM-5 [10]. The DSM-5

definition not only does acknowledge the strong interplay between desire and arousal but actually moves a step further to merge the two disorders into one (see Table 10.1) [10].

Female sexual desire disorder is now merged with sexual arousal disorder in one new disorder named female sexual interest/arousal disorder (SIAD). However, the fourth International Consultation on Sexual Medicine (ICSM) decided that merging the two disorders is not based on sufficient evidence and that the available research evidence supports the separation of the two disorders [11]. In addition, although some women experience both desire and arousal problems, others experience one of the two (e.g., a woman that feels desire to have sex; but once she engages in sexual activity, her feeling of arousal is low). A similar view is adopted by the ICD-11 that defines hypoactive sexual desire as a separate condition to female sexual arousal dysfunction (12) [12]. Both the DSM-5 and the ICD-11 acknowledge the importance of the problem being present for several months and causing significant distress in order to receive a diagnosis of a disorder. When a woman's low sexual arousal or sexual desire does not cause distress, then it is called a sexual desire or arousal *problem* instead of a *disorder*. In addition, the disorder can be acquired or lifelong and generalized or situational (for a description, see Table 10.2).

Although the majority of data on epidemiology, risk factors, and treatments have until today considered desire problems as separate to arousal problems, this chapter will present them together, because in clinical practice their interplay must always

**Table 10.1** Definitions of desire and arousal disorder according to DSM-5 and ICD-11

| *DSM-5* |
|---|
| *Female sexual interest arousal disorder (FSIAD)* |
| Lack of or significantly decreased sexual interest or arousal is manifested by at least three of the following characteristics: (1) absent or decreased interest in sexual activity; (2) absent or decreased sexual or erotic thoughts or fantasies; (3) no or decreased initiation of sexual activity and typically unreceptive to a partner's attempts to initiate; (4) absent or decreased sexual excitement or pleasure during sexual activity in almost all or all sexual encounters; (5) absent or decreased sexual interest or arousal in response to any internal or external sexual or erotic cues or absent or decreased genital or non-genital sensations during sexual activity in almost all or all sexual encounters |
| *ICD-11* |
| *Hypoactive sexual desire dysfunction* |
| Characterized by absence or marked reduction in desire or motivation to engage in sexual activity as manifested by any of the following: (1) reduced or absent spontaneous desire (sexual thoughts or fantasies); (2) reduced or absent responsive desire to erotic cues and stimulation; or (3) inability to sustain desire or interest in sexual activity once initiated |
| *Female sexual arousal dysfunction* |
| Characterized by absence or marked reduction in response to sexual stimulation in women, as manifested by any of the following: (1) absence or marked reduction in genital response, including vulvovaginal lubrication, engorgement of the genitalia, and sensitivity of the genitalia; (2) absence or marked reduction in non-genital responses such as hardening of the nipples, flushing of the skin, increased heart rate, increased blood pressure, and increased respiration rate; (3) absence or marked reduction in feelings of sexual arousal (sexual excitement and sexual pleasure) from any type of sexual stimulation |

**Table 10.2** Specifiers of sexual dysfunctions

| | |
|---|---|
| Acquired | The problem was present after a period of relatively normal sexual function |
| vs | |
| Lifelong | The problem was present since first sexual encounters |
| Generalized | The problem is not limited to certain types of situations, stimulation, or partners |
| vs | |
| Situational | Occurs only with certain stimulation, situations, or partners |

be considered during the assessment. Subsequently, treatment should be adjusted to the needs of the patient. Sometimes treatment would focus on desire, sometimes on arousal, and sometimes on both.

Out of all female sexual dysfunctions, sexual desire problems are the most frequently reported followed by arousal and orgasm problems. Prevalence rates of low sexual desire range from 17 to 35% in most studies but reach 40–50% in samples of women older than 65 years. Data on the prevalence of arousal disorders usually report the frequency of genital arousal disorder and lubrication problems, and in most studies, these range between 21 and 28% [13]. However, the prevalence rates of desire and arousal problems when they are combined with distress have much lower prevalence rates, especially in the older age groups [14].

### 10.2.2 Pathophysiology

Sexual motivation and arousal can best be understood as a dynamic state in which enhancing and inhibitory factors interact, and this interaction determines the degree of subjectively experienced desire and arousal [15].

On the level of the brain, the main inhibitory "messengers" are serotonin (5-HT), endocannabinoids, and opiates, whereas sexual excitation involves other neurochemicals such as oxytocin (OXT), norepinephrine, dopamine, and the melanocortin system.

Sex steroids (estrogens, progestogens, and androgens) exert organizational and activational effects and prime the brain to be selectively responsive to sexual incentives. With proper functioning, this creates a neurochemical state more likely to induce sexual excitation than sexual inhibition [16]. (See also Chap. 7 for more details on the neurophysiology of sexual response.)

Pathophysiological changes can be understood as either a decrease in excitatory impulses or an increase in inhibitory signaling.

Somatic inhibitory signals can come from:

- Disorders affecting the peripheral sensory system (urogenital diseases, operations, pain conditions, endocrine disorders, etc.)
- Neurologic and psychiatric diseases and drug effects on the brain

Somatic decrease of excitatory signaling is mainly due to endocrine changes:

- Menopause and postpartum
- Hormonal treatments

Psychosocial inhibitory signals come from:

- Sexual life experiences associated with anxiety, shame, and regret

Psychosocial decrease of excitatory signaling is mainly due to:

- Habituation and lack of external stimuli

### 10.2.3 Assessment

The diagnostic procedure should always include sexual, medical, and psychosocial history. The need for a focused clinical evaluation is highly recommended [17]. Clinical evaluation is important to assess changes of the vulvovaginal region including assessment of pelvic floor function.

Inspection of the vulva and vagina is important for signs of vulvovaginal atrophy. Other dystrophic changes may cause pain and discomfort and lead to secondary arousal and desire disorder. Laboratory examinations are rarely necessary. Laboratory assessment of ovarian and other hormones is rarely needed because serum values vary largely, and the main parameter of hormone deficiency is clinical symptoms like hot flashes, irritability, sleep disorders, and symptoms of genitourinary syndrome.

*Sexual history* A sexual history should help the physician define the problem of sexual desire and/or arousal. A woman complaining of low desire must always be assessed for arousal, and vice versa. Questions to identify signs of sexual urge and signs of responsive desire and identification of the woman's motivation to engage in sexual activity would all give a good description of a women's desire problem. Questions on the experience of subjective arousal and physical arousal would help describe the arousal problem. The duration of the problem, the available stimuli, and the context of sexual encounters, and whether it is generalized or situational and lifelong or acquired should always be part of the sexual history (for a description of indicative questions, see Table 10.3).

*Medical history* A medical history includes:

- Reproductive life phase (adolescence, postpartum, peri- and postmenopause)
- Menstrual disorders (heavy menstrual bleeding, dysmenorrhea, etc.)
- Gynecological and urological disorders (endometriosis, PMS, PMDD, polycystic ovary syndrome, recurrent cystitis, incontinence, prolapse)

**Table 10.3** Indicated questions to assess a woman's sexual desire and arousal

| The following questions should be used in order to |
|---|
| 1. Identify *signs of sexual urge*<br>– Do you sometimes feel an innate urge to initiate a sexual experience?<br>– Do you have erotic dreams, sexual thoughts, or sexual fantasies? (however, many women who are satisfied with their sexual life do not have sexual fantasies, or they use them deliberately in order to increase arousal)<br>– Do you sometimes feel like masturbating and pleasing yourself? |
| 2. Identify signs *of responsive desire*<br>– Do you ever feel sexual desire after you've received sexual stimulation?<br>– Once sexual activity is initiated and you start receiving pleasurable sexual stimulation, do you feel like wanting to continue? |
| 3. Describe the woman's *motivation for sex*<br>– When you engage in sexual activity, what is your motivation for that?<br>– What comes in your mind when your partner invites you for sexual activity? |
| 4. Assess the relative *distress* caused by low desire<br>– Why is low desire a problem for you?<br>– Does your partner think this is a problem?<br>– How have you and your partner been coping with the problem?<br>– Do you feel *pressure* (imposed by self or by partner)? |
| 5. Identify *variance* of sexual desire<br>– "'Some women do not feel desire to have sex with their partner, but they do feel desire in other occasions, for example, when they are on their own or during self-stimulation or with another partner. Have you experienced something similar?" The first part of the question aims to neutralize masturbation and extramarital sexual activity in order to help a woman talk about such experiences. In many countries, women still don't feel comfortable to admit that they masturbate or that they have extramarital sexual activity |
| 6. Identify signs of subjective *sexual arousal*<br>– Once you engage in sexual activity, do you feel pleasure? Do you enjoy it (independently of whether you reach orgasm)?<br>– If 10 is ultimate pleasure and 0 is a feeling of aversion, how would you rate your sexual experiences?<br>– Out of 10 occasions of sexual activity, how many would you say are satisfying?<br>– Some women don't feel sexual arousal from sexual activity with a partner but may feel arousal from self-stimulation or sexual activity with another sexual partner. Do you have a similar experience? |
| 7. Identify signs of *physical arousal*<br>– Once you have received sexual stimulation, do you feel wet/lubricated, throbbing, warmth, tingling, etc.?<br>– Do you feel that other parts of your body are aroused?<br>– Do you sometimes feel genital pain or irritation? If yes, which came first, pain or (lack of) desire/arousal?<br>– Do you experience an orgasm, either during partnered sex or self-stimulation? |
| 8. To define the duration of the problem, a brief description of previous periods of satisfying sexual desire/arousal or activity should also be described<br>– When was the last time you remember experiencing sexual desire, arousal, or feeling satisfied from your sexual life? |

**Table 10.3** (continued)

| | |
|---|---|
| 9. | Identify the *sexual context or cues*<br>– Is there emotional intimacy?<br>– How erotic is the context? (e.g., love/emotional bonding cues, erotic or explicitly sexual cues, cues from physical closeness and appearance of the partner, romantic cues)<br>– Is there adequate sense of privacy and available time? |
| 10. | Identify the *sexual stimuli*<br>– How useful are the sexual stimuli?<br>– Describe types of stimulation—whole body, foreplay, etc.<br>– Is the woman aware of her own stimulation preferences? |

- Prescription drugs like SSRIs and hormonal contraceptives
- Malignant diseases (breast cancer, other cancers)

Concerning mental health, any psychiatric condition, past sexual abuse, problems with body image, and general mood should be assessed. History of medication use, substance abuse, and past and current mental health treatments should be monitored.

*Psychosocial history* A psychosocial history includes:

- Lifestyle factors, such as life stresses, childcare, and work/ job stress, and lifestyle patterns, especially sleep quality.
- Relationship factors, such as global satisfaction with relationship, leisure time together, sexual communication, e.g., do you feel comfortable to express your sexual needs, fears, and wishes? Also, issues of past or current infidelity or jealousy could be assessed.
- Partner factors, such as own sexual dysfunction, reactions to the woman's sexual problem, life concerns, health, and mood. When possible, the partner must be interviewed alone (See Chap. 9 for more details on sexual interview.).

### 10.2.4 Clinical Management

*Education* Education for the patient and partner may include:

- A discussion of the impact of age, duration of relationship, the role of sexual thoughts and stimuli, responsive desire, the role of motivation for sexual activity, and the impact of mood, health, and lifestyle factors.
- The way couples interact should be explained. It is important to demonstrate examples of positive or negative circularity. Eventually the therapy may enhance the couple's ability to intervene and shift negative circular interactions to positive ones.
- The formulation of realistic expectations. For example, helping the patient to understand what sexual stimuli are pleasurable and what sexual contexts are

desirable, are components of the patients' sexuality that can be influenced, but not necessarily altered or determined. Therefore, the patient or couple should be encouraged to adopt an approach which enhances interest in understanding and respecting one's own sexuality, rather than a mechanistic approach focusing on fixing something that is wrong.

*Medical treatments* Medical treatment strategies can be subdivided into treatments targeting the genitourinary system and treatments targeting brain mechanisms involved in desire and arousal [18].

(a) Genitourinary system: local estrogen treatment of vulvovaginal atrophy contributing to arousal problems and/or pain during intercourse which may contribute to diminished desire has proven to be highly effective. Local estrogens or the prohormone dehydroepiandrosterone (DHEA) exerts a trophic effect (increasing blood flow, stimulation of epithelial growth within the vulvovaginal region, and modulation of the threshold of tissue response to external and internal stimuli throughout a vast array of molecules, e.g., vasoactive intestinal peptide, neuropeptide Y, nitric oxide, cytokines, etc.) [18, 19].
(b) Central regulatory system:
   - Systemic hormonal treatments are indicated in those patients in whom lack of sexual hormones (mainly estrogens, androgens, less progesterone) contribute to low desire and arousal difficulties (see above). Systemic estrogen therapy has proven to be effective in peri- and postmenopausal women [20–23].
   - The selective tissue estrogenic activity modulator tibolone has proven to enhance arousal and desire in postmenopausal women [24].
   - Non-hormonal treatment can be subdivided into two groups of therapies:
     – Treatment improving the peripheral response, i.e., mainly enhancing sexual arousal: PDE-5 inhibitors (Sildenafil) have proven some efficacy in special groups of patients (diabetes, spinal cord injury, MS, etc.) with arousal problems. One study showed that women with sexual problems due to SSRI treatment had improved orgasms when treated with PDE5 inhibitors [25]. Other substances under investigation are L-arginine and phentolamine. Zestra is a locally acting massage oil that has shown some efficacy in a small trial on sexual arousal [26].
     – Treatment targeting the central response: This approach includes flibanserin, bupropion (in combination with trazodone especially in women with comorbid depression), buspirone, apomorphine, and bremelanotide. These drugs act on 5HT, dopamine, and noradrenergic pathways or on the melanocortin regulation in the hypothalamus (bremelanotide). Flibanserin has been investigated in pre- and postmenopausal women (26–28) [27–29]. Flibanserin and bremelanotide are approved by FDA for treatment of HSDD in premenopausal women, while the others are used off-label or indicated for the treatment of concomitant mental disorder.

*Psychosexual treatment* When low desire is the symptom of a psychiatric disorder, then the initial step is to ensure remission of the psychiatric condition [30]. If pharmacotherapy is required to achieve remission, then every effort should be made to choose sexually neutral drugs. Patients with psychotic symptoms may not be able to participate in psychosexual therapy, requiring instead a more supportive therapeutic approach [30]. When salient relationship problems and negative feelings toward the partner are evident, the couple may not benefit from psychosexual therapy unless these issues are managed before the introduction of psychosexual therapy.

The following must be clearly explained at the initial stages of therapy:

- Any sort of sexual activity, including sensate focus exercises, must be initiated only when each person feels wanting or neutral. In case one or both feel negative, sexual activity must not be initiated or continued. A feeling of freedom and safety to express level of desire must be encouraged.
- Sexual activity that is distressing and painful or causes negative experience should be stopped. The importance of distinguishing neutral from negative experiences and learning to protect oneself from negative experiences, but being open to neutral or positive ones, should be explained.

#### 10.2.4.1 Psychosexual Treatment for Women with No Signs of Arousal Disorder but Complain of Low Sexual Desire

These women typically complain of rarely wanting to have sex, almost never initiating sexual activity, or avoiding sex and their partner's sexual invitations. However, once they have engaged in sexual activity, they find it satisfying and pleasurable. In such cases, these women seem to lack the urge and motivation, but once they engage in sexual activity, they usually experience responsive desire and pleasure. However, although their sexual activity is pleasurable, it doesn't reinforce future urge or desire for sexual activity. The following could be the target of intervention, depending on the contributing factors identified in the sexual history:

- Modification of lifestyle factors, such as fatigue (especially with childcare), daily stress, and negative mood, or inappropriate sexual circumstances (e.g., lack of time and privacy).
- Coping with sexual desire discrepancy between the partners. The partner desires sex more frequently and often complains of not having it as often as he would like to. The woman, on the other hand, would be satisfied with a lower frequency and avoids his invitations (often feeling inadequate). The more he reaches out for it, the more she avoids it. This usually causes a negative feedback loop with significant distress for both.
- Understanding the woman's sexual motivation, identifying negative motivation, and enhancing positive motivation. This should be encouraged to be done with a willingness to increase understanding of her own sexuality and motivation, instead of trying to fix it and pressure herself to want sex. Interpersonal issues, such as intimacy and satisfaction in the relationship, may influence motivation.

- Modifying the daily routine when the couple has gradually habituated to sexual abstinence could be the focus of treatment, most likely in couples with long relationship duration. Lack of sexual context and sexual cues could be the focus of treatment.

#### 10.2.4.2 Psychosexual Treatment for Women with Low Sexual Desire and Diminished Sexual Arousal

In this case, women typically report that they are unwilling to participate in sexual encounters and experience difficulty becoming aroused once they have engaged in sexual activity. They may report dryness or even pain. In such cases, the health provider needs to try to understand whether desire is low because sexual encounters aren't pleasurable or sexual encounters aren't pleasurable because of lack of sexual desire and positive sexual motivation. In clinical practice, we often work simultaneously on both issues. Aside from working on the issues relative to desire described in the previous section, treatment should also focus on arousal. The following could be the target of interventions:

- Increase acceptable and pleasurable sexual stimuli. Sensate focus could be helpful, as non-demanding sexual activity may alleviate performance anxiety.
- Educate the woman to direct her focus of attention on her sensations and available stimuli.
- Train the woman to be aware of her automatic thoughts and concerns during sexual activity, without responding to them. The content of her thoughts could be discussed during consultations. In case her thoughts are especially persistent and distressing, the therapist may choose to halt sensate focus and work on the content of her thoughts.
- Train the partner to focus on his own pleasure and effectively cope with his negative emotions and thoughts. The partner often feels inadequate or unwanted, which in turn causes distress to him and often poses pressure to the partner. Eliminating partner pressure and communication skills of the couple could be the target of interventions.

#### 10.2.4.3 Psychosexual Treatment for Women with Satisfying Sexual Desire and Diminished Sexual Arousal

These are women who want to have sex but report distressing non-arousing sexual experiences. In such cases, the abovementioned issues relative to arousal could be the focus of psychosexual treatment.

#### 10.2.4.4 Psychosexual Therapeutic Tools for Female Sexual Arousal/Interest Disorder (FSAID)

Today, sex therapy is a specialized form of psychotherapy that draws upon an array of technical interventions known to effectively treat male and female sexual dysfunctions. Current sex therapy comprises a synthesis of interventions that the clinician chooses in order to treat *the needs of the patient/couple*. For example, an arousal disorder that is explained by lack of adequate stimuli would be treated

differently to an arousal disorder that is explained by couple conflicts or lack of estrogens. Today's psychosexual therapy comprises cognitive-behavioral interventions which often incorporate mindfulness, systems/couple interventions, and sometimes psychodynamic interventions. These are often combined with medical therapy, thus providing care through a biopsychosocial perspective. For the treatment of low desire, there is level 2 evidence for sensate focus, for cognitive behavioral therapy (CBT), and for CBT combined with mindfulness. For low arousal, there is level 2 evidence for combination of mindfulness and CBT [18]. With the multiple psychogenic factors that may underlie sexual dysfunctions, the need to consider the complex interplay of multiple factors is especially important in today's clinical sexology [18].

**Case Report 1**

*Presenting Complaint*

28-year-old woman in a 5-year relationship with a man 36 years old. She complains of absence of genital and subjective sexual arousal during partnered sexual activity, with considerable distress, since the beginning of her current relationship. When she receives sexual stimulation from her partner, she initially feels excited, but her arousal is abruptly diminished, and she stops in 7 out of 10 times. She masturbates a few times a year since she was 18, but she is not familiar. Sexual urge, sexual thoughts, and fantasies occur a few times per month, mostly when she is alone, but she usually doesn't act on them. She initiates sexual activity in 9/10 times, although at the beginning of the relationship it was her partner who initiated sexual encounters 10/10 times. Now, her partner avoids initiating sexual activity.

*Initial Assessment of the Woman*

Her sexual history shows that sexual arousal is situational and acquired, and there is also diminished responsive sexual desire. They have sexual intercourse almost one time a week; the partner always initiated this during the first 4 years of the relationship. She always responded positively to his invitation because she didn't want to let him down and make him angry. She always felt he was pushy and liked wild sex, while she wanted more time for intimacy to develop. Sexual intercourse is always unpleasant. During the last year, she feels very guilty for hindering their sexual life, and this is her motivation to initiate sexual activity. Automatic thoughts during sexual encounters are characterized by negative self-criticism about her arousability that causes feelings of inadequacy and guilt.

Her medical history reveals no chronic conditions, nor medication use, but she has a history of one abortion 9 years ago that caused her high guilt. Currently, there are signs of body image concerns but do not constitute a diagnosis for body image disorder. The menstrual cycle is normal, and there are no signs of thyroid disease. Mental health is good.

Psychosocial history reveals low stress and fatigue.

Relationship quality reveals that she is satisfied by her relationship in general and their relationship has several positive aspects, such as that she enjoys his company and she describes her partner as very caring and reliable. However, they have dysfunctional communication skills. It is very difficult for her to express her needs, fears, and wishes in both the non-sexual and sexual communication.

Also, the sexual context is problematic. They usually have sex late in the evening when he has come home from work. Sexual stimulation is inadequate for her, as there is too little foreplay.

Biological etiology is not suspected, so no lab tests are required.

*Assessment of Partner*

The partner feels distressed by the fact that she never enjoys their sexual interaction. He often felt angry because since the beginning of their relationship she was reserved and reluctant to express herself sexually. He is generally happy with the non-sexual aspects of the relationship.

*Management*

First step—patient/partner education. This could be provided by any physician with adequate comfort level to discuss sexual desire and arousal. Initially it would be important to discuss the negative impact of engaging in dissatisfying sexual activity and also an explanation of the ongoing negative feedback loop they have experienced. At the beginning of their relationship, he was spontaneous and enthusiastic for sex, while she was reserved and needed more time for their sexual encounters to be initiated. This discrepancy quickly made him feel rejected, which he expressed with frustration and pressure for sex. This contributed to her feelings of inadequacy and guilt, which she expressed with sexual avoidance. Once they started having sex, she was highly concerned about whether she would fulfill his sexual expectations. Thoughts of self-criticism distracted her away from sexual stimuli causing low arousal. This in turn enhanced his feelings of being unwanted and rejected. The more rejected he felt, the more guilty she would feel, and it would become more difficult to get aroused.

Second step—the couple would need to receive a combination of techniques from couple therapy and CBT. This could be provided by a specialist or by a physician with an adequate level of sex therapy techniques.

Couple therapy techniques would focus communication skills in order for the couple to start communicating needs, fears, and wishes. For example, the couple should feel free and safe to express desire or non-desire. In addition, the couple could learn to enhance differentiation. In other words they could learn to identify their own emotions and needs, respect them, and manage them, instead of focusing on managing their partner's emotions and needs by feeling responsible for them. In our case, both individuals had feelings of inadequacy. She felt inadequate to be sexually aroused, and he felt inadequate

to cause her sexual arousal. Each individual should learn to increase his/her own arousal by focusing on his/her own sensations. At the same time, the therapist could help her manage her feeling of guilt (when she feels she doesn't reach her partner's expectations) and his feeling of frustration (when he feels he can't cause her arousal).

The behavioral part of CBT would include ways for improving the sexual context, better time management, as well as sexual exercises (sensate focus) for experiencing pleasure through non-demand sexual activity. These sexual exercises could also be enhanced with some mindfulness techniques to increase attention focused on sexual stimulation. The cognitive part of CBT would focus on altering thoughts and beliefs that cause or maintain low arousal, e.g., "I am incapable of enjoying sex," but also thoughts and beliefs that maintain low sexual satisfaction such as "Denying my partner sex is a threat to my marriage" or "I can never enjoy sex anymore."

Because the woman in this case has body image concerns, the therapist must assess the impact of this not only in the initial assessment but also subsequently. If such concerns become more salient, therapy will need to focus on that. However, it must be kept in mind that any patient presenting with body image *disorder* must first receive treatment for this and not focus therapy on increasing sexual arousal. In our example this was not the case.

## 10.3 Genitopelvic Pain/Penetration Disorder

### 10.3.1 Definitions and Epidemiology

According to DSM-5, this disorder is characterized by at least one of the following: (1) difficulty with vaginal penetration during intercourse; (2) marked vulvovaginal or pelvic pain during vaginal intercourse or penetration attempts; (3) marked fear or anxiety about vulvovaginal or pelvic pain in anticipation of, during, or as a result of vaginal penetration; or (4) marked tensing or tightening of the pelvic floor muscles during attempted vaginal penetration.

According to the ICD-11 definition [12], sexual pain-penetration disorder is characterized by at least one of the following:

- Marked and persistent or recurrent:
  - Difficulties with penetration, due to involuntary tightening or tautness of the pelvic floor muscles during attempted penetration
  - Vulvovaginal or pelvic pain during penetration
  - Fear or anxiety about vulvovaginal or pelvic pain in anticipation of, during, or as a result of penetration
- The symptoms are recurrent during sexual interactions involving or potentially involving penetration, despite adequate sexual desire and stimulation, and are not attributable to a medical condition that adversely affects the pelvic area,

result in genital and/or penetrative pain or to a mental disorder, are not entirely attributable to insufficient vaginal lubrication or postmenopausal/age-related changes, and are associated with clinically significant distress.

ICD-11 defines dyspareunia as a pain condition that has an identified physical cause.

Genitopelvic pain/penetration disorders usually refer to pain occurring at a specific part of the vulva (localized) or the entire area of the vulva (generalized). Pain can be provoked (in response to pressure) or unprovoked (occurring at any time). In other cases, the most distinct characteristic is the fear of the pain, rather than the pain itself. The following types of genital pain have received most attention and have been described as follows: [11, 31–33]

- *Provoked vestibulodynia (PVD)*: the most common situations that evoke PVD are vaginal penetration during sexual activity, during gynecological examinations, and during the use of internal feminine hygiene products. Women with PVD may be pain-free for much of their day, only experiencing the pain during activities that involve vaginal pressure or penetration.
- *Generalized vulvodynia (GVD)*: women suffering from GVD typically report a fairly constant burning or itching pain over a large region of their external genitals. It can occur at any time of day during various activities and can also occur "out of the blue." The pain of GVD, however, can be exacerbated by contact to the vulva during sexual activity.
- *Vaginismus*: characterized usually by the presence of fear/avoidance as well as muscle tension so pronounced it prevents entry to the vagina of any object (penis, finger, tampon, gynecological examination).

Data on the prevalence of pain disorders are not consistent and vary with some studies showing 2% and others reaching 17% or even 22% [11].

### 10.3.2 Pathophysiology

Different pathophysiological pathways can be differentiated:

- Tissue damage leading to activations of nociceptors in the vulvovaginal region and the pelvis. This pathway relates to gynecological, dermatological, and systemic disorders.
- Chronic irritation of nervous pathways leading to neuropathic pain. This pathway relates to neurological disorders.
- Chronic pain due to peripheral pain mechanism over-activation and/or central nervous signal processing as known from other chronic pain disorders. This relates to the association of these pain conditions to affective disorders.
- Disorders of the pelvic floor and surrounding tissues. This is most prominent in patients suffering from vaginism with unvoluntary contractions of the smooth

muscles around the vaginal introitus thus making penetration impossible. This pathophysiological mechanism is also involved in other conditions mentioned above.

### 10.3.3 Assessment

*Pain assessment* Initially, the pain characteristics and how it developed need to be described. Many patients have been told for many years that their pain is not real, so meeting a clinician that trusts them and their symptoms can result in enormous relief. The location of the pain, the intensity (on a 0–10 scale), and the triggers are necessary information. Also, how the woman has dealt with this problem and mostly if she continues to have sexual intercourse despite pain is crucial information. How she has coped with the problem, including behavioral adjustments, medical treatments, and her partner's response, should also be explored.

- Was pain experienced since the beginning of sexual life or after a period of normal sexual activity (if it has always been the case, then keep in mind that this woman may have pain because of vaginismus and also that this woman has probably low sexual self-efficacy)?
- If the problem is acquired, what could have triggered it?
- Where is the pain located? (Provide options.) Is it at the entrance of the vagina, further inside, or deep inside?
- Do you feel pain before or after intercourse? Before intercourse may indicate a phobic reaction that may be causing the pain or may be the consequence of pain.
- Out of 10 times of sexual activity, how many times do you feel pain?
- When was the last time you had an intercourse attempt? Is your partnered sexual activity always followed by intercourse attempts?
- How have you and your partner coped with this problem?
- How does pain interfere with your daily activities?
- How does pain interfere with your relationship?
- Some women like to masturbate. Do you masturbate, and what is your experience? Do you feel pain during masturbation? Is there pain on the external genitals or when you insert your finger or a vibrator?

*Physical/medical assessment* The medical history has to be comprehensive including somatic and mental health disorders and respective treatments including dermatological, urogynecological, musculoskeletal, and affective disorders. All these can contribute to the pathogenesis of chronic pain (see above).

Physical examination includes the following steps:

- Inspection of the vulva and vagina. Look for signs of inflammation or atrophy.
- Q-tip test. The physician touches with a Q-tip along the vestibulum in a clockwise manner. The patient reports whether she feels touch or pain or burning sensation. Typically, in patients with provoked vestibulodynia, the

patient will report pain either in all regions of the vestibulum or typically at 3 and 9 o'clock.
- Special examinations include bimanual palpation and ultrasound. This is important in women reporting deep pain (pain in the pelvis) during intercourse [33, 34].

*Psychological assessment* This part of the assessment aims to collect information about psychological, sexual, and partner-related factors that may be contributing to the pain (most probably they do not cause the pain but exacerbate it).

Questions that assess possible psychological contributing factors should include:

- What do you believe causes or influences your pain?
- What emotions has this pain experience caused?
- How has the problem influenced the way you think about yourself and your life?
- What are your biggest concerns related to this pain experience?
- Have you talked to anybody about this?
- Would you talk to a new partner about this problem, or would you prefer to avoid initiating the relationship (in case the patient is single)?
- How do you usually cope with problems? Are your coping strategies problem focused or emotion focused?
- What personal resources (personality characteristics or social support) have helped you cope with this problem?
- How is your general mood? What other life concerns or stressors do you have at the moment?
- How do you feel with your body and genitals?
- What image or thought comes into your mind when you think of vaginal penetration?
- Have you had any mental health concerns in the past?

Questions to assess possible sexual contributing factors:

- How was your sexual life before the initiation of the problem? In case the problem was initiated at first sexual intercourse, the clinician may assess the patient's beliefs and attitudes toward sex before the first attempt.
- Has this problem stopped you from flirting (in case the patient is single)?
- Do you have foreplay? Do you enjoy it?
- If you knew you would not attempt intercourse, would you enjoy non-intercourse sexual activity with your partner?
- Do you feel sexual desire or pleasure from non-intercourse sexual activity?
- Do you feel pressure to have intercourse? Either self-imposed or imposed by partner?
- Do you and your partner have sexual activity? How often? What does this include?
- What thoughts come into your mind when you are about to initiate sex, during sex, and after sex?
- Do you masturbate? How would you describe the experience?

Questions to assess possible partner and relationship-related contributing factors:

- How has your partner coped with this problem?
- What kind of information does he have? What does he think contributes to the pain?
- Does he have a sexual problem, such as difficulty with ejaculation?
- How does he react when intercourse is abruptly stopped?
- How has this problem influenced your relationship?
- Do you talk about this problem? How satisfied are you with your partner communication about this problem?
- Are you satisfied with your relationship?

### 10.3.4 Clinical Management

*Medical management* Medical treatment includes the therapy of underlying disorders such as infections, dermatological diseases, endometriosis, ovarian cysts, vulvovaginal atrophy, or dystrophia (see above).

The second medical strategy is based on chronic pain medication like gabapentin in combination with amitriptyline or serotonin and noradrenaline reuptake inhibitors (SNRIs), which is usually off-label.

Part of medical therapy should be routine pelvic floor physiotherapy. Due to the chronic pain condition, the perception of signals from the vulvovaginal region is amplified and accompanied by catastrophizing cognitive patterns. At the same time, pelvic floor muscles contract and intensify the pain perception.

Pelvic floor physiotherapists can help women to become aware of the pelvic floor muscles and help them to learn to differentiate sensations coming from the vulovaginal region by guided self-controlled touch, visual feedback, and breathing techniques. This setting allows patients to communicate about their experience and learn how to modify their cognitions on one hand and how to relax and contract their pelvic floor in accordance to their wish (see also below).

In some cases of vestibulodynia, a surgical excision of the superficial tissue of the vestibulum is performed, and vaginal mucosa is sutured to the perineal skin thus covering the introitus of the vagina by vaginal epithelium instead of the vestibular surface epithelium. The operation is called vestibulectomy. Surgical treatment is considered the last resort option due to the controversial success rates reported and the aggravation of symptoms in case of non-success. It should only be performed in the context of a multidisciplinary team approach and should be done by an experienced surgeon.

Until now there is no consensus about the best treatment for vestibulodynia and vulvodynia.

There is general agreement that the therapeutic algorithm should be based on a multidisciplinary approach starting with low-risk procedures (counselling, physiotherapy) to reversible medication (analgetics, anticonvulsants, antidepressants) to more invasive procedures [32–34].

*Psychological management* The aim is for the woman herself to achieve pain control, reduce her catastrophic fear of pain, and reestablish satisfying sexual functioning. Pain reduction during sexual situations would be the ultimate goal.

Cognitive behavioral therapy would help the woman identify her thoughts, emotions, and behaviors, as well as their interplay, that influence the pain experience [35]. This is similar to the management of any type of chronic pain.

Mindfulness has also been integrated with cognitive therapy, where the focus is on tuning in rather than tuning out or distracting from the pain experience. Interventions that aim to facilitate pleasurable sexual activity for the couple may also be useful. For example, non-penetrative sexual activity may be encouraged, also the expression of sexual desire and physical intimacy during the day, or expressing one's preferences or dislikes in a setting of freedom and safety. Problems with body image and genital image are often part of the treatment process. It is a challenge for a woman with genital pain to maintain a positive self-image of her genitalia, which is important for her sexual satisfaction. Cognitive behavioral therapy could intervene on this aspect as well [36].

In cases of vaginismus, the treatment options would typically target the muscle spasm/contraction over and above the symptom of (feared) pain. The major focus of treatment tends to be vaginal dilation combined with progressive desensitization and a variety of relaxation techniques. Additional components may also be part of the treatment regimen, ranging from sex education to decreasing penetration fear and anxiety. The addition of sex education and sensate focus may also be beneficial [37–39].

**Case Report 2**

*Presenting Complaint*

A 21-year-old patient, a history student at the local university, comes for a consultation with the following complaint:

"I cannot have intercourse………It is too painful……….When he tries to enter me I could cry…… He is very empathic and stops…. It is so frustrating.

She starts crying.

*Initial Assessment*

The patient appears timid, vulnerable, and in acute distress.

This problem started since she had her first intercourse at the age of 17 years. It was unpleasant but not as painful as it is now. She kept on "having sex" without really enjoying it. She used the pill which she did not tolerate very well. Then she suffered from recurrent bladder infections which she treated with antibiotics. This treatment was followed by recurrent candidiasis infections which she had to treat with an antimycotic.

For about 2 years, the pain increased during intercourse attempts. This led to the disruption of a previous relationship. She felt humiliated and not like a real woman. Now she has a new boyfriend and is afraid to lose him also. There are no other complaints.

*Sexual History*

She grew up in a traditional southern German family. During puberty, she focused on her female peer group and was late in getting interested in boys.

She felt not attractive and had difficulty to contact boys. She received her sexual education at school and from youth journals.

She rarely masturbated. It did and does not provide her "real" pleasure.

First intercourse was at the age of 17. No orgasm. Pain. (see above)

*Medical History*

Apart from recurrent infections, no major diseases or operations.

She has tried a lot of different treatments for her sexual pain including local treatments, gabapentin in combination with amitriptyline as a local cream and cortisone locally and orally.

*Psychosocial History*

Childhood and adolescence without major life events.

She went through high school experiencing difficulty in developing career interests and a professional vision. She had to leave home and live in Austria to follow studies in media technique in Vienna as there were no comparable programs near home. She is still trying to find a profession which would please her.

*Gynecological Examination*

Apart from positive Q-tip test, normal gynecological examination. No signs of infection, etc.

Ultrasound normal

*Diagnosis*

Provoked vestibulodynia

*Management*

Psychoeducation

The patient was informed about the different pathways and factors which can lead to her pain experience. She was invited to bring her boyfriend to treatment. But she informed the provider that they had decided to stop the relationship to give her time to find out about herself.

Combined Therapy

Based on this understanding, the different therapeutic options were discussed, and after excluding those which have already been tried without success, it was agreed to work on two levels. Level 1 would be focusing on body perception and processing of body signals.

Level 2 would be physiotherapy of the pelvic floor as a complex organ in itself.

After consent by the patient, treatment was initiated with a combination of relaxation and imagination techniques including elements of mindfulness to help the patient rebuild an inner representation of the vulvovaginal region and the signals coming from there (imagine being touched—increase pressure until you feel pain, decrease pressure—let the pain go, imagine the sun shining and giving a warm feeling on your vulva- increase warm to heat- decrease etc.).

A physiotherapist worked with her exploring trigger points in the outer third of the vagina and the pelvic floor and helping her to become aware of the muscles and the tissue surrounding the vestibulum.

After 2 months of combined therapy, the patient could touch the vestibulum herself without pain She did not have a partner at that time.

## 10.4 Female Orgasmic Disorder

### 10.4.1 Definition and Epidemiology

Even among women without sexual dysfunctions, subjective experiences of orgasm vary considerably, and female orgasm has been a difficult concept to operationalize. In 2003, an International Consultation [40] agreed on the following definition of an orgasm:

> An orgasm in the human female is a *variable*, transient peak sensation of intense pleasure, creating an altered state of consciousness, *usually* accompanied by involuntary, rhythmic contractions of the pelvic striated circumvaginal musculature, often with concomitant uterine and anal contractions and myotonia that resolves the sexually-induced vasocongestion, *usually* with an induction of well-being and contentment.

According to DSM-5, an orgasmic disorder is manifested by either of the following symptoms and experiences on almost all or all (approximately 75–100%) occasions of sexual activity (in identified situational contexts or, if generalized, in all contexts): (1) marked delay in, marked infrequency of, or absence of orgasm or (2) markedly decreased intensity of orgasmic sensations. As with all other sexual disorders, the presence of significant distress is necessary for a diagnosis [4].

The International Consultation of Sexual Medicine defined female orgasmic disorder (FOD) as a marked delay in, marked frequency of, or absence of orgasm and/or (2) markedly decreased intensity of orgasmic sensation (grade B recommendation). Without the experience of distress, a dysfunction cannot be diagnosed. In addition, the ICSM proposed a definition for hypohedonic orgasm disorder (lifelong or acquired decreased or low level of sexual pleasure with orgasm, expert opinion) and for painful orgasm disorder (the occurrence of genital and/or pelvic pain during or shortly after orgasm, expert opinion) [11].

In the most recent prevalence studies with nationally representative samples, prevalence figures range from 3.5 to 35%. The highest prevalence figures are found in Southeast Asia (34%) and the lowest in Northern Europe (10%) [13].

### 10.4.2 Pathophysiology

Orgasm can be understood as a combination of a peripheral reflex which is associated with a specific brain activation [41]. The peripheral reflex involves sensory inputs coming from central stimuli (images, thoughts) and peripheral stimuli (touch, visual, auditory) which activate sympathetic and parasympathetic neurons travelling in the pudendal nerve and hypogastric plexus. These signals lead to neurovascular and neuromuscular reactions in the outer third of the vagina and the pelvic floor.

The observable preorgasmic changes are swelling and change of color of the labia due to vasodilation. During orgasm, paravaginal muscular tissue contracts with variable intensity and frequency [40]. The parallel processes in the brain are not completely understood. Specific areas in the prefrontal cortex seem to have a

decrease in their activity, while others are increased. Amygdala activation and deactivation seems to play an important role [41, 42]. The most important neurotransmitters involved are dopamine and oxytocin. (See Chap. 7 for more information on neurophysiology of sexual response.)

Orgasmic dysfunction can result from organ damage of those involved in stimulus perception or production (see arousal disorder), damage to the involved nervous structures (neurological diseases), central inhibitory processes and drugs (SSRIs, opiates, etc.), and hormonal changes mainly involved also in the physiology of arousal (see above). Psychological risk factors include the fear of losing control, performance anxiety, lack of confidence in the partner, and/or unresolved conflict in the relationship. These emotions have an inhibitory effect on the excitatory process and thus interrupt the individual dynamics reaching from arousal to orgasm [41].

### 10.4.3 Assessment

#### 10.4.3.1 Sexual history

The following are indicative questions that can help define the type of problem, the relevant distress, and partner-related factors:

- Are orgasms absent and/or very delayed and/or markedly reduced in intensity?
- During partnered sexual activity, is the problem experienced with manual stimulation and/or with intercourse?
- Is the problem acquired, or has it been lifelong?
- Is it global or situational?
- Does the problem cause significant distress? When did this become a concern or problem?
- Do you masturbate? If yes, is the problem experienced during masturbation?
- Are there any concomitant problems (arousal, desire, sexual pain problems)?
- Concerning your orgasm experience, what would you expect to achieve? What would you think is a normal response?
- Is there adequate and acceptable stimulation? Also, is attention focused on stimulation?
  - When with partner
  - During masturbation
- Do you feel free to enjoy your sexual activity despite the lack of an orgasm?
- Is there fear of letting go control? What do you fear may happen that could be negative?
- How does your partner react to this problem? What is his level of bother from 0 to 10?
- Concerning your orgasm experience, what does your partner expect you to achieve?
- Does your partner have a sexual dysfunction, such as early ejaculation?
- How has this problem influenced your sexual activity?
- What thoughts come into your mind during sexual activity?
- What thoughts come into your mind after your sexual activity?

#### 10.4.3.2 Psychosocial History

- Personality characteristics that could influence the woman's perception and coping with the problem could be assessed. Sexual submissiveness, non-assertiveness, and restrictive attitudes toward sexuality could be identified.
- Relationship factors, mostly focusing on the couple's sexual interplay. For example, does the man pressure the woman to obtain an orgasm, and does this increase her performance anxiety? Also, the couple's communication skills could be assessed.
- The partner must be interviewed alone when possible. His beliefs about female orgasm and his perception of his own role in this could be discussed. A sexual dysfunction that was initiated prior or after the partner problem is of importance.

#### 10.4.3.3 Medical history

The medical history should include:

- Conditions leading to impairment of stimulus perception and transmission like vulvovaginal atrophy, incontinence, etc. (see arousal disorders).
- Neurological diseases leading to impaired nerve transmission or central signaling like multiple sclerosis, amyotrophic lateral sclerosis, spinal cord injury, etc.
- Psychiatric diseases and treatment leading to disturbance of central signaling like affective disorders and their treatment.

### 10.4.4 Clinical Management

*Education and Psychosexual Interventions* The ICSM clearly states that *education* is the cornerstone of all evidence-based psychological interventions for FOD. Women should be provided with accurate information about sexual anatomy and physiology, variations in sexual response, and common forms of stimulation used to reach orgasm. This process can be therapeutic in itself [18]. Beyond education, interventions can focus on the factors that explain the maintenance of the problem according to the sexual history. *When a woman can reach orgasm on her own, but is unable to experience an orgasm within partnered sex*, treatment may focus on various factors such as:

- *Increasing the effectiveness of the available stimulation*. Sensate focus, adequate clitoral stimulation during partnered sex, or engaging in intercourse using positions that maximize clitoral stimulation could be suggested.
- Altering the woman's negative emotions (e.g., anxiety, shame, or fear to let go) with cognitive behavioral therapy.
- Enhancing a sense of freedom and security within the couple interaction. Communication skills could be helpful in this case.
- Treatment of the partner's dysfunction.

*When a woman reports that she has never obtained an orgasm, whether during partnered stimulation or masturbation*, then it is most likely that the treatment

would have to focus on helping the woman to find ways to stimulate herself and obtain an orgasm during masturbation through directed masturbation (DM). Subsequently, this could be applied in partnered sexual activity. One evidence-based treatment for female orgasmic disorder showed that with DM there was an 80% efficacy to obtain orgasm during masturbation in lifelong anorgasmic women and 20–60% efficacy to obtain orgasm during partnered sexual activity [43]. (See Chap. 12 for more information on techniques used in sexual therapy.)

*Medical treatments* All treatments improving arousal should be considered (see above). In patients treated with antidepressant drugs, the treatment should be re-evaluated, and if possible a transition to drugs with less negative impact on arousal and orgasm like bupropion should be initiated (see above). (See Chap. 24 for more information on the impact of psychopharmacology on sexual response.)

In addition to those mentioned above, PDE-5 inhibitors, oxytocin, and dopaminergic drugs have been investigated. There are preliminary results indicating that in subgroups of patients with diabetes sildenafil could enhance the response. However, no larger-scale studies showing beneficial effects have been performed.

**Case Report 3**

*Presenting Complaint*

A 31-year-old woman (she is a musician) is in a 1-year relationship with a 36-year-old man (he is a young and very successful business man). She complains of absence of orgasm during partnered sexual activity, with significant distress. She recalls an absence of orgasm during partnered sex in all her previous relationships, but distress is evident only in her current relationship. Sexual desire and arousal are satisfactory. She masturbates a few times a week since she was 16, and she can obtain an orgasm with clitoral stimulation. With partnered sexual activity, she doesn't have any clitoral stimulation, mainly because she feels uncomfortable and also because her partner's focus is on intercourse. She describes a high level of distress which is triggered mostly by her partner. Her distress is triggered by the fact that her partner has told her that all his previous partners had orgasms with intercourse.

*Initial Assessment of the Woman*

Her sexual history shows orgasm disorder is lifelong and situational with distress. They have sexual intercourse almost two times a week; the partner always places great importance on her achieving an orgasm. Her automatic thoughts during sexual encounters are characterized by negative self-criticism about her difficulty to orgasm. She feels arousal but is inhibited to express it vocally. She would like to have clitoral stimulation, but has never asked for it. She leaves her stimulation to her partner to decide.

Her medical history reveals no chronic conditions nor medication use. Her menstrual cycle is normal, and there are no signs of thyroid disease. Mental health is good.

Psychosocial history shows she is non-assertive and feels sexually inadequate.

She describes her relationship as satisfactory in all aspects, except their sexual life. Couple interaction is influenced by him being "controlling" and an achiever, while she is very jealous and fears losing the relationship.

Biological etiology is not suspected, so no lab tests are required.

*Assessment of Partner*

The partner feels distressed by the fact that he cannot make her orgasm. He feels frustrated and blames her for not trying enough. He never had a long-term relationship in the past, but he describes his sexual life as very active, with many women and experiences.

He is generally happy with the non-sexual aspects of the relationship.

*Management*

First step—patient/partner education about how women become aroused, a discussion about the fact that many women are not able to experience orgasm with vaginal intercourse and when they do it usually does not occur on all sexual encounters. The role of the clitoris should be discussed. Also, a discussion about the importance of placing realistic goals and the importance of the woman to feel she is in charge of her own orgasm should be emphasized.

Second step—the couple would need to receive a combination of techniques from couple therapy and CBT in order to alter the pressure he poses on her and also her self-pressure which is mostly associated with her jealousy. At the same time, they could experiment with introducing clitoral stimulation during partnered activity. After orgasm is experienced within the context of partnered sex, then engaging in intercourse using positions that maximize clitoral stimulation should be discussed.

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