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## Female Sexual Dysfunction

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### Abstract

If a woman finds that she has a problem in sex life, if they are interfering with these relationships, it is definitely a moment to visit a doctor. Initial problems can in most cases be successfully monitored; By advancing the problem they will only accumulate, and inter-party relations will irreversibly be disrupted. It would be ideal to apply an interdisciplinary approach to treatment, meaning to include specialists of various specialties, such as gynecologists, psychiatrists, psychologists, general practitioners and others. Of course, treatment, or therapeutic approach, will be adjusted to the root cause. In treatment should be considered estrogenic creams, modification of basic therapy, psychotherapy and medicaments according to the recommendation of a psychiatrist, physical exercise etc.

**Keywords:** Sex; Helth; Dysfunction; Female

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### Introduction

The diagnostic investigations and treatment opportunities for women with sexual health concerns are limited, in large part, due to the lack of current global government-approved agents for any sexual health concerns (desire, arousal, orgasmic and sexual pain-related dysfunctions) of pre-menopausal women or for non-sexual pain concerns of post-menopausal women [1]. There are, in contrast, more than 20 US government-approved treatment strategies for men with bother some male sexual dysfunctions. The availability of safe and effective medicaments for men with sexual

health problems has, in part, motivated clinicians to better understand the nature of men's sexual health concerns. This has led to more clinical diagnostic procedures for men with sexual dysfunction.

The WHO (World Health Organization) defines reproductive health as a 'state of complete physical, mental and social well being and not merely the absence of disease or infirmity in matters related to the reproductive system and to its functions and processes' [2]. Thus, it also includes sexual health, the purpose of which is enhancement of life and personal relations and not merely counselling and care related to reproduction and STI (sexually transmit- ted

infections]. This holistic approach is important in the promotion of gender-sensitive and woman-centred health.

The 12 pillars of reproductive health care include adolescent reproductive health and sexual behaviour, the status of women in society, family planning, maternal care and safe motherhood, abortion, reproductive tract infections, HIV/AIDS, infertility, reproductive organ malignancies, nutrition, infant and child health and environmental and occupational reproductive health. The role of community gynaecologists and reproductive health care doctors in the UK is to manage the provision and delivery of such services, to oversee and co-ordinate school sex education, co-ordinate screening for sexually transmitted infections, deliver contraceptive and legal abortion services, screening for breast and cervical cancer and management of psychosexual dysfunction and menopausal problems. This transition from providing only family planning services to delivering a package of integrated and comprehensive reproductive health care across the boundaries of disciplines is gaining momentum.

### **Sexual Dysfunction**

The symptoms of sexual dysfunction are generally nonspecific [3]. A particular physical disorder or psychological characteristic is not necessarily responsible for a particular symptom. The same sexual problem in one person may well have a different, even opposite, cause in another. In order to eliminate any potential organic causes, or to assess the relevance of factors like age, pregnancy, cardiac disease, radical surgery, etc., an adequate sexual history and physical examination is necessary. Since sexual dysfunctions exist within relationships, both partners and the relationship should be evaluated. The factors which must be considered before specific treatment can be recommended include motivation for therapy and the coping mechanisms and ability of each

partner to adapt, as well as physical or psychological disorders.

While sexual dysfunction symptoms are often multifactorial, they can be divided into three basic groups, depending on whether the etiology is primarily physical (3--20 percent of sexual dysfunction, depending on the specific population studied), primarily psychological, or combined. In this latter group, an existing organic problem can result in psychologically based symptoms. For example, a person with cardiac disease may lose interest in sex because of anxiety about possible cardiac damage. Or, a person who has had radical surgery may have serious problems with body image resulting in sexual symptomatology.

Female sexual dysfunction (FSD) is a continuum of psychological and organic disorders focused on sexual desire with interrelated problems of arousal, orgasm, and sexual pain that impairs quality of life for many women [4]. FSD can afflict women of any age, and its severity worsens with the endocrinology of advancing years. Impact is often subtle. FSD may express as apparently unrelated emotional manifestations that could degrade quality of life and family relationships, in social sphere and in the workplace. Female sexual dysfunction is defined as any problem that may be encountered in the sexual response cycle that deviates from a woman's normal range of functioning. Defining female sexual dysfunction is not as absolute for women because of the qualitative nature of female sexual function. What may be abnormal for one woman may be normal for another woman. Sexual dysfunction falls on a continuum with female sexual disorder.

In sexual dysfunction, there is a break in normal sexual functioning at one or many points in the sexual response cycle. In comparison, a sexual disorder consists of both the sexual dysfunction element in addition to persistent distress. An abnormality in one's sex life can exist but may not justify further evaluation except when the woman experiences a certain degree of distress over it. When investigating female sexual

function versus dysfunction and disorder, distress has to be included and is perhaps the most important variable because of the large range of what can otherwise be normal for women. The distress must be experienced by the woman herself, and that which bothers her partner alone is not then a sexual dysfunction of the woman but rather of her partner. Female sexual dysfunction and disorder must be debated in the context of each individual woman's life, culture, social, individual experiences, relationship, and health in order to extricate the distress element.

The physical examination for a woman with sexual health concerns should be tailored to the sexual medicine complaint obtained during the history interview [5]. For example, if the history uncovers that genital itching is a major sexual health problem, a careful assessment should follow for the presence of a genital dermatitis condition. If a woman with sexual health problems is under age 50 and experiences sexual pain, a careful physical examination should evaluate for the presence or absence of vulvar vestibulitis syndrome/vestibular adenitis. Similar complaints of sexual pain in a woman over age 50 should assess for the presence of vaginal atrophy with dryness, loss of rugae, mucosal thinning, pale hue, and lack of shiny vaginal secretions. Ideally, the physical examination should be performed without menses and without intercourse or douching for 24 h before the exam. If dysfunction occurs at a specific time, such as midcycle dyspareunia, the physical examination should be scheduled at the time of the sexual problem. Such scheduling may require two visits: one for history-taking and one for the physical examination.

The genital-focused examination should be considered routine in the diagnosis of women's sexual health problems, but its personal character demands that a rational explanation exist for its inclusion in the diagnostic process. A focused peripheral genital examination is recommended in women with sexual dysfunction for complaints of dyspareunia, vaginismus, genital arousal disorder and combined arousal disorder, orgasmic disorder,

pelvic trauma history, and any disease that affects genital health (such as herpes or lichen sclerosis). For women with suspected neurological disorders, the examiner may also assess for anal and vaginal tone, voluntary tightening of anus, and bulbocavernosus reflexes.

The normal physiological changes ageing men and ageing women experience affecting sexual function, include in women for example, a drop in oestrogen levels resulting in less lubrication and possibly discomfort during sex, and in men erectile dysfunction increases with age with both leading to changes in sexual function [6]. However, generally the increase in sexual dysfunction observed in some older people can be attributed to health problems rather than ageing processes. For example, endocrine, vascular and neurological disorders may independently interfere with optimum sexual functioning. Pharmacological treatment or surgery for these disorders may enhance or impair sexual drive and or performance. Older adults with significant health problems, who are cared for in specialist nursing homes are generally discouraged from engaging in sexual activity or sexual expression, or through using tranquilizers. Treatment for sexual dysfunction is relatively effortless, and can involve pharmaceutical or behavioural interventions. Older people with sexual dysfunction may benefit from therapeutic interventions of, for example, hormone replacement therapy or Viagra. However, there is some controversy over the safety of long-term hormonal therapy in women, with the American College of Physicians recommending postmenopausal hormone treatment to alleviate bone loss and protect against cardiovascular disease, and the Women's Health Initiative publishing the results of its randomized controlled trial stating no protective effects of hormone use on cardiovascular disease.

### **Psychiatric Disorder**

Many psychiatric disorders are associated with sexual dysfunctions [7]. Impairment of sexual

functioning in a person with mental illness could be possibly part of her/his mental illness symptomatology (e.g. lack of sexual desire in depression), adverse reaction to medication used for treatment of her/his mental illness (e.g. delayed ejaculation or anorgasmia associated with serotonergic antidepressants), result of substance abuse (e.g. low sexual desire due to chronic cocaine abuse), or due to chronic physical illness (either independent of mental illness or as a result of adverse reaction to medications used for mental illness, for example metabolic syndrome or diabetes mellitus due to some antipsychotics) and/or its treatment. Impairment of sexual functioning could, of course, occur due to one of these causes or a combination of two or more.

The exact diagnosis of the underlying cause of sexual impairment is not always possible and thus treatment may either target the underlying cause, or be symptomatic, for example using treatments that work for a specific sexual dysfunction in general (e.g. using medication such as sildenafil (Viagra) for erectile dysfunction). The diagnosis is usually established during a careful clinical interview. The clinician has to ask very specific questions focused on particular parts of sexual functioning, for example on sexual desire, arousal (erection), orgasm (ejaculation) and pain associated with sexual activity. It is imperative to obtain a baseline evaluation of the patient's sexual functioning during the first visit. This will be helpful later, in cases of sexual dysfunction possibly associated with any medication prescribed. There are no specific tests for sexual dysfunction(s). However, certain laboratory tests may help in some clinical situations. For instance, measuring the level of prolactin may help confirm suspected sexual dysfunction during the treatment with an antipsychotic drug.

The most common complaint of depressed patients is decreased libido (up to 72% of patients in one study). It seems that the more severe the depression, the greater the loss of libido. Impairment of other aspects of sexual functioning, for example erectile dysfunction,

impaired arousal in women, delayed ejaculation/orgasm and anorgasmia have also been reported in depressed individuals, although less frequently than decreased libido. Depressed individuals may also be anxious and anxiety is also associated with impairment of sexual functioning. It is important to note that while their sexual functioning may be impaired, good sexual functioning is important for them. The situation is also complicated by the fact that most medications used to treat depression have been associated with sexual dysfunction. Changes of sexual functioning also occur frequently in bipolar patients—30–65% of manic patients may display hypersexuality, while some may report decreased libido. Some patients suffering from bipolar or cyclothymic disorder (mild depression and hypomania) may also report episodes of promiscuity or extra relationship affairs.

## Cancer

The diagnosis of cancer is the first, critical moment, which causes in hearers feelings of incredulity, fear, and insecurity about their future. Its reverberations also affect the partner, if there is one, who in turn may suffer from preexisting sexual dysfunctions [8]. As is logical, in the past studies on cancer and sexual dysfunction were at first focused on cancers directly or indirectly involving the sexual and reproductive organs. Later research has widened out to include sexual dysfunctions in oncological patients regardless of the seat of the original neoplasia.

As can be imagined, gynecologic and breast cancers are those that most frequently have a negative impact on a woman's sexual health. The surgical treatment undergone by these patients creates direct anatomical damage and distorts their body image, causing them to perceive their body as sexually unattractive. This in turn creates changes in the response to the stimuli that influence desire, with inadequate vaginal lubrication and genital swelling that in the end lead to less frequent sex, with the absence of well-being, pleasure and

sexual satisfaction, and consequent inability to reach orgasm.

A paradigmatic example is represented by premenopausal salpingo-oophorectomy, which leads to the physical and hormonal changes typical of early menopause, seen in the various domains that characterize female sexual dysfunctions as they are currently classified. Besides the aftermaths of surgery, more and more frequently multimodal protocols also consider the consequences of chemo and/or radiotherapy, which can continue to have negative effects after many years. Cancers apparently “distant” from the parts of the body associated with sexuality constitute a separate question. Examples are head and neck tumors, which by causing significant facial alterations (disfigurement), vocal changes (speech), and changes in breathing and salivation, can have a strong impact on self-esteem and therefore on interpersonal and couple relationships.

### **Drug Effects**

Sexual dysfunction is typically the consequence of multiple contributory factors, rather than of one single factor [9]. The use of prescribed medication and recreational drugs should always be considered in a comprehensive biopsychosocial assessment of sexual dysfunction in both men and women. Drug effects are commonly cited as a cause of sexual dysfunction, but the evidence for this is limited and often anecdotal. Underlying conditions for which drug treatments are prescribed may also cause or contribute to sexual dysfunction.

As a general rule, if there is a temporal relationship between the introduction of a new drug therapy, and the onset of a change in sexual response, or sexual dysfunction or dysfunctions, then it is more likely that the newly introduced drug is a causal or contributory factor; where a drug has been introduced more than a month before the onset of sexual symptoms, this is less likely. Prescribers should enquire about their patient's sexual function before they prescribe a drug

known to be associated with sexual dysfunction; this information may lead them to prescribe a drug less likely to affect sexual function in patients with pre-existing dysfunction, as well as helping them to more readily identify drug-induced dysfunction.

### **Sex Crimes**

Some researchers suggest that certain biological factors, such as hormones, contribute to why individuals engage in sex offending behaviors [10]. Perhaps most common within this category is the role of high testosterone levels, which are found to be associated with increased sex drive and aggression. Additionally, some biological theories suggest that certain individuals may be predisposed toward problematic sexual behaviors because of physiologically or biologically predetermined sexual appetites or sexual preferences. These offenses are often viewed as opportunistic crimes committed by individuals who could not control their behaviors or sexual desires. Previous research on rape offenders, focusing on the role of brain dysfunction, innate mating rituals, sex hormones, neurotransmitters, and the limbic system in promoting sex crimes has found little empirical support for uncontrollable sexual desires of offenders. Findings from these studies suggest only limited support for the role of biology in sexual offending. This biological approach provides some understanding to causes of sex offending; however, psychologists have offered alternative explanations for criminal rape.

In a psychological spectrum, sex offenders' behavior originates with issues in childhood that affect their attachments to others, social skills development, and personality traits. These antisocial behaviors could be products of sexual and physical abuses and neglect during childhood, which impede the development of proper attachments to others, and normative social skills. These experiences can also result in uninhibited or improper responses to opportunities and situations in which offending may occur.



## Conclusion

In all sexual problems, regardless of whether they have a biological background or not, a huge role plays relationship and communication between partners. Although we often think in terms of sexual compatibility - does he have a greater need for sex than her? is she more passionate? - Difficulties often arise from unresolved conflicts in other spheres of relationship or marriage, lack of communication, and lack of respect and appreciation. The sexual problem is rarely exclusively of a sexual nature. Much more often is a reaction or even an adaptation to the situation in which a couple is found. Sometimes one of the partners is constantly sabotaging therapists' efforts. Sometimes the "cure" of one leads to the full withdrawal of the other partner, often even in sexual dysfunction. In some cases, the problem can not be resolved within the existing relationship.

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