Female Sexuality

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“Normal” female sexuality defined by cultural norms

- Victorian era: discovery that female orgasm irrelevant to conception
- Historically given little attention
- 2009: women’s sexuality hits ‘Primetime’ but not quite its ‘Prime’
Human Sexual Response: Classic Models

- Excitement
- Plateau
- Orgasm
- Resolution

Linear progression

Female Sexual Response Cycle

Female Sexual Response Cycle

Emotional and Physical Satisfaction

Emotional Intimacy

Spontaneous Sexual Drive

Arousal and Sexual Desire

Sexual Arousal

Seeking Out and Being Receptive to

Sexual Stimuli

Biologic

Psychological

Women’s endorsement of models of female sexual response

- *The Nurses’ Sexuality Study*, N=133
- Equal proportions of women endorsed the Masters and Johnson, Kaplan, and Basson models of female sexual response as representing their own sexual experience.
- Women endorsing the Basson model had significantly lower FSFI domain scores than women who endorsed either the Masters and Johnson or Kaplan models.

Female Sexual Dysfunction (FSD): DSM-IV-TR Definitions

<table>
<thead>
<tr>
<th>Sexual Desire Disorders</th>
<th>DSM-IV Definitions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hypoactive Sexual Desire Disorder*</td>
<td>Deficiency or absence of sexual fantasies and desire for sexual activity</td>
</tr>
<tr>
<td>Sexual Aversion Disorder*</td>
<td>Aversion to and active avoidance of genital sexual contact with a sexual partner</td>
</tr>
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</table>

<table>
<thead>
<tr>
<th>Sexual Arousal Disorders</th>
<th>DSM-IV Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Female Sexual Arousal Disorder*</td>
<td>Persistent or recurrent inability to attain, or to maintain until completion of the sexual activity, an adequate lubrication-swelling response of sexual excitement</td>
</tr>
</tbody>
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<table>
<thead>
<tr>
<th>Orgasmic Disorders</th>
<th>DSM-IV Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Female Orgasmic Disorder*</td>
<td>Persistent or recurrent delay in, or absence of, orgasm following a normal sexual excitement phase</td>
</tr>
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<table>
<thead>
<tr>
<th>Sexual Pain Disorders</th>
<th>DSM-IV Definitions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dysspareunia*</td>
<td>Genital pain that is associated with sexual intercourse</td>
</tr>
<tr>
<td>Vaginismus*</td>
<td>Recurrent or persistent involuntary contraction of the perineal muscles surrounding the outer third of the vagina when vaginal penetration with penis, finger, tampon, or speculum is attempted</td>
</tr>
</tbody>
</table>

*All FSDs are classified as causing "marked distress" or "interpersonal difficulty." Also sexual dysfunction is not better accounted for by another Axis I disorder and is not exclusively due to physiological effects of a substance (eg, drug abuse or medication) or general medical condition.

Overlap of FSDs

Sexual Desire Disorders

Sexual Arousal Disorder

Dyspareunia

Orgasmic Disorder

Vaginismus

Prevalence of Sexual Dysfunction

- 43% of women between the ages of 18-59 (n=1749)
- 31% of men between the ages of 18-59 (n=1410)

Laumann et al, JAMA, 1999
Prevalence of Sexual Dysfunction in Women

43% of Women Experienced Some Form of Sexual Dysfunction

- Lack of Sexual Interest: 32%
- Unable to Achieve Orgasm: 28%
- Pain During Sex: 21%
- Sex Not Pleasurable: 27%

Women aged 18 to 59 years.
Prevalence of Sexual Problems Associated with Distress (PRESIDE)

<table>
<thead>
<tr>
<th>Age-stratified prevalence</th>
<th>Desire 2868/28,447</th>
<th>Arousal 1556/28,461</th>
<th>Orgasm 1315/27,854</th>
<th>Any 3456/28,403</th>
</tr>
</thead>
<tbody>
<tr>
<td>18-44</td>
<td>8.9</td>
<td>3.3</td>
<td>3.4</td>
<td>10.8</td>
</tr>
<tr>
<td>45-64</td>
<td>12.3</td>
<td>7.5</td>
<td>5.7</td>
<td>14.8</td>
</tr>
<tr>
<td>65 or older</td>
<td>7.4</td>
<td>6.0</td>
<td>5.8</td>
<td>8.9</td>
</tr>
</tbody>
</table>

The Impact of Dysfunctional Sex on Relationships

Bad Sex Plays a Much Larger Role in Subverting an Otherwise Good Relationship than Good Sex Does in Promoting it

McCarthy B. Journal of Sex & Marital Therapy, 2001
Hypoactive Sexual Desire Disorder

The persistent or recurrent deficiency or absence of sexual thoughts, fantasies and/or desire for, or receptivity to, sexual activity, which causes marked personal distress or interpersonal difficulties.
### Prevalence of Low Sexual Desire and Hypoactive Sexual Desire Disorder in a Nationally Representative Sample of US Women

<table>
<thead>
<tr>
<th>Category</th>
<th>Low Desire N</th>
<th>Low Desire %</th>
<th>HSDD N</th>
<th>HSDD %</th>
</tr>
</thead>
<tbody>
<tr>
<td>All</td>
<td>1936</td>
<td>36.2</td>
<td>1920</td>
<td>8.3</td>
</tr>
<tr>
<td>Age 30-39</td>
<td>453</td>
<td>30.8</td>
<td>453</td>
<td>8.3</td>
</tr>
<tr>
<td>Age 40-49</td>
<td>542</td>
<td>25.3</td>
<td>539</td>
<td>9.0</td>
</tr>
<tr>
<td>Age 50-59</td>
<td>824</td>
<td>37.8</td>
<td>814</td>
<td>9.4</td>
</tr>
<tr>
<td>Age 60-70</td>
<td>117</td>
<td>60.7</td>
<td>114</td>
<td>5.8</td>
</tr>
<tr>
<td>Surgical Menopausal</td>
<td>635</td>
<td>39.7</td>
<td>631</td>
<td>12.5</td>
</tr>
<tr>
<td>Natural Menopausal</td>
<td>551</td>
<td>52.4</td>
<td>541</td>
<td>6.6</td>
</tr>
<tr>
<td>Premenopausal</td>
<td>750</td>
<td>26.7</td>
<td>748</td>
<td>7.7</td>
</tr>
</tbody>
</table>
Components of Sexual Desire

- Drive
- Expectations, Beliefs and Values
- Motivation

Levine, SB Sexual Lives, 1994
Social Psychology Theories: Understanding Psychosocial Aspects of Female Sexual Desire

• Self-Perception Theory
  – People make attributions about their own attitudes by relying on observations of external behaviors (Bem, 1965)

• Wundt's schema of sensory affect (aka Kingsberg’s Ice-Cream Analogy)
  – increases of stimulus intensity above threshold are felt as increasingly pleasant up to a peak value beyond which pleasantness falls off through indifference to increasing unpleasantness.
Prevention and Treatment of Sexual Problems

Communication!

You cannot treat a problem if you don’t know it exists
Patient Perception

• Although 85% of adults want to discuss sexual functioning with their physicians
  – 71% feel physician doesn’t have time
  – 68% don’t want to embarrass physician
  – 76% believe no treatment available

• They report
  – Non empathetic judgmental responses
  – Physician discomfort
  – Concerns regarding privacy
  – Lack of cultural sensitivity

Barriers to Taking a Sexual History

- Embarrassment
- Impression of being unapproachable or uncaring
- Inadequate knowledge/skills
- Lack of awareness of associated comorbid conditions
- Personal discomfort about sex
- Cultural and language barriers
- “Improving quality of life” may not be considered a high priority
- Concern that management will be time-consuming and/or poorly reimbursed

Predictors of Addressing Sexual Health

- Study of physicians participating in ED educational program
- Best predictors of sexual history taking
  - *Previous training in communication skills (only 29.5%)
  - Specialty (cardiology 87.1%, urology 84.5%, internists 75.8%, GPs 63.6%)
  - Liberal sexual attitudes, psychosocial orientation
  - Private practice
- Predictors of perceived difficulty
  - Lack of experience treating sexual problems
  - Gender (female)

Importance of Sexual Function to Overall Health

• Provides same benefit as cardiovascular exercise
  – Muscle Tension, Increased Heart-Rate, Calorie Burn
• Reduces Stress
  – Oxytocin release provides calming effect
• Improves sleep
  – Induces relaxation and oxytocin release
• Reduces Pain
  – Release of corticosteroids and endorphins increase pain threshold
• Improves mood/depression
  – Endorphin and oxytocin release as well as improved intimacy and relationship