# Managing Sexual Problems among Couples

**Introduction**
Sexual dysfunction is common problem among couples but are usually less discussed. Patients expect doctors to ask about sexual functioning, but many doctors have little education and training about sexuality. Furthermore, many patients will not talk about this due to shame, guilt or embarrassment.

**Classification of Sexual Disorders among Women**
**(As issues of sexual disorders among men and not discussed – premature ejaculation, impotence, etc.)**

- Hypoactive sexual desire disorder : Lack or loss of interest in initiating sex and little desire to seek stimulation.
- Sexual aversion disorder : Aversion, avoidance or dismissal of sexual prompts or sexual contact. It may be life-long or acquired following sexual or physical abuse or trauma.
- Female sexual arousal disorder : Failure to achieve and progress through the stages of normal sexual arousal.
- Female orgasmic disorder : A delay or absence of orgasm after normal female arousal.
- Dyspareunia : Genital pain before, during, or after intercourse.
- Vaginismus : Involuntary contraction of the muscles around the vagina as a response to attempted penetration. The contraction makes penetration painful or impossible.

**Examination**
Your doctor will examine you to look for any physical findings however, there may be no abnormalities to be found. Other signs which your doctor may look for may include signs of mental distress or abnormality, the development of secondary sexual characteristics (looking for hirsutism or other signs of excessive male hormone). Your doctor will check your blood pressure, peripheral pulse etc.

The doctor may look for sign of loss of sensations or reflexes in the perineal area which may occur in multiple sclerosis or spinal nerve damage. Irritable bowel syndrome with pain from pressure on the distended or tender gut can be a cause of dyspareunia and extensive pelvic surgery may damage pelvic nerves.

A digital examination can confirm or exclude pain and your doctor will look for signs of STI or of irritation or thrush (which could cause dyspareunia). Other abnormalities such as fibroids, ovarian cysts or endometriosis are also looked for.

**Investigations**

Investigations are guided by the history and it may include :

- Prolactin level: raised levels may indicate a pituitary problem but if only mildly raised it may not be significant.
- Follicle-stimulating hormone and luteinising hormone to establish whether a woman is pre-mature menopausal or has a pituitary problem.
- Thyroid hormone and thyroid-stimulating hormone levels.
- Liver function tests (if drug or alcohol abuse is suspected).
- Biochemical screen or full blood count (e.g. in complaints of fatigue to exclude physical illness such as diabetes, leukaemia or Addison's disease).
- Ultrasound scan of the pelvic organs for elucidation of abnormal findings.
- Laparoscopy if the history is suggestive of pelvic inflammatory disease or endometriosis.

**Treatment**

You would need to talk to your doctor about your sexual problems so he/she can help you find the solutions. You may be referred to a knowledgeable therapist to help to modify specific problems with disability, medication or illness. Some common problems are discussed below.

1) **Lack of Knowledge**

It is still surprisingly common. And it may be due to being brought up in a family where sex was not discussed. Sometimes it can be due to abuse, or an unpleasant event, that makes the patient avoid sex. Source of information are important; however, obtaining information from reading or watching pornography may represent fantasies and not reality and should be avoided.

2) **Lack of Loss of Desire**

Many people complain about this when they have a lower level of sexual interest than their partner does. It can be due to :

- Fear of being found not to be good enough at sex – so it is avoided; being too busy or preoccupied with other matters — common in couples who have children and jobs that keep them on the go all the time.
- Being ill, depressed or grieving — it is usual not to want sex if attention is focused on something else.
- Guilt about sexual activity — because of upbringing, religious beliefs, or that they are letting someone else down.
- Fear — of pregnancy, or infection, or damage (common after a heart attack, operation or stroke).
- Boredom — the same routine may be turning them off; concentrating on the bad points of the partner instead of the reasons why they got together in the first place.

Loss of desire is the commonest complaint in women, but is a spectrum of disorders. The complaint may have always been present. Some medical problems may make loss of desire more likely or be causative (Table below).

| Medical factors to consider in loss of desire | |
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| Illnesses | Medications |
| • Pain on intercourse from gynaecological, obstetric or urological disorders. E.g: from pelvic infections, endometriosin.<br>• Alcohol or illegal drug misuse.<br>• Stress or chronic anxiety. E.g: from work, social environment.<br>• Endocrine disorders, e.g. pituitary tumours, hypothyroidism, possibly diabetes.<br>• Neurological disorders, e.g. hypothalamic disease, strokes. | • Anti-androgens, e.g. cyproterone; gonadotrophin releasing hormone analogues.<br>• Anti-oestrogens, e.g. tamoxifen, some contraceptives*.<br>• Cytotoxic drugs.<br>• Psychoactive drugs e.g. sedatives, narcotics, antidepressants, neuroleptics, and stimulanis. |

3) **Lack of performance**

Lack of failure to achieve an orgasm is a more common complaint in women than in men. Orgasmic dysfunction in women is often linked to myths about the responsibility of the male partner to be able to produce the orgasm ‘for the woman’.

The use of phosphodiesterase type 5 inhibitors, sildenafil (Viagra), tadalafil (Cialis) and vardenafil (Levitra) are useful to improve or initiate erection after sexual stimulation in men, but trials have not shown the same benefits for women.

**Vaginismus**

Vaginismus is the symptom of a disorder in which spasm of the vaginal muscles prevents the penile penetration into the vagina or it can only be possible with associated pain or discomfort. Penetration may be impossible and the woman may be unable to touch the vulva herself; find any opening; allow anyone else to touch; allow anything inside; but can sometimes have a vaginal delivery after artificial insemination (i.e. something can come out even if not allowed in).

Secondary vaginismus has often been caused by the woman’s experience of pain after infection, forced intercourse, a difficult delivery, imagined or real disfigurement after episiotomy, or any instrumentation in that area whether vaginal, urethral or rectal.

Primary vaginismus is usually due to fear and is similar to a panic disorder or phobia. This is rarely susceptible to an operation under anaesthetic to ‘open it up’. Many women with minor problems can be helped with advice and learning how to explore their own vagina to remove the fear of the unknown. Others have a more complex phobia or fantasies that can take many months of therapy.

**Vulval Pain**

Superficial vulval pain is common and has a multiplicity of possible underlying factors: vulvitis or vulvovaginitis from infection; vulval vestibulitis — with severe pain to the touch; vulvodynia — a condition of persisting pain of unknown aetiology possibly related to post viral infection sensitivity or psychological fears, that may overlap with vestibulitis; urethritis; inadequate lubrication; irritants such as spermicides, detergents, scents, dyes, or sweat.

Although the majority of women have short-lived symptoms, relieved by treatment of the underlying cause, a few continue to suffer considerable distress. For others it may be part of a psychological defence, and a few remain ‘medically unexplained ‘even after tertiary specialist referral and investigation.

**Infertility**

When pursuing a pregnancy, it is very stressful for a couple to be concentrating on having intercourse ‘to order’, whether they feel desire for intercourse or not. The investigations, the waiting, the disappointments, all add to the lack of enjoyment in sexual activity.

Some infertility may be secondary to lack of intercourse or non-consummation, showing that a good sexual history is essential right at the start. It is important that a couple undergoing investigations and treatment for infertility are encouraged to have sexual activity for enjoyment as well as precreation.

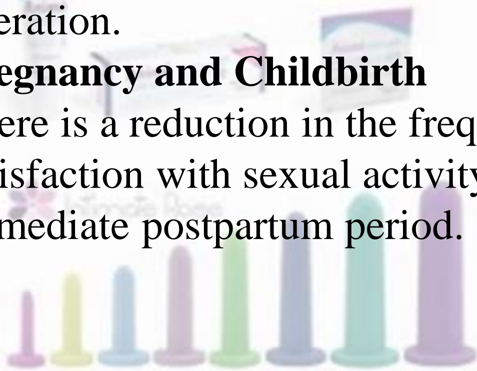
**Hysterectomy and Other Operations**

Hysterectomy for heavy bleeding usually improves sexual functioning. Patients who had a bulky uterus may find they have altered sensation and need to change positions afterwards to achieve the same stimulation.

Quite a few women (and their husbands) are fearful of doing some damage to the scar afterwards, or that the vagina will not be long enough to contain the penis. Factual handouts promote good sexual functioning after the operation.

**Pregnancy and Childbirth**

There is a reduction in the frequency of intercourse, and interest and satisfaction with sexual activity, over the course of a pregnancy and in the immediate postpartum period.



**Conclusion**

As a patient, you are encouraged to discuss with your doctor the sexual problems you may have which can contribute to infertility. Sexual dysfunction management is an inter-disciplinary approach band And proper management is essential for the couple's well being.

**Reference**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Helping Women Overcome Sensitive & Painful Health Issues