Sexual Health in Women Across the Lifespan

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Disclosures

- I have no financial relationships to disclose.
- Generative AI was not used for the development or content of this presentation.

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About Dr. Buehler

- PsyD specialized in family systems, with a focus on chronic illness.
- Partnered with an endocrinologist to open an integrated wellness center in 2002 to help women with sexual issues and began the journey to becoming an AASECT Certified Sex Therapist.
- Contracted as a sex therapist with a major regional hospital to women with pelvic pain issues, as well as providing sexuality counseling to women at high risk for breast and ovarian cancer.
- Authored a textbook on sex therapy as well as a book on sexual issues and reproduction.
- Fellow of the International Society for the Study of Women's Sexual Health.
- Created a continuing education platform for courses on sexuality and relationships.

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Learning Objectives

1. Identify biological, psychological, relational, and sociocultural factors influencing women's sexual health across the lifespan, including examples from diverse populations.
2. Discuss three cultural or systemic barriers to sexual health for LGBTQ+ women and women from diverse racial, ethnic, and cultural backgrounds.
3. Design one actionable intervention plan that integrates culturally responsive and affirming practices to improve sexual health outcomes for women.

I. Introduction

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Why Sexual Health Matters

Integrative behavioral care

- Sexual issues are prevalent, affecting 30-50% of women globally
- Because sexual health impacts physical and mental well-being, women should be routinely screened and treated (Parish & Pope, 2024)

Addressing stigma and silence

- Women often feel embarrassed or ashamed to bring up sexual issues
- Clinicians sometimes have inadequate training or their own unresolved sexuality-related issues

Optimal sexual health is associated with…

- Fewer reports of depression and anxiety
- Greater life satisfaction for all, including older adults, pregnant women, and same-sex and mixed-sex couples

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Prevalence

- Unclear because of several factors (Davis, 2024)
  - May have excluded women who aren't partnered or who aren't currently sexually active
  - Broad vs. localized studies (US vs. India or Kenya)
  - Did not use measures that captured the level of distress
- Generally accepted that about 40% of women will have a sexual complaint sometime in their lifetime.
- Complaints cluster in early adulthood, the postnatal period, and perimenopause

Trauma-Informed Sex Therapy

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Using A Social Justice Approach

- **Center** intersectionality and structural competence regarding the role of oppression in the consideration and treatment of BIPOC and LGBTQ+ clients
- **Affirm** LGBTQ+ clients and diverse sexual practices; consider bias regarding cisgender and heteronormative scripts.
- **Integrate** sexual health as part of mental health.
- **Provide access** to sexual health providers who share at least one identity with the client when possible.
- **Avoid assumptions** about identity; ask general questions such as “What can you tell me about your sexual identity?

II. Model Of Assessment And Framework For Understanding

Frances

- Age 43, Black cisgender female, heterosexual, married to a supportive partner, with one child.
- Complaint of low desire.
- Reports symptoms of menopause, including hot flashes, insomnia, and moodiness.

Elena

- Age 24, Hispanic, cisgender, queer, nonbinary, currently not partnered.
- Reports that she has never had an orgasm.
- Feels shamed by parents regarding her identity.

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Melissa

- Age 32, mixed ethnicity, cisgender, heterosexual female married to a supportive partner.
- Postpartum one year.
- Complaint of pain with intercourse.

PLISSIT + R and SEA

- PLISSIT+R
- Sexological Ecosystemic Assessment (SEA)

PLISSIT+R Model

- Clinical decision-making model (Annon, 1976)
- Best for:
    - Time-constrained sessions
    - Brief interventions
- Key Use: Introducing the topic of sex for possible exploration
- Structured steps: Permission, Limited Information, Specific Suggestions, Intensive Therapy + Referrals
- Continues to be a effective and practical approach (Ozdemar, et al., 2024)

Sexological Ecosystemic Assessment

- Contextual biopsychosocial framework
- Best for:
  - Comprehensive and holistic understanding
  - Flexible timing across sessions
- Key Use:
  - Integrated at any stage of assessment or treatment
- Emphasizes relational, cultural, and psychological contexts

Comparison Summary

Feature	PLISSIT+R	Sexological Ecosystemic Assessment
Model Type	Clinical decision-making	Biopsychosocial, contextual
Time Efficiency	Ideal for brief sessions	Ideal for extended, thorough work
Flexibility of Use	Stepwise, structured	Integrative at any stage
Scope	Primarily symptom-focused	Systemic and contextual insight

PLISSIT + R

- Permission to talk about sex
  - Sexual well-being is tied to overall physical and mental health. With your permission, I'd like to ask some questions about your sexual health.
  - Sexual problems are prevalent. Do you have any concerns in that area you'd like to discuss?
  - I talk to all patients about sexuality, with their permission, of course. Is it okay to spend a few minutes on this area?
- Getting permission or consent to talk about sensitive topics is an on-going consideration

Brief Sexual Assessment Questions

- In your own words, please tell me what symptoms you have?
- When did you first notice the problem?
- What else was going on in your life at the time you noticed the problem?
- What have you tried? If it didn't work, what is your best guess as to why?
- Is this problem causing you distress?
- How well do you get along with your partner?
- Is there anything about your sexual identity that you'd like to share?
- Do your feelings about your sexuality play a role in the problem?

LI + SS *OR* IT

- Limited Information and Specific Suggestions
  - “Many people with vaginas experience dryness and discomfort as estrogen levels decrease. Using a lubricant can help with that. I have a handout available. Would you like one?”
- Intensive Therapy
  - Trauma, moderate to severe depression, relationship distress
  - When a person has difficulty following suggestions, or they aren’t of any help
  - Questioning, or conflicted by, sexual identity

R - Referrals

- Sexual medicine specialists: Gynecologists and urogynecologists
  - International Society for the Study of Women's Sexual Health
  - Sexual Medicine Society of North America
  - The Menopause Society
  - International Pelvic Pain Society
- Endocrinologists to help with hormonal issues, including diabetes and pituitary problems
- Neurologists in the case of nerve-related issues, particularly with some sexual pain disorders
- Psychiatrists regarding current medications or prescribing medications for present diagnosis.

Sexological Ecosystem

- Developmental, systemic, and interactive biopsychosocial model based on work by Bronfenbrenner
- Characterized by five systems: micro, meso, macro, exo, and chrono

Subsystems

- Microsystem: Individual biology and development; family of origin; close caregivers
- Mesosystem: Interaction between the individual and local systems
- Exosystem: Local systems, including healthcare, education, politics, religion, regular and social media
- Macrosystem: Significant external influences, including the legal system, social justice movement, sexual and reproductive rights, gender roles, values and beliefs, culture*
- Chronosystem: The effect of time, both internal (one's development; impact of personal gains and losses) and external (social changes, technological changes)

Integrating SEA into PLISSIT+R

- Use the SEA after Permission or during Intensive Therapy
- Adapt the SEA based on the setting/time constraints
- Use the SEA questions as a guide for inquiry
- Create your own SEA questions based on the population you work with
- Open access article listed in References: Buehler, S. (2024). Sexological Ecosystemic Assessment: A systems approach to understanding sexual issues in individuals and couples. *Journal of Counseling Sexology & Sexual Wellness: Research, Practice, and Education*, *5*(1), 1.)

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Assessing And Treating DSM-5 Diagnoses

Table 1. Diagnostic and Statistical Manual of Mental Disorders (DSM-5) Female Sexual Dysfunction Disorders.

DSM-5 Female Sexual Dysfunction Disorders	Diagnosing Specific Female Sexual Dysfunction Disorders *	Other Conditions to Consider when Making Diagnoses of Specific Female Sexual Dysfunction Disorders
Female Orgasmic Disorder; 302.73 (F52.31)	Significant delay, infrequency, absence, or reduced intensity of orgasms in all/most sexual experiences with clinically significant distress over 6 months or more. Important additional considerations: - Barriers to orgasm are not due to lack of clitoral stimulation during vaginal penetration, a mental disorder, a medication/substance, history of abuse or interpersonal or sociocultural factors. - Consider whether an orgasm was experienced under any situation previously. - Diagnosis is based on subjective, self-reports from women.	1. Nonsexual mental disorders. 2. Substance/medication use. 3. Other medical condition. 4. Interpersonal factors. 5. Other sexual dysfunctions.
Female Sexual Interest/Arousal Disorder; 302.72 (F52.22)	Absent or markedly reduced sexual arousal or interest for at least 6 months with clinically significant distress as reflected by: 1. Lacking or low interest in sexual activity with reduced or no sexual or erotic thoughts. 2. Diminished openness to creating a sexual experience and/or being receptive to a partner's sexual initiation. 3. Diminished or absent sexual arousal or pleasure during most or all sexual experiences. 4. Diminished or absent sexual responsivity to adequate intrapersonal, interpersonal, or external sexual cues. Additionally, sexual dysfunction is not better attributed to a mental disorder, relational distress, other life stressors, a medication/substance, history of abuse or interpersonal or sociocultural factors. Important additional considerations: - Desire discrepancy with a partner is not sufficient for diagnosis, although assessing for interpersonal contexts contributing to experience and symptoms is relevant to identifying etiology of distress or concerns. - With asexual self-identification, no diagnosis is made.	1. Nonsexual mental disorders. 2. Substance/medication use. 3. Other medical condition. 4. Interpersonal factors. 5. Other sexual dysfunctions. 6. Inadequate or absent sexual stimulation.
Genito-Pelvic Pain/Penetration Disorder; 302.76 (F52.6)	Experiencing difficulties with one or more of the following for at least 6 months with clinically significant distress: 1. Challenges to vaginal penetration during sexual activity. 2. Significant pain with attempted vaginal penetration. 3. Significant fear or anxiety about experiencing pain in anticipation of vaginal penetration, during or after vulvovaginal touch or attempted penetration. 4. Significant reflexive or involuntary muscular contraction of the pelvic floor muscles during attempted vaginal penetration.	1. Other medical condition (pelvic inflammatory disease, endometriosis, etc.) 2. Somatic symptom and related disorder. 3. Inadequate sexual stimulation.

* Specify: Lifelong or Acquired, Generalized or Situational, Mild/Moderate/Severe; for additional information, see the Fifth Edition of the Diagnostic and Statistical Manual.

Female Sexual Interest/Arousal Disorder Across the Lifespan

The Most Common Clinical Presentation

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Overview of Sexual Desire

- Hormones, which may fluctuate during the menstrual cycle as well as phase of reproductive life, and neurotransmitters (dopamine and norepinephrine – excitatory; serotonin – inhibitory) contribute to the experience of sexual arousal and desire (Adabisi & Carlson, 2024).
- As production of estrogen and progesterone decrease with age, so does testosterone, which contributes to arousal and sensation.
- Prevalence of FSIAD in Europe is 6-16%, and 9-26% in North America
- As previously stated, arousal and interest are impacted by a variety of ecosystemic factors.
- Rule out medical causes; vaginal dryness and painful sex; difficulty with orgasmic function.

Adolescence / Early Adulthood (Teens to 20s)

- Shame or guilt linked to cultural/religious messaging
- Lack of sexual self-knowledge and confidence
- Fear of judgment (“slut shaming”) or performance anxiety
- Minimal communication skills in relationships
- Inexperience with what arouses or interests them
- Mixed messages from media
- Lack of sex education beyond “plumbing and prevention”
- Essential understanding of consent, and consent as an ongoing process.
- Coming out, sexual experimentation, gender identity, questioning
- Forming relationships, identifying partners that are emotionally and physically safe

Reproductive Years (20s to 40s)

- High stress from parenting, work, or caregiving roles
- Division of labor in cis het couples vs. lesbian couples
- Relationship fatigue or emotional disconnection—loss of sexual interest
- Sleep deprivation and mood disturbances; lifestyle factors like diet, exercise, sleep hygiene
- Decreased spontaneous desire, especially in long-term relationships: responsive desire

Sexuality and Pregnancy

- Hormonal shifts due to contraceptives and fertility treatment, and during pregnancy and postpartum
  - Little attention was paid, and until recently, very little research
  - Contraceptives themselves may suppress drive (black box warning?), responsibility of contraception, unplanned pregnancy, miscarriage, unpreparedness for sexual changes during pregnancy
  - Infertility and its challenges—reverberating forward for years
  - Some women find that their drive and capacity for orgasm increase during pregnancy, while some find a decrease in libido as pregnancy advances
  - Postpartum, most people resume sexual activity, though at a decreased rate, esp. during the first year
    - If not, why not: body image, navigating new roles, not asking or receiving help, time and role management, r/o depression

Buehler, S. (2018). *Counseling couples before, during, and after pregnancy: Sexuality and intimacy issues*. Springer Publishing Company.

Desire and LGBTQ+ Population

- LGBTQ+ individuals had higher desire for solo sexual activity than heterosexual counterparts, which researchers attributed to sex positivity (Makarenko et al, 2022).
- In a report from ISSM, lesbian and bisexual women may experience lower sexual desire
  - Minority stress
  - Stigma and internalized homophobia
  - Relationship challenges
  - Higher rates of depression and other mental illness (ISSM, 2025)

Desire in BIPOC Women

- Married and white women were found to have less desire than single and Black women (Adebisi & Carlson, 2024)
- Female circumcision, still practiced in various cultures, can have a deleterious effect on sexual desire, arousal, and orgasm, and contribute to GPPPD.

Perimenopause and Menopause (40s to 60s)

- Many medical providers aren't trained to help women who experience symptoms of menopause
- Estrogen/testosterone decline reduces arousal and lubrication
- Physical changes (vaginal atrophy, hot flashes); diagnosis of inflammatory and other disease
- Genitourinary Symptoms of Menopause (GSM)
- Similar late effects whether natural or surgical menopause
- Psychological impact of aging, self-image decline
- Empty nest or life transition stressors; loss of novelty in long-term sexual relationships; partner issues
    - Partner's sexual issues, grey divorce, illness; death

Geniturinary Symptoms Of Menopause (GSM)

- GSM include (Kaufman, et al., 2025):
  - Atrophy and dryness of the vagina and introitus
  - Shrinkage of clitoris and labia
  - Urinary incontinence
  - Increased risk of urinary tract infections
  - Painful intercourse due to vaginal dryness

Postmenopausal Years (60+)

- Statistically, 75% of women between the ages of 40 and 69 are sexually active
- Further reduction in hormones affecting the arousal response
- Chronic medical conditions or medications (e.g., SSRIs, antihypertensives)
- Bereavement or lack of a sexual partner
- Societal de-sexualization of older women
- Mental health and body confidence issues
- The limiting belief or narrative that one must be able-bodied to have pleasurable sex
- Invisibility of LGBTQ+ people as they age makes finding a partner difficult

Treatment of Female Sexual Interest/Arousal Disorder

Key Considerations in Clinical Practice

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Assessment Based on SEA

- Microsystem: What were you taught about sex? Were there any gendered messages about sex? What did you see modeled in terms of sexual interaction in an intimate relationship? Is it possible the client is asexual or is questioning their gender or orientation?
- Mesosystem: Compare/contrast SE of client and partner? Who is experiencing distress? How have healthcare interactions been? For example, was a person in their 60s told they were “too old” to worry about sex?
- Exosystem: What cultural and religious messages did you receive about desire? What about from peers? The media?
- Macrosystem: Have social attitudes and stigma impacted your desire? In what way?
- Chronosystem: Has your drive fluctuated during life transitions?

Referrals

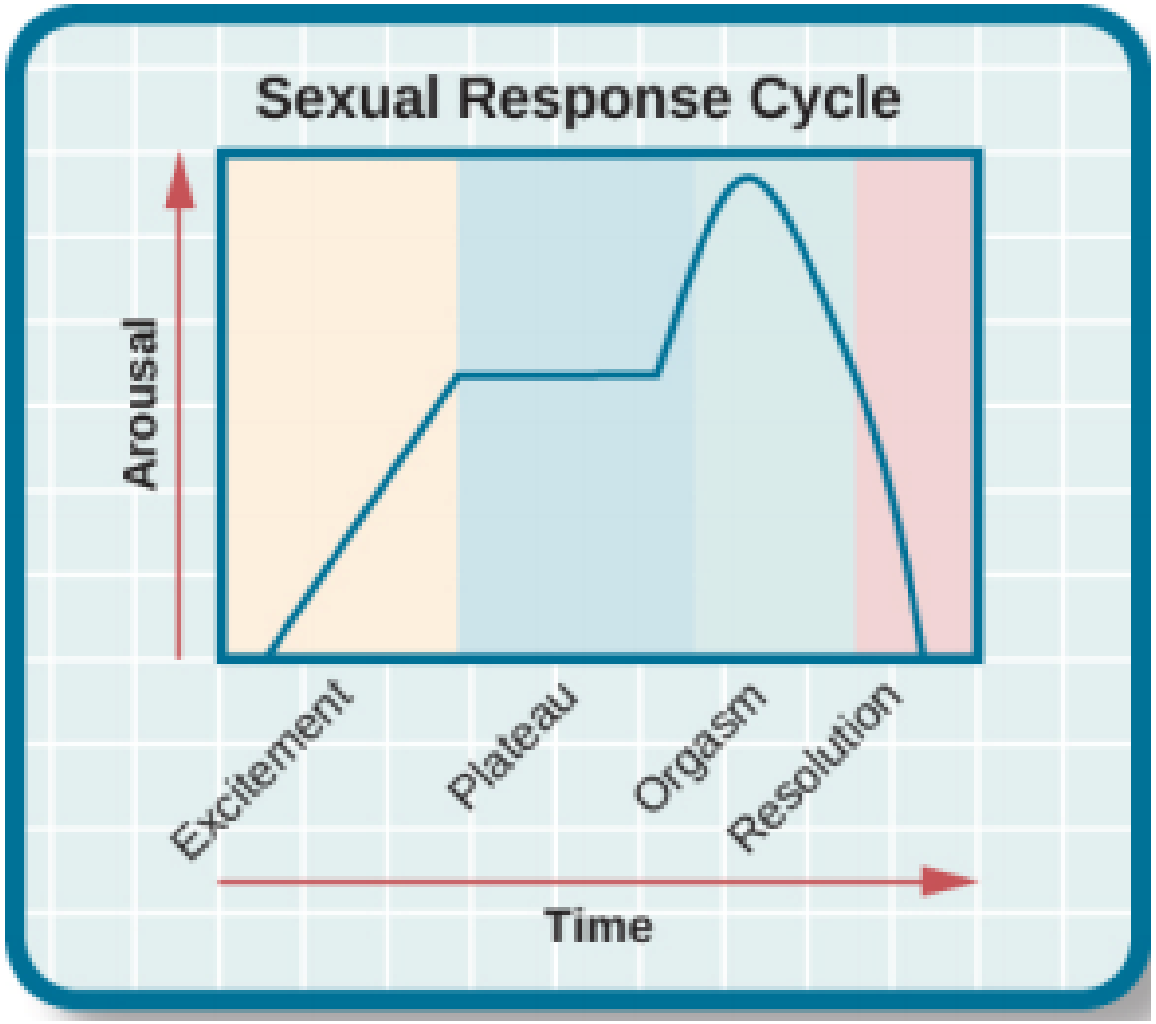
- Rule out medical problems, including those associated with medications and OCPs
- Address hormonal imbalances—estrogen, progesterone, and testosterone
- Options for medication to treat FSIAD in premenopausal women
  - Flibanserin (Addyi): balance of neurotransmitters
  - Bremelanotide (Vyleesi): activates melanocortin receptors
  - “Tools in the toolbox”
- Consider the effect of psychotropic medications and make appropriate adjustments as needed.

CBT

- The International Society of Sexual Medicine (2025) recommends addressing cognitive, social, cultural, and relational factors before initiating any exposure therapy, such as sensate focus or self-exploration.
- Normalize changes in sexual desire over time and with phases of life
- Discuss linear, responsive, and dual control model (“accelerators” and “brakes”)
- Education regarding mismatched desire
  - Information about how often couples experience this issue and why
  - Need for differentiation as well as attachment
  - Problem-solving and coping skills
- Consider referral to couples therapy first if there are moderate to severe issues.

Models of Sexual Desire

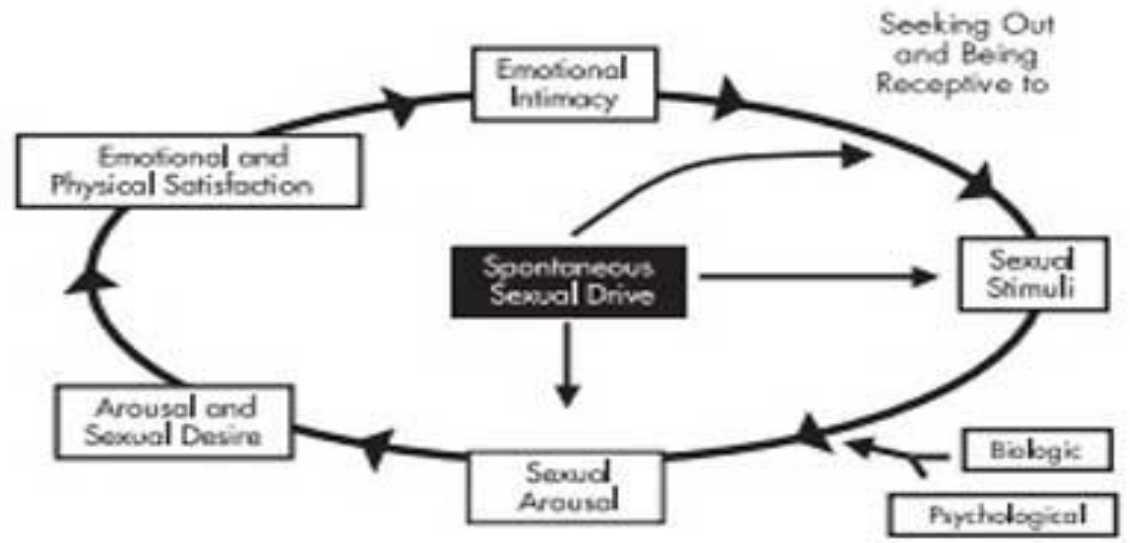
- Spontaneous (linear) desire
  - More common at the beginning of a relationship
  - Goal-directed activity that results in a climax
- Responsive (circular) desire
  - Includes a relational component
  - Sexual activity includes affectionate and healing touch
  - May or may not include orgasm
- Dual control model
  - Neurological / motivational model of desire
  - “Accelerators” and “brakes”



Masters, W. H., & Johnson, V. E. (1966). Human sexual response.

Basson's Sexual Response Model

FIGURE 3. Non-linear Model of Female Sexual Response Developed by Basson[6]



Basson, R. (2000). The female sexual response: A different model. *Journal of Sex & Marital Therapy*, *26*(1), 51-65.

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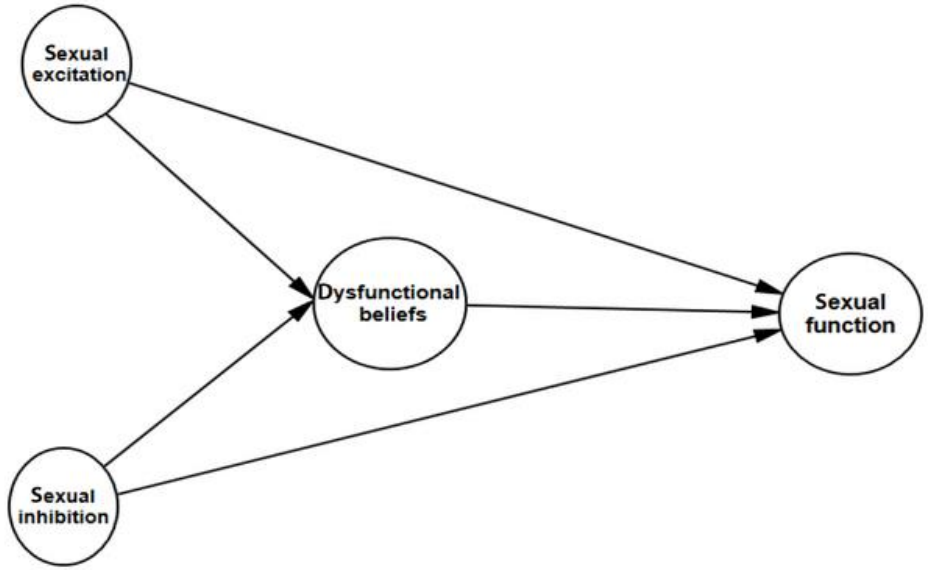
Bancroft Dual Control Model

- Bancroft & Janssen developed a model based on the concept that sexual desire was mediated by opposing factors:
  - Sexual excitation: seeing partner naked, kissing, having an intimate conversation, genital and non-genital touch, positive thoughts (this will be enjoyable, I will feel more connected, I'm glad my partner initiated)
  - Sexual inhibition: relationship issues, partner's hygiene, dislike of partner's initiation, negative cognitions (this won't be fun, I can't believe partner is in the room, what's the point, etc.)
- Popularized as "accelerators" and "brakes'
- Mediated by neurotransmitters:
  - ↑ Dopamine creates excitation and arousal
  - ↓ Serotonin creates inhibition

Cognitive Model

Examples

Yahagh et al. 2024



- Sex is embarrassing.
- I feel guilty for wanting sex.
- Sex is dirty or disgusting.
- Sex is a sin.
- Do it for your partner.
- Sex is supposed to hurt.

CBT

- Negative beliefs associated with sex
- Address depression, anxiety, and trauma
- Explore shifts in identity, for example, from partner to spouse
- Addressing role conflicts
  - Fatigue created by caregiving and/or childrearing
  - Work demands
- Couple relationship issues
  - Blaming and shaming
  - Division of labor (physical and emotional)
  - Differentiation

Mindfulness and Sexuality

- Mindfulness, in general, helps liberate the practitioner from persistent negative or repetitive thought patterns and cultivates a calm presence (Kabat-Zinn, 2021).
- A study (Brotto et al, 2024) found women who self-reported stress and demonstrated physiological stress via cortisol testing who underwent Mindfulness-Based Cognitive Training (MBCT) reported higher levels of sexual desire.
- Mindfulness practiced during sex also improves sexual function, as most recently found in couples (Goldberg, et al, 2025)

Intimacy and Sensuality

- Implement sensate focus and other non-demand touch activities to increase awareness of physical sensations of arousal
- Self-sensate focus may be a helpful first step in exploring one's eroticism.
- Baths or showers, alone or together, for sensual exploration and/or relaxation
- Massage—each other, or by a masseuse for one's well-being and body image
- Dancing, either at home or out, alone or together, consider dance lessons
- Breathwork or yoga to help with body awareness and physical well-being

WSW and Desire

- Have a higher frequency of orgasm and sexual satisfaction than heterosexual women
- Experience a similar variability in desire over the course of the lifespan
- Higher relationship satisfaction is associated with sexual satisfaction in WSW, with implications for treatment (Bondarchuk-Mclaughlin & Anderson, 2025)

Female Orgasmic Disorder Across the Lifespan

Considerations Across the Lifespan

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Prevalence and Contributing Factors

- 5-10% of American women report never having experienced orgasm (total anorgasmia)
- Primary, secondary, situational, generalized
- CFs include depression and anxiety, relationship issues, hormone imbalance, medications, alcohol and recreational drug use, pelvic floor dysfunction, nerve damage, aging, and shame or guilt. (Giraldi, 2025)
- Situational factors may include relationship conflict, work stress, changes in caregiving and parenting roles, and identity shifts.
- CBT is the standard of care, as there are no medical treatments.

The “Orgasm Gap”

- A study by Mahar, Mintz, & Akers (2020) found that during partnered penis-vagina intercourse (PVI), emphasis was on activity that facilitated male orgasm.
- Activities that help with clitoral stimulation (manual and oral stimulation and/or sex toys) are often not used or suggested.
- Lack of sexual knowledge, assertiveness, and empowerment are CFs
- One study (Gesselman et al., 2024) found that male orgasm rates were 70-85% while female orgasm rates were 46-58%.
  - The orgasm gap persists between men and women, regardless of age.
  - Older lesbian women had higher orgasm rates than younger lesbian women.
  - Lesbian women had a more egalitarian approach to sex.

Assessment Questions

- Microsystem: What did you learn about sexual pleasure? What differences were there in talking about male v. female sexual pleasure? What were you taught about masturbation? Are you sure whether you have experienced an orgasm or not? What does having an orgasm mean to you
- Mesosystem: What kinds of conversations have you had with your partner about sex? Have you spoken to your healthcare provider? Peers?
- Macrosystem: What exposure have you had to female sexual pleasure in the media? What messages have you received from religion or culture?
- Exosystem: In what ways have attitudes toward sexual identity and orientation impacted you? Do you experience minority stress?

Adolescence / Early Adulthood (Teens to 20s)

- A qualitative study found that about half of women ages 18-28 experienced orgasm during partnered sex (Bell & McClelland, 2017).
- Three themes emerged:
  - What's the big deal? (Is it, or isn't it? Struggle to understand normalcy.)
  - It's all biology. (Internal attribution to not having an orgasm; resolving cognitive dissonance.)
  - Not now, but maybe someday. (Defining orgasm on their terms and freedom from pressure vs. empowerment felt by learning to have an orgasm not.)

Reproductive Years (20s to 40s)

- Ability to, and rate of, orgasm are dependent on multiple factors
  - Hormonal effects from contraceptives, pregnancy, and postpartum
  - Stress from parenting, work, and caregiving roles
  - Reduced time/energy for sexual exploration
  - For heterosexual women, focus is often on the male partner's pleasure
  - Changes in body image and sexual self-concept
  - Impact of relationship quality and support

Orgasm and Pregnancy

- Tendency for sexual activity and satisfaction to decrease in the first and third trimesters, with an increase in the second trimester (Buehler, 2018, 2021)
- With increased hormones and sensitization of nipples and other erogenous tissue, some women experience their first orgasm during pregnancy.
- Other women have zero interest in sexual activity throughout the pregnancy
- It may be problematic for some couples, but not for others.
- Risk for IPV and breach of fidelity

Postpartum Sexuality

- Little attention has been paid to this issue in research, though perinatal sexual problems are common (Graziottin et al., 2025).
- Mental and relationship health can have a direct effect on sexual function.
- Labor and delivery: Physical and psychological trauma that may have occurred.
- Postpartum sexual pain, genital atrophy associated with breastfeeding, shifts in what feels pleasurable

Couples

- Heterosexual partners
  - Division of household labor and other factors create fatigue for female partner (Brotto, van Anders)
  - Women who did not adhere to typical heterosexual scripts--for example, that men always had higher desire--experienced fewer complaints regarding libido and orgasm
- WSW have more frequent orgasms than do heterosexual women; speculation is that sex is more focused on foreplay and clitoral stimulation.

Perimenopause and Menopause (40s to 60s)

- Decline in estrogen/testosterone affecting arousal/orgasm
- Increased difficulty reaching orgasm or decreased intensity
- Changes in sexual scripts or preferences
- Self-image and aging-related concerns
- Relationship transitions, including increased conflict, partner illness or disinterest

Sexual Triggers

- Women with a history of CSA may be triggered by sexual activity at any age, but the risk may be notable during perimenopause. (Gewirtz-Meydan & Godbout, 2023)
  - Decline in interest and distortion of the partner's desire for sex
  - Dissociation during sex and lack of sexual pleasure
  - An increase in depression and anxiety creates increased vulnerability to be triggered
  - Poor sleep patterns associated with menopause may create sleep disturbance, specifically, nightmares

LGBTQ+ Care And Perimenopause

- Glyde (2024) conducted a small qualitative study of queer people and identified needs:
  - Clinician should not make assumptions about menopause status
  - Understand client may have had previous negative experiences and need more support to build trust
  - Provider needs to become knowledgeable about perimenopause in general
    - Example #1: Trans women experience symptoms of menopause as the decline of endogenous testosterone occurs.
    - Example #2: Women who have sex with women (WSW) have elevated distress during perimenopause (Sobel, et al., 2024)

Postmenopausal Years (60+)

- Ongoing hormonal decline, chronic illness or medication effects
- Partner loss or decreased partner availability
- Societal invisibility of older women's sexuality
- Body confidence issues and myths about aging and orgasm
- Adaptation to new ways of experiencing pleasure
  - Rigidity regarding what constitutes “sex”
  - Acceptance of changes in one’s body due to mobility, painful conditions, or due to illness and cancer

Assessment and Treatment of Female Orgasmic Disorder

Key Considerations in Clinical Practice

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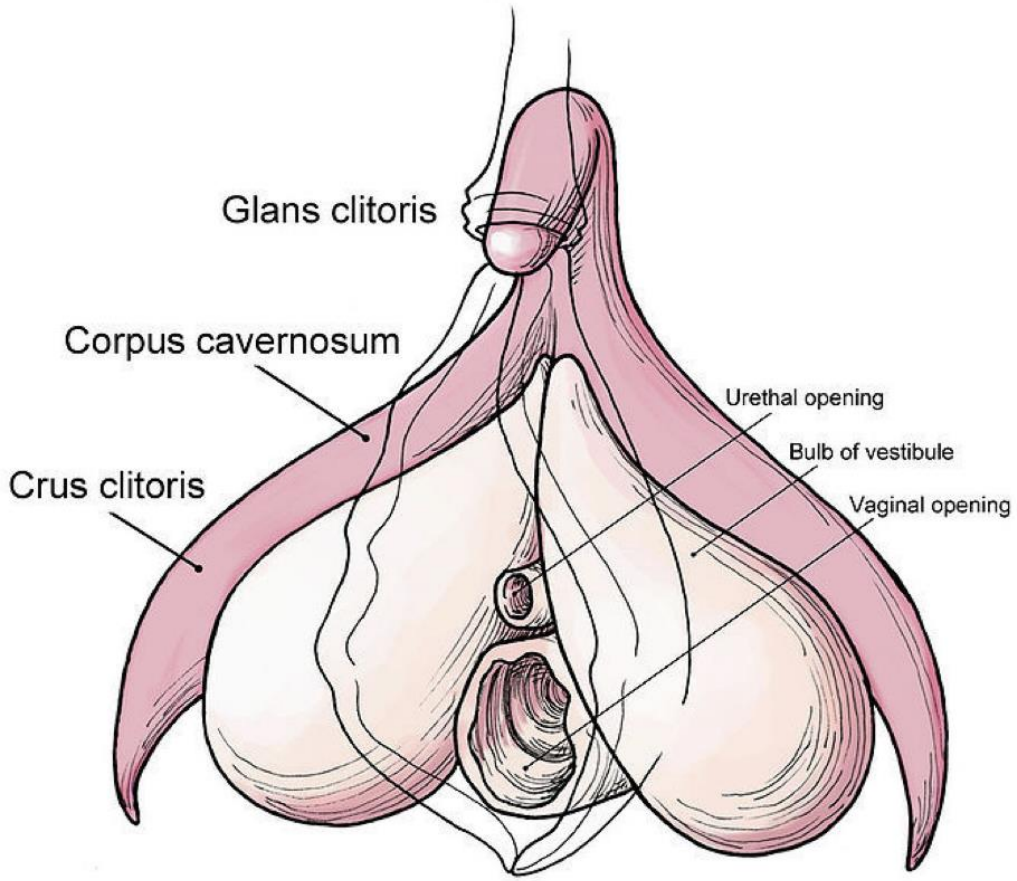
Referrals

- Assess interference caused by medications, including SSRIs
- Chronic illness such as diabetes or MS can have a direct impact on orgasm
- Address lifestyle issues and alcohol or recreational drug use; however, some women find that cannabis is helpful for orgasm (Mulvehille, 2024)
- Assess for GSM and pelvic floor dysfunction

CBT

- Education about female anatomy, especially the clitoris
- Nondemand forms of pleasure and sensuality
- Explore negative beliefs about sex
- Stress reduction
  - Setting boundaries, assertiveness, differentiation
  - Exercise, sleep, mindfulness practices
- Psychotherapy to address themes of shame and guilt

Sexual Anatomy Of The Clitoris



Self-Exploration

- Discuss attitudes and beliefs regarding masturbation and sexual discovery (directed masturbation)
- Education regarding the use of sexual aids and identify vetted resources, if possible
- Mindfulness to help maintain focus on sensation
- Inclusion of the partner in educational session
- Books (“Sex for One,” Dodson)
- Online learning (OMGYes, Scarleteen, Planned Parenthood)

Couples Work

- Partner communication and education, particularly assertiveness
- Sensate focus (Masters & Johnson;)
  - Meant as an exercise for couples a slow, sensual exploration of one another's bodies
  - Begins with taking turns to explore the extremities, and then torso.
  - Becomes mutual touching
  - Traditionally leads to intercourse for heterosexual couples; modify instructions as appropriate, for example, lesbian women may or may not have penetrative activity (Weiner & Avery-Clark, 2017)
  - If there is confusion or repeat failure to do homework, pause and re-educate, and/or suggest self sensate focus

Genito-Pelvic Pain/Penetration Disorder Across the Lifespan

Considerations Across the Lifespan

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Vaginismus and Dyspareunia

- Multifactorial causes and the need for a collaborative team approach tailored to the individual.
- Vaginismus is an involuntary spasm of the pelvic floor muscles in anticipation of vaginal penetration.
  - Occurs more often in young women, but can occur in conjunction with GSM
  - Affects 1-7% of the female population worldwide (Lowskaska & Gronowski, 2022)
- Dyspareunia is diagnosed when there is pain during penetration, e.g, vulvodynia or pelvic pain.
  - Often associated with medical conditions such as breast cancer and suppression of estrogen, gynecological problems such as endometriosis or infection, or GSM.
  - Affects about 10-20% of American women (Hill & Taylor, 2021)

Vaginismus

- Involuntary spasm that is sometimes referred to as a “phobic response” (McEvoy et al., 2024)
- Difficult to pin down the prevalence because many women are too ashamed or stigmatized to acknowledge or seek help.
- Prevalence varies by culture, for example, Middle Eastern women have high rates of vaginismus.
- Primary or secondary; situational or global; may contribute to unconsummated marriage.
- Physical causes include dryness, lack of sexual arousal (DeWitte, 2024), pelvic floor dysfunction (can be related to activities such as rock climbing), and use of hygiene products; painful first penetration.
- Psychological: Shame and guilt about sex; sexual trauma; avoidance; relationship problems
- Systemic: Negative experiences with providers, providers needing education; culture and religion

GPPPD: Dyspareunia

- Psychological risk factors include depression, anxiety, and low libido; also, more likely to be caused by past sexual abuse than vaginismus (Tetik & Yalçınkaya Alkar, 2021)
- May not seek help due to shame, embarrassment, and stigma
- May occur comorbid with other conditions such as IBS, interstitial cystitis (IC), or fibromyalgia
- May be the result of vaginal delivery especially with vacuum device
- Can result from abdominal or pelvic radiation or surgery
- Dryness and atrophy due to hormonal shifts, for example, GSM

Referrals

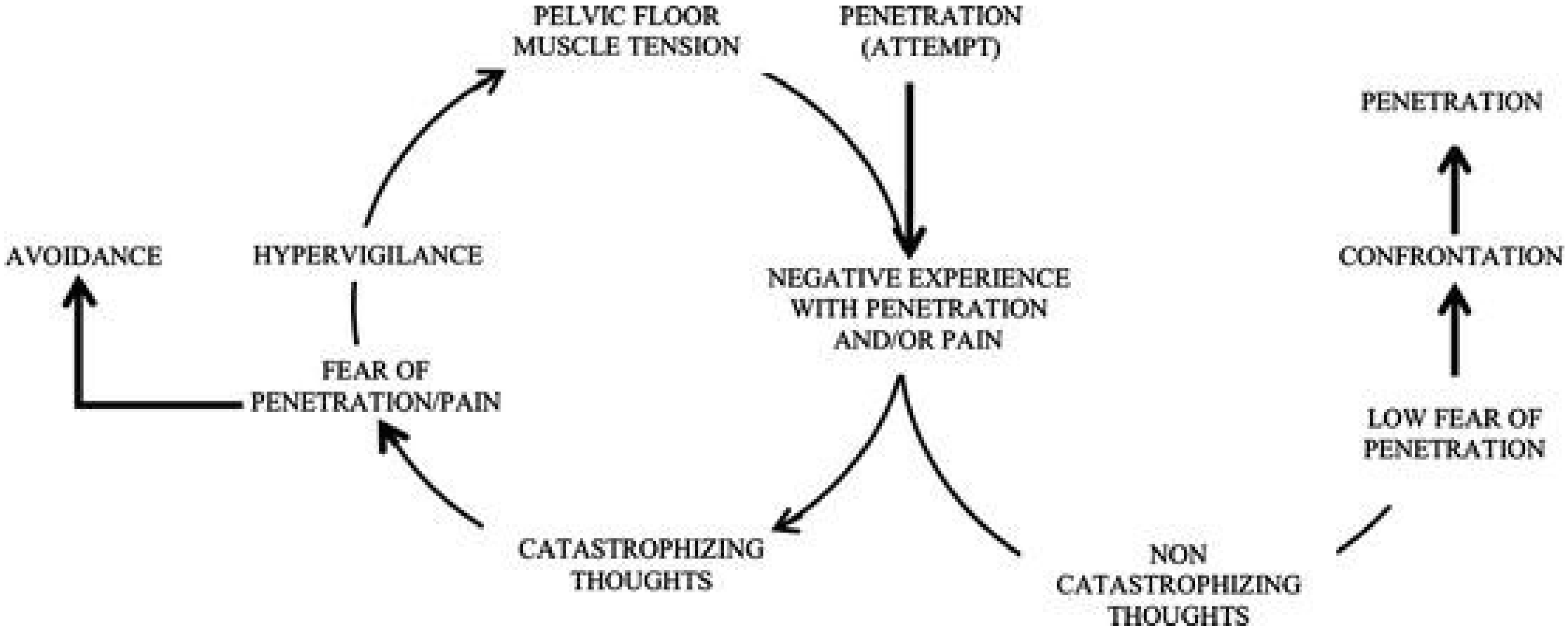
- OB/GYN to assess for vaginismus, dyspareunia, or other issues including vulvodynia, vulvovaginitis, lichen sclerosis, yeast infection, or hormonal issues contributing to GSM
  - Recommend the use of a lubricant and prescribe topical estrogen
  - Prescribe systemic estrogen, depending on history
- OB/GYN and pelvic floor PT to assess and treat problems with hypertonicity of pelvic floor muscles.
  - Education for the client and partner about the pelvic floor
  - Internal trigger point massage to release fascia
  - Home exercise program with dilators

Fear-Avoidance Model

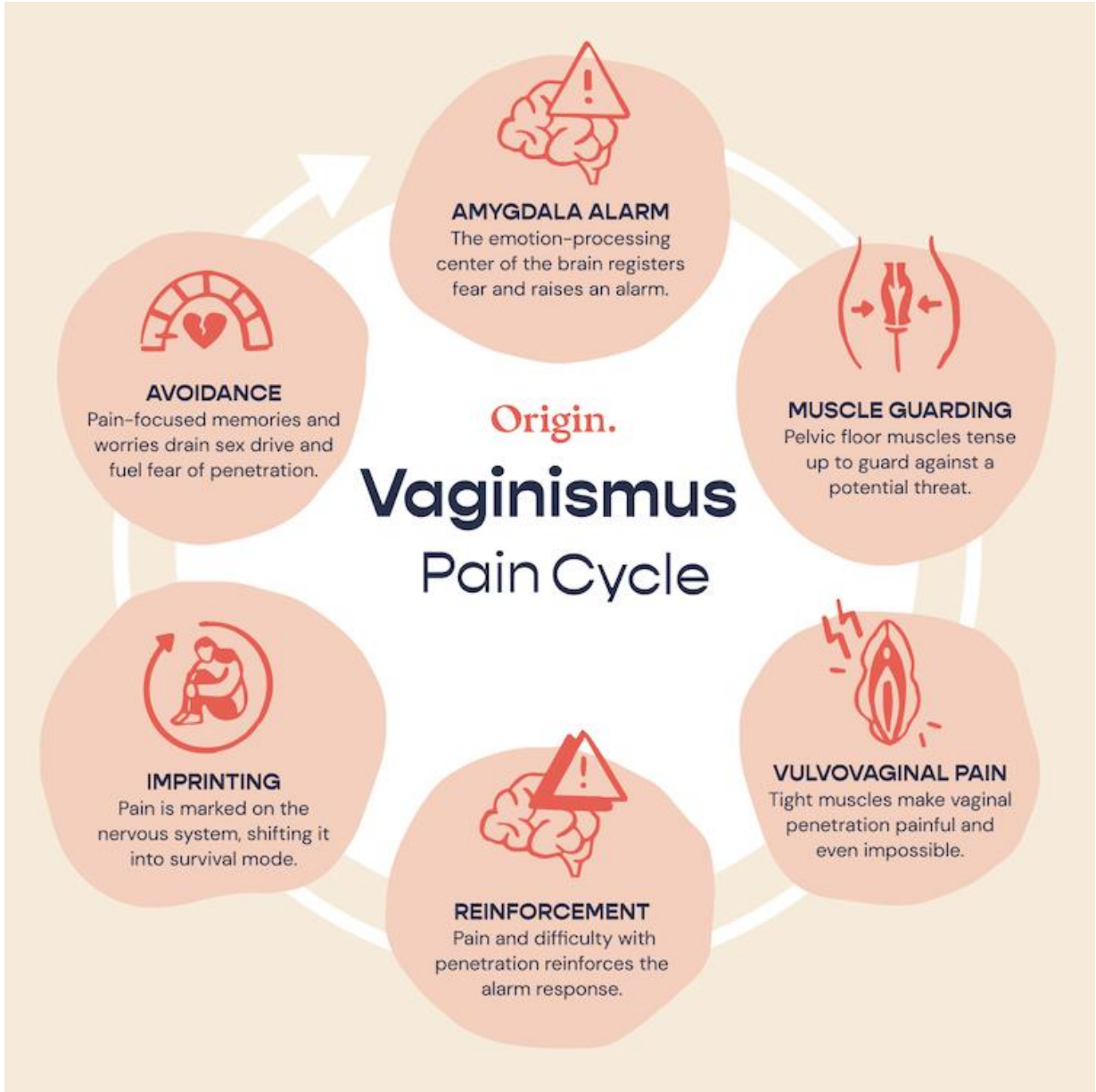
- Anticipation of pain: The individual expects that vaginal penetration will be painful, often due to past negative experiences, cultural messaging, or misinformation. (Jackowich et al, 2024)
- Fear response: This expectation triggers anxiety and fear, leading to increased muscle tension, particularly in the pelvic floor muscles.
- Avoidance behaviors: To prevent anticipated pain, the individual may avoid sexual activity, gynecological exams, or using tampons, reinforcing the fear; pain catastrophizing ("This is going to be the worst experience.")
- Maintenance cycle: The lack of corrective experiences and persistent avoidance perpetuate the problem, creating a self-reinforcing cycle of fear and non-penetration.

Negative Cognitions

- “[S]ex is dangerous, pregnancy is frightening, you can be damaged, childbirth is frightening, sex is painful, sex is undignified, contraception is frightening, sex is disgusting, sex is animal-like, nice girls don’t, pleasure is not allowed, sex makes me feel guilty, sex is terrifying, I’m too small, I’ll be ripped apart.” (Ward & Ogden, 1994, p. 442)



Ter Kuile, M.M., Weijenborg, P.T.M. (2017)



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Adolescence / Early Adulthood (Teens to 20s)

- Vaginismus is more common during this life phase than dyspareunia
- Fear of or actual pain during the first sexual experiences; partner lacking in knowledge
- Inadequate sex education on comfort and consent
- Undiagnosed conditions (e.g., endometriosis, urinary or vaginal infection)
- Pelvic floor dysfunction which can be related to posture, gait, certain sports (horseback riding)

Adolescence / Early Adulthood (Teens to 20s)

- Shame, secrecy, or trauma related to sexual activity
- Negative feedback loops: pain, fear, avoidance
- Lack of safe communication with partners or providers

Reproductive Years (20s to 40s)

- More likely to experience dyspareunia
- Pain due to childbirth trauma or postpartum recovery
  - Pelvic floor muscle involvement during pregnancy and labor and delivery, regardless of vaginal birth or C-section
- Hormonal contraceptives contribute to dryness or discomfort
- Chronic pelvic pain, endometriosis, vulvodynia, or other conditions
- Lack of knowledge, for example, belief that “sex is supposed to hurt” or “my partner won’t be able to handle it if I told them”
- Limited access to pelvic floor therapy or sexual health support

Perimenopause and Menopause (40s to 60s)

- Vaginal atrophy and dryness related to estrogen decline
  - Natural and surgical menopause; treatment for breast cancer
- Delayed or misdiagnosed genitourinary syndrome of menopause (GSM)
- Self-stigma or shame about symptoms
- Impact on sexual desire and relationships and intimacy

Postmenopausal Years (60+)

- Progression of GSM and other comorbidities
- Cumulative effects of untreated pain over time
- Embarrassment or resignation about pain as ‘normal’ aging
- Reduced access to or awareness of treatment options
- Need for provider education and inclusive care for older women

Black Women And Sexual Pain Disorders

- Often feel intense negative self-judgment and complex emotional distress regarding sexual pain (Thorpe et al, 2022).
- May be underdiagnosed due to insufficient clinical awareness that black women are thought to have high pain tolerance.
- Historical mistrust of medical providers in general
- Benefit from culturally responsive care and open communication

SE Questions About Vaginismus

- Microsystem: Feelings of shame or guilt about sex; messages about sex and first intercourse; cognitions concerning virginity and sexuality in general.
- Mesosystem: Who is distressed? Is the partner relationship supportive? What about initial sexual experiences? What happened before the first sexual experience? Was healthcare provider affirming?
- Macrosystem: Cultural and religious messages about sex, for example, that a marriage must be consummated to be legitimate, or that providing intercourse is mandated.
- Exosystem: Broad social beliefs and myths about women's sexuality.
- Chronosystem: Prepared for an intimate relationship? Prepared with sex education?

Dilators In The Treatment Of GPPPD

- Dildos that graduate in size
- Intended for desensitization of having something inserted into the vagina
- Not intended for use as a sex toy
- Best recommended by OB/GYN or PT
- Provide psychological support
  - CBT, deep breathing, reward for compliance
  - Bridging from solo insertion to partnered insertion prior to intercourse

Lubricants

- First line treatment for vaginal atrophy
  - Water-based (e.g., K-Y) is suitable for sensitive skin and is easily washed off, but needs to be reapplied
  - Silicon-based (e.g., Uberlube) has great “slip” and is long-lasting, but it may be difficult to wash off
  - Hybrid lubricants (e.g., Good Clean Love Hybrid) contain hyaluronic acid, which also provides moisturizing benefits.
- Coconut oil can also be used as a lubricant and moisturizer
- The best lubricant? One that is enjoyed and used

VI. Case Vignettes and Clinical Application

Frances

- Age 43, Black cisgender female, heterosexual, married to a supportive partner, with one child.
- Complaint of low desire.
- Reports symptoms of menopause, including hot flashes, insomnia, and moodiness.

Clinical Considerations

- Determine quality of intimate relationship and division of labor.
- History of interactions with healthcare providers and therapists.
- Provide referral to an affirming medical provider.
- Education regarding types of desire.
- Introduce / suggest mindfulness practice.
- Identify “accelerators” and “brakes,” and communicate these to partner.

Elena

- Age 24, Hispanic, cisgender, queer, nonbinary, currently not partnered.
- Reports that she has never had an orgasm.
- Feels shamed by parents regarding her identity.

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Clinical Considerations

- Provide affirming approach.
- Identify sources of support for her identity.
- Increase assertive communication not only with parents, but with sexual partners.
- Address negative cognitions regarding sexuality, pleasure, and orgasm
- Education regarding safer sex.
- Educate regarding approaches to experiencing an orgasm, including directed masturbation.

Melissa

- Age 32, mixed ethnicity, cisgender, heterosexual female married to a supportive partner.
- Postpartum one year.
- Complaint of pain with intercourse.

Clinical Considerations

- Refer to OB/GYN or Uro/GYN and/or pelvic floor physical therapy.
- Support for attending appointments and completing assigned homework with dilators.
- CBT regarding fear-avoidance of sexual intercourse.
- Consider assigning sensate focus activity
- Education along with the partner regarding the resumption of intercourse.

VII. Conclusions

Key Takeaways

- Sexual issues are common and impact physical and mental well-being.
- Medical rule-outs are essential in treatment.
- Variable according to sexual development, reproductive life stage, relationship quality, and life stressors
- BIPOC and WSW often need support coping with minority stress when addressing sexual issues.
- An ecosystemic approach can help pinpoint problems that need resolution.
- Many issues can be addressed using a brief approach that offers limited information and specific suggestions.
- Issues that are not resolved in this way will require intensive therapy that incorporates CBT.

Patient Resources

- **General Information**
- Joannides, P. & Gross, D. (2022) *The guide to getting it on.* Goofy Foot Press. Great information, accompanied by many illustrations, written for all.
- Scarleteen—especially for younger patients: https://www.scarleteen.com/read
- Sexual Anatomy, Planned Parenthood: https://www.plannedparenthood.org/learn/health-and-wellness/sexual-and-reproductive-anatomy/what-are-parts-female-sexual-anatomy
- Sexual Medicine Society of North America: https://www.smsna.org/patients
- **Sexual Desire**
  - Nagoski, E. (2021) *Come as you are: The surprising new science that will transform your sex life.* Simon & Schuster. A favorite amongst sex therapists.
  - Brotto, L., and Nagoski, E. (2018). *Better sex through mindfulness.* Greystone Books. Helpful for a variety of sexual health issues

Patient Resources, cont.

- **Orgasm**
- Dodson, B. (1996). *Sex for one: The joy of selfloving.* Harmony. Classic book on self-directed masturbation.
- Mintz, L. (2017). *Becoming cliterate: Why orgasm equality matters and how to get it*. HarperOne. A psychologist's approach to female sexuality.
- **Sexual Pain**
- National Vulvodynia Association. https://www.nva.org/learnpatient/ Great online tutorial for patients about vulvodynia.
- Prendergast, S. & Akincilar, E. (2017). *Pelvic pain, explained.* Rowman & Littefield.
- Vulvodynia, Mayo Clinic: https://www.mayoclinic.org/diseases-conditions/vulvodynia/diagnosis-treatment/drc-20353427
    - The Mayo Clinic offers patient information on various topics related to sexual health.

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Organizations

- American Association for Sexuality Educators, Counselors, and Therapists (AASECT): https://www.aasect.org
- International Society for the Study of Women's Sexual Health (ISSWSH)
- Society for Sex Therapy and Research: https://www.google.com/search?client=safari&rls=en&q=society+for+sex+therapy+and+research&ie=UTF-8&oe=UTF-8
- Sexual Medicine Society of North America: https://www.smsna.org
- The Menopause Society: https://www.menopause.org

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