

# Female Sexual Arousal Disorder and Counseling Deliberations

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*Female sexual arousal disorder, a prevalent sexual problem for women, presents clinical challenges to counselors. The multifactorial etiology of female sexual arousal disorder requires a holistic treatment approach. This article describes both the objective and subjective aspects of the disorder and offers assessment and treatment considerations.*

**Keywords:** female sexual arousal disorder; sex therapy; female sexual function

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Sexual dysfunction is estimated to occur in about 30% to 50% of women (Laumann, Paik, & Rosen, 1999). Female Sexual Arousal Disorder (FSAD), referring to a lack of physiological or psychological response to stimulation in women, accounts for about 10% to 50% of women's sexual problems (Michael, Gagnon, Laumann, & Kolata, 1994). Along with other sexual disorders in women, it used to be referred to as *frigidity*, a term no longer used by clinicians as it is considered to be colloquial, vague, and condescending (Leiblum, 2001; Wincze & Carey, 1991).

FSAD is defined in the *Diagnostic and Statistical Manual of Mental Disorders* (4th ed., text revision) (American Psychiatric Association, 2000) as "persistent or recurring inability to attain, or to maintain until completion of the sexual activity, an adequate lubrication-swelling response of sexual excitement" (Code 302.72). To qualify as a disorder, the woman must experience considerable personal or interpersonal distress. It must be specified as to whether the condition is (a) lifelong or acquired, (b) generalized or situational, and (c) due to psychological or combined factors. The criteria have changed in revised editions of the *DSM*. For example, the *DSM-III-R* (American Psychiatric Association, 1987) substituted the terms *sexual arousal disorder* and *male erectile disorder* for *inhibited sexual excitement disorders*. The *DSM-III* (American Psychiatric Association, 1980) delineated subjective and objective arousal, a point of clarity that unfortunately was omitted in the *DSM-IV* (American Psychi-

atric Association, 1994) and *DSM-IV-TR*. The *DSM-IV* diagnosis depends primarily on objective criteria and is considered by some to lack needed specificity (Leiblum, 2001; Seagraves, 2001).

Objective arousal includes reduced vaginal lubrication, decreased clitoral and labial sensation and/or engorgement, or reduced vaginal smooth muscle relaxation (Goldstein, 2000). Subjective arousal, referring to a woman's perception of sexual excitement, used to be referred to as *psychogenic* sexual arousal disorder with the accompanying belief that FSAD consisted only of genital (i.e., objective) arousal.

The *DSM* bases its classification of female sexual disorders largely on Kaplan's (1979) model of sexual response, which considers sexual desire, arousal, and orgasm as separate sexual stages (Meston, 2000). The stages often overlap, and the resolution of one stage's problems might alleviate problems in a different stage. Desire is such an example. The restoration of desire within a sexual experience can also affect one's level of satisfaction with orgasm or arousal.

FSAD often occurs alongside a myriad of physical problems, psychosocial problems, or both. Physically, FSAD could result from (a) the intake of antihistamines, hypertensives, and psychoactive medications such as selective serotonin reuptake inhibitors and tricyclic antidepressants (Phillips, 2000); (b) a vascular disease associated with diabetes (Phillips, 2000); or (c) urogenital atrophy in postmenopausal women (Phillips, 2000); (d) prior pelvic trauma, injury from childbirth (Goldstein, 2000); or (e) menopause (Goldstein, 2000). Inadequate stimulation could also produce a reduced arousal response, particularly with older women who require more stimulation than they did at younger ages (Phillips, 2000). Psychosocial problems pose injuries to primary sexual relationships from conditions such as sexual avoidance and anxiety, fear, guilt, and anger in general toward self or one's sexual partner.

Briefly stated, the physiological process of sexual arousal involves sexual stimulation through the five senses of smell,

sight, sound, taste, and touch (Walton & Thorton, 2003). The brain translates sexual signals to release sex hormones and the central nervous system releases neurotransmitters. Vaginal smooth muscle relaxation follows. The vaginal canal is lubricated and the vagina is lengthened during sexual arousal (Goldstein, 2000). The clitoris achieves tumescence during sexual arousal and increases in length and diameter with a corresponding blood flow that almost doubles (Goldstein, 2000; Goldstein & Berman, 1998).

Objective measures of women's sexual arousal are not always associated with women's subjective experience (Basson, 2001; Meston, 2000). For example, Brody, Laan, and van Lunsen (2003) found a correlation between genital arousal and subjective arousal in women with orgasm consistency during intercourse, but the relationship was not present with orgasm involving other sexual behaviors, such as masturbation. These results point to the relevance of the meaning women attribute to a particular sexual situation (Laan & Everaerd, 1995) as well as beliefs and values a woman may have about sexual experiences. Coordinated by the neurologic, vascular, and endocrine system, a sexual experience is affected by individual characteristics, relationship dynamics, religious beliefs, health status, and prior sexual experiences (Phillips, 2000). Basson et al. (2002) called for more understanding between the mind and genital response in women with FSAD.

Studies are conflicting regarding the impact of age on the subjective component of arousal for women (Laan & Everaerd, 1995; Laan, van Bellen, & Hanewald, 1994; Pennebaker & Roberts, 1992). Brody et al. (2003) found that younger premenopausal women demonstrated higher subjective sexual arousal than postmenopausal women. Others, such as Brotto and Gorzalka (2002), argued with these findings and provided evidence that subjective arousal is not affected by age or menopausal status. Brotto and Gorzalka speculated that their findings may have produced more positive results because the erotic stimulus they presented to the women was more sexually stimulating, consisting of a contemporary erotic video with explicit sexual material.

There is little information in the counseling literature regarding FSAD other than studies involving mostly medical treatment, although the condition is prevalent and may underlie some marital problems. The subjective component of arousal for women is particularly relevant to counselors as women's sexual relationships have emotional components and systemic pressures. For example, the passion and intimacy within a partnership can be what turns the sexual switch off or on, with the brain determining whether body parts will be aroused. Passion can be considered the flip side of FSAD and occurs with what McReynolds and Schnarch (1997) described as intimate sexuality (i.e., the desire to know and be known by one's partner). Bridges, Lease, and Ellison (2004) found, in a study of 2,632 women within a nonclinical population, that sexual satisfaction is related to partner communi-

cation. Other factors connected to low sexual satisfaction for women include conservative sexual attitudes, lack of sexual assertiveness, and limitations in knowing and using a variety of sexual techniques (Haavio-Mannila & Kontula, 1997), all of which could be addressed in counseling.

## ASSESSMENT AND HISTORY TAKING

FSAD requires a comprehensive approach to assessment. Basson (2002) suggested that assessment of FSAD include the different components of arousal, including (a) cognitive sexual excitement, (b) genital throbbing, (c) report of sexual satisfaction resulting from direct stimulation of genitals, (d) report of sexual satisfaction resulting from direct stimulation of breasts and other body areas, (e) fluctuations in blood pressure and heart rate, and (f) vaginal lubrication.

To address all of these components, it is necessary to develop a consulting relationship with a physician (Goldstein, 2000). Before referring, determine the names of physicians who are knowledgeable about female sexual dysfunction and have the means to physiologically assess for FSAD. Such assessments include the vaginal photoplethysmograph (a tampon-shaped device that illuminates part of the vaginal wall and reflects the blood circulating within it), measures of heat dissipation (one type attaches to the labia and the other type measures vaginal temperature changes using a sensor attached to a diaphragm ring), and pulsed wave Doppler ultrasonography that measures blood velocity in the clitoris (Meston, 2000). The physician should also acknowledge the importance of both the measurement and treatment of subjective sexual arousal.

Keeping in mind that many sexual problems are interpersonal, it is relevant to assess both individuals and couples. Clients frequently experience anxiety when they begin to acknowledge and confront sexual problems in therapy. Sensitivity and empathy are necessary to counter their self-doubt, embarrassment, and of course, to develop the therapeutic relationship. Charlton's (1997) formula for evaluation of sexual problems offers structure to the assessment process. If meeting first with a couple, plan on two sessions with the couple and one session individually with each of the partners. If first meeting with an individual, plan on two to four sessions for evaluation purposes. Acknowledge that time may be a factor and be efficient in gathering information. The following are offered as additional considerations for assessment:

1. Determine if the dysfunction occurs with a particular partner or in a particular setting and distinguish whether the problem is lifelong or recently acquired (Basson, 2001). A sexual history should include at what times, places, and with whom the client has sexual problems.
2. Assess satisfaction with sexual arousal by asking the client to record satisfactory sexual experiences. In addition, use other assessments such as the Female Sexual Encounter Profile designed specifically for use in FSAD studies (Ferguson,

2002) and the Female Sexual Functioning Index (Rosen et al., 2000) designed to assess several areas of sexual functioning, including arousal. Another means of assessment is the Detailed Interview Assessment (see Basson & Brotto, 2003, for a copy of the assessment).

3. Obtain information regarding education about sex attained from the family of origin. Such messages include reference points of (a) acceptable types of touch in the family, (b) ability to maintain eye contact, (c) trust of others, (d) ability to express empathy, (e) self-image, and (f) personal power (Zoldbrod, 2003). Zoldbrod (2003) purported that family-of-origin messages are associated with a variety of factors that influence sexual satisfaction, such as one's ability to tolerate and express feelings as well as sustain emotional closeness.
4. Assess individual factors such as personality disorders that could interfere with sexual functioning. Also, consider the client's current life situation as well as a history of abuse or molestation (Slowinski, 2001).
5. Discuss with the client her emotional and/or sexual attraction to her partner (Everaerd & Both, 2001; Lieblum, 2003). If the client is not attracted to her partner, delineate whether this is a situational or persistent response. Although diagnostic criteria involve this distinction, determine if you can reasonably say a woman is sexually dysfunctional because she is not attracted to her partner.
6. Evaluate the client's ability to communicate her sexual needs to her partner. Sexual relationships, often draped in secrecy for one or both partners, can deteriorate for lack of clear communication regarding sexual needs and/or desires.
7. Determine the woman's view of self. Sexual problems can translate into poor self-image, with the reverse being true as well. A poor self-image can also affect one's ability to effectively communicate with a partner.
8. Identify cognitions and emotions associated with the sexual experience, as these are particularly important in women with FSAD, at least as important as genital feedback. Also determine how sexual behavior may be related to a struggle for control within the relationship.
9. Determine how the couple has coped thus far and identify their sexual script (i.e., the way each partner views his or her sexuality). In addition, ask couples how they negotiate their sexual problems.
10. Include an assessment of touch for partners. Zoldbrod (2003) suggested using a body map. With an outline of the front and back of the body, partners indicate which areas of the body are acceptable to touch. Counselors can assign colors for yes, no, prohibited, or encouraged. After each partner has completed the map, each shares the map with one another.

## TREATMENT

FSAD requires a holistic treatment approach. The mind-body distinction is often blurred in both the etiology and treatment of the disorder. The most comprehensive method and the approach probably in the best interests of the client is the biopsychosocial model (Walton & Thorton, 2003). The field

of sex therapy has recently been dominated by the medicalization of sexual disorders with a focus on pharmaceuticals (Kleinplatz, 2003). The assumption that biology works outside the context of the sexual experience ignores the client's perceptions, emotions, relationships, and interpersonal skills—all factors that could affect sexual arousal.

Biology is not to be understated in the role of sexual function; however, competency in counseling women with FSAD includes knowledge about the physiological functions of human sexuality and potential medical options.

## Medical Options

Medically, physicians note their treatment limitations for FSAD, listing commercial lubricants, vitamin E, and mineral oils as treatment options (Phillips, 2000). For postmenopausal women, Phillips (2000) suggested estrogen replacement. She is less optimistic about medical treatment options for premenopausal women. The EROS-Clitoral Therapy Device, approved by the U.S. Food and Drug Administration for treatment of women with sexual dysfunction, is another treatment alternative (Wilson, Delk, & Billups, 2001). Designed to increase blood flow to the clitoris, the device provides a vacuum suction to the clitoris in one of three levels of intensity. Several studies provide evidence of EROS physiological effectiveness in women with sexual arousal disorder (Billups et al., 2001; Munarriz, Maitland, Garcia, Talakoub, & Goldstein, 2003; Wilson et al., 2001).

Ferguson et al. (2003), in a small sample of women, found encouraging results for women's sexual arousal regarding the use of Zestra for Women. A feminine massage oil, Zestra for Women is formulated to produce an enhanced arousal response for females when the cream is applied to the vulva. Other reported benefits of the cream include improved level of desire, genital sensation, sexual pleasure, and ability to have orgasms.

Sildenafil, a vasoactive drug and the equivalent of Viagra for men, has been tested on women for treatment of FSAD because of the assumption that a woman's clitoris functions similarly to a man's penis. Sexual arousal in both males and females involves vasodilation. Sildenafil, the drug of choice for facilitating vasodilation in men, is often the first treatment option for male erectile disorder (Millner & Ullery, 2002). It has mixed reviews on its successfulness, however (Basson, McInnes, Smith, Hodgson & Koppiker, 2002; Segraves, 2002). One possible explanation is that the reasons for sexual dysfunction in women appear to be more a result of personal distress and depression, whereas men's sexual problems are often related to cardiovascular abnormalities (Talakoub et al., 2002). Another possible explanation of the drug's ineffectiveness with women may be due to the context of the sexual stimulus used in the studies (Basson & Brotto, 2003; Basson et al., 2002; Padma-Nathan, 2002).

## Counseling Considerations

If the client has had a recent medical evaluation and the problem persists within the context of certain relationships or situations, then proceed with a biopsychosocial treatment approach. A holistic approach can assist both the client and partner in recognizing the impact of psychological and social components on the sexual experience (Millner & Ullery, 2002).

Arousal can occur without contact and be initiated by fantasy as well as varying types of touch. One avenue for arousal is erotic films viewed either alone or with a partner (Walton & Thornton, 2003). Fantasies and images are an individual domain, however. It is germane to help clients identify precisely how they are aroused. Some individuals are not aware of their specific preferences and engage in what they believe should arouse them. The dissonance between engaging in what they believe they ought to do rather than what distinctly pleases them can create a body that refuses to respond on demand.

FSAD can create dissension in relationships, especially one already stressed with other life demands. Lack of arousal can result in a shift of power within relationships with the woman deciding when and how she will engage in sexual activity. In addition, a woman may feel compelled to fake arousal and could eventually withdraw from sexual activities as well as distance herself in general from her sexual partner. Conversely, her partner may feel pressure to perform and feel guilty for not being able to arouse her, ultimately withdrawing from sexual activity with her, the relationship, or both.

Sexual dysfunction is often related to the type and degree of intimacy allowed by the partners within the relationship. Breaches or lack of intimacy and withdrawal of affection can translate into sexual chasms in the relationship. Couples therapy should include the exploration of intimacy within the relationship including (a) the willingness of each partner to trust the other, (b) the ability of each partner to share self with the other, and (c) fears of negative evaluation by one or both partners (Gehring, 2003).

This is consistent with Gottman's (1994) findings that marital discord often corresponds with the four factors of criticism, stonewalling, nonverbal or verbal expression of contempt, and defensiveness. The bank account model (Gottman, 1998) of therapy proposes that couples turn toward one another rather than turn away. It also includes the premise that positive sentiment expressed by partners assists in conflict resolution.

A related matter concerns the beliefs women may have about sexual activity that are associated with shame or guilt. Charlton and Brigel (1997) identified several myths that can create difficulties with arousal, including, in part, (a) women must not be sexual, (b) women's responses to sex should be similar to men's responses, and (c) there are correct and incorrect ways to become aroused. Other beliefs that can

interfere with arousal are associated with a woman's sexual history involving rape or some type of abuse. In addition, a woman's negative beliefs and/or feelings about the partner can create negative sexual experiences. Shame and guilt can be related to how a woman believes she is treated by her partner. If she believes she is being used for sexual activity or if her partner either allots sex for reward or withholds it for punishment in their relationship, she can develop frustration and shame. The result can be a lack of arousal when the couple engages in sexual activity. Cognitive-behavioral therapy is typically best suited for countering negative beliefs, and the resolution of partner control issues is central to treatment.

Also, differentiation of self is important to sexual satisfaction within long-term relationships (McReynolds & Schnarch, 1997). The ability to be oneself and remain engaged with one's partner is conducive to a healthy sexual relationship. The opposite of differentiation is fusion (i.e., the inability to maintain one's sense of self). This usually results in defining oneself according to others' opinions. Those able to maintain a sense of self are generally more resilient than those who depend on others to define their existence, a condition that often results in anxiety and self-doubt.

For women who have difficulty achieving intimacy and passion within a marriage due to family-of-origin messages, prematurely giving them permission to be sexual can be disconcerting and disruptive to successful therapy (Zoldbrod, 2003). For example, if a woman received the message within her family that women are second best to men, she may resist communicating her needs to her male partner, believing her primary job is to please him. Cognitive-behavioral techniques are an effective means to identity and counter any demoralizing or desexualizing messages.

In addition, issues may arise regarding abandonment or inhibitions that decrease arousal. Therapy involves the resolution of these factors (Leiblum, 2003). The focus on nongenital pleasure can be introduced after partners exhibit signs of increased trust. An example is sensate-focus exercises wherein one partner sensually massages the other while receiving feedback as to what is and is not pleasurable (Phillips, 2000). Recommendations to follow can include increasing foreplay and using vibrators to increase stimulation (Phillips, 2000). Overall, therapy involves sensitivity from the counselor regarding clients' uneasiness about confronting and changing their sexual behavior.

In summary, FSAD is a relatively common sexual problem for women. The multifactorial nature of the disorder requires a holistic treatment approach. Treatment considerations include consultation with a knowledgeable physician, development of a complete sexual and psychosocial history, and assessment of relationship factors with the primary sexual partner. Couple and individual factors that are relevant to therapy include power, intimacy, negative affect, differentiation of self, type of communication pattern, and beliefs about sex, self, and partner. A humanistic approach emphasizing

cognitive-behavioral techniques, sensate-focus exercises, and Gottman's (1998) bank account model emphasizing positive exchanges between partners are appropriate approaches to therapy.

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