Female Sexual Dysfunction
A Critical Look at the Paradigms Associated with Female Sexual Concerns
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As I thought about my grave concerns with the medical paradigm of Female Sexual Dysfunction, in preparation for this panel presentation, I pictured a collective "well, Duh." In fact, I'd be greatly relieved to discover that we all have similar fears that we are being propelled by the pharmaceutical megalith to view ourselves as plumbing systems that simply need a chemical boost. It is my sincere hope we all want healthcare providers to insist on interdisciplinary collaboration when dealing with female sexual concerns.

In 1996, Leonore Tiefer stated a warning that, "medicalization [may well be] a bold attempt to replace our multidimensional perspective with biological reductionism and thus medical privilege." I don't think most concerned medical professionals are consciously trying to remove those without medical training from the practice of sex therapy. Many clinicians are trying to work out a more effective way to treat women's sexual concerns with a collaborative approach. Yet, the medical paradigm is enticingly simple and the groundswell of media coverage encourages practitioners to join the bandwagon of medicalization. We appear to be on a runaway train, fueled by the media that seems to be headed for this destination.

A recent article reporting on the medicalization of male sexual dysfunction found that there has been a significant decline in the last 30 years in the use of counseling interventions for treatment and an increase in the medical model as the dominant theoretical perspective for all major research journals. Can treatment of women's sexuality be far behind?

Today, our panel has chosen to speak about our views based on our varied clinical backgrounds because we have concerns about the possibility of this biological reductionism becoming the major diagnostic viewpoint. I'd like to establish at the outset that the meaning of the word *paradigm* is essentially an image that serves as a model of a subject matter, within a science. The *power of a paradigm* is that it *shapes our view* of reality. It also shapes our beliefs, or in this particular case, the cultural narrative about sexuality. If medical authority focuses on the paradigm of female sexual dysfunction as a disease, it can lead the public to view women's sexuality as a purely physiological process.

You will hear our various points of view that will speak for themselves—the following are my views as a clinician treating couples, and individual men and women in sex therapy for over seventeen years.

Women come to sex therapy, because they think something is inherently wrong with their sexuality. In some ways, the effect of the new terminology of Female Sexual Dysfunction or FSD seems to be another version of "frigid" dressed up for biological research. Ever since Masters and Johnson laid to rest the issue of female orgasm, women have been trying to fit themselves into the Procrustean bed of an essentially male model of sex. And yet, the model persists as **the** way to view sexuality.

We now hear references to low female desire as an epidemic. The Masters and Johnson Clinic director estimated that fully one out of three women in long-term relationships are distressed by lack of desire. The Scientific American offers the statistic

of 43% of women suffer from FSD some time in their lives. This could apply to just about anybody the way it is stated, but it sounds an alarm bell in our minds.

So now we have the advancements of modern technology, specifically medication that can increase blood flow to the genitals, suction pumps applied to the clitoris and chemically engineered creams that can be rubbed into various parts of the body, especially the clitoris.

On the heels of the successful launching of a "cure" for male erectile dysfunction, we now have a movement towards renaming female problems of desire and arousal as: Vaginal Engorgement and Clitoral Erectile Insufficiency syndromes. These are collectively referred to as: Vasculogenic Female Sexual Dysfunction**.** Since diagnosis shapes the way we view a problem it also determines the treatment protocol.

Because of the distortion of "sexuality as physiology," many clinicians in psychotherapy are lulled into a false notion of male and female sexuality as similar. According to the accepted system, diagnosis can be neatly separated into four categories, disorders of: 1) Desire, 2) Arousal, 3) Orgasm and 4) Pain. The paradigm leads to viewing a problem in a particular way and then treatment follows from it.

Let's be honest and acknowledge that sexual difficulties are big business and the pharmaceutical industry is often paying for the research that proves that sexual disorders can be cured through medication. On the heels of the research publications comes an appalling amount of media hype about quick cures with cookbook techniques. Such techniques could become the protocols for treatment in the future. These are featured on TV and radio and result in causing many women to feel worse because they cannot figure out why this or that, often expensive, pill, pump or cream doesn't work.

Two Oprah shows on low female sexual desire, less than a year apart, first endorsed testosterone crème as the answer and then featured a retraction. Oprah's own gynecologist stated that there had been no research to substantiate any of the previous claims. But a lot of women, urged by their mates, went out and bought a lot of expensive testosterone crème. *48 hours* just did a piece again suggesting testosterone for women as the answer. There are some positive research indications, but by itself, testosterone is not the answer, especially without at least therapeutic assessment and possible treatment.

As the **"**New View of Women's Sexual Problems," so aptly states: the diagnosis system of the DSM (III & IV, R's included) seriously distorts sexual problems by reducing them to disorders of physiological function comparable to breathing and digestive disorders.

The whole underpinnings of the research into FSD must be challenged or we will see the increasing medicalizing of sexuality (both men and women's) and an erosion of the interdisciplinary approaches. One of the basic challenges to the FSD paradigm is that it erases the relational context of sexuality. Relationship dynamics are often the root of women's lack of desire or are at least a significant contributing factor even in apparent physiological problems. The FSD paradigm assumes that if the sex parts, including

hormones, don't work, that's the problem. (Here's where I expect you all to say DUH, what a simplistic way to look at it.).

This is a serious problem when we look at helping women to find their unique way of expressing sexuality because women's sexuality is **fundamentally different** than men's sexuality. The pathways women have taken to get to their sexual dilemmas are so varied and so complex that to adequately address and effectively treat the problems, they must be viewed with a multi-causal approach.

According to John Gottman's research, it takes an average of six years before a couple will seek help after they have become aware that there are marital problems. It is troubling to think of how long sexual problems persist before treatment is sought. By then, couple sexual patterns have become chronic. Given the huge increase in requests for chemical solutions, the quick fix may supercede comprehensive therapy for a vast proportion of couples. For some women, this may be enough, but for many "something is wrong with me" goes to the next level.

Let me state at the outset that a fundamental concern that I have is the common usage of the word *sex* as a synonym for intercourse or penile penetration. In women's life experience (and I suspect for a growing number of men) the notion of sex meaning intercourse does not reflect the totality of their sexuality. As John Bancroft of the Kinsey Institute stated "women's sexuality is different in a variety of important ways, but we are still trapped in male conceptual boundaries."

For the past thirty years, virtually since the inception of sex therapy we have been treating couples and women from this primarily male model of sex. That is:

Sex=Intercourse
The goal of Sex=orgasm
Great Sex=a technically virtuoso performance

I have proposed a feminine paradigm for women that has at least four distinct features:

- Pleasure rather than orgasm is central to an erotic encounter
- Sensual touch is the vehicle rather than genital performance
- Orgasm is perceived as multidimensional
- Female sexual power is magnetic attraction

When the notion of sex is strictly limited to a masculine template into which women are supposed to fit, *there is no counterpoint of active, female energy.* If the feminine way is to be represented in contemporary, sexual knowledge *in equal measure*, female desire must be a clearly represented as an active urge, as powerful as the male's but very different.

The various professions treating female sexual problems are from such diverse points of view that the situation can be likened to the proverbial blind persons describing the elephant, each from the part of the animal they are touching. A list of perspectives would include: Developmental, Biological Evolutionary, Psychological (with many subsets), Socio-cultural, and Medical.

Essentially, the medical model assumes that there is a causal factor somewhere in the interaction of biology and chemistry within the body and this cause can be diagnosed

by the physical symptoms. On the other hand, the psychological model assumes that there is a sexual problem that is psychosocially based. In this model, even bodily pain is sometimes seen as psychosomatic in origin. Obviously neither is complete and adequate

in itself. There are additional considerations, which I shall propose, that must also be noted.

Treatment options are further complicated by the fact that practitioners differ in the way they view the intended result. As Beverly Whipple pointed out at the 1999 World Congress of Sexology, "there are two commonly held views about sexual expression." The most commonly held view is goal directed, such as producing an orgasm or erection. The alternative view is pleasure-directed, in which any experience that is satisfying is an end in itself. I prefer the alternative view as a far more "user friendly" way to treat couples with complex issues.

However, I suspect that self-report studies of different levels of pleasure are far too subjective to facilitate experimental research designs. Measures of erection, lubrication, engorgement and orgasm are much easier to duplicate experimentally.

Here is an example of treatment of a woman with a complex interaction of psychological and physical symptoms the result in low desire. My patient, let us call her Jane, had been in individual therapy several times in her life, but never in couple therapy. When I first suggested that she might want to involve her husband, she was extremely hesitant. She was most comfortable doing insight therapy although nothing to date had helped her sexual desire problems. She was sure that her lack of sexual desire was her problem, not his. As she described her sexual situation, it became clear that she had experienced some pain and fear associated with the possibility of pain recurring.

Previously, she had consulted gynecologists about her pain. They had checked her for physical problems but could not identify the source. They proceeded to prescribe various medications and creams that had made things worse at times. I suggested that she see a physician that was a member of our local interdisciplinary San Diego Society for Sex Therapy and Education. After ruling out vaginismus because the problem was not involuntary contractions of the vaginal muscles, the physician was able to diagnose Vulvar Pain.

Vulvar pain is a chronic, debilitating array of painful symptoms affecting the vaginal opening, inner and outer lips, and/or clitoris. In 1997, The Women's Digest offered a conservative estimate of a quarter of a million women that suffer from it. The authors of the study state: "the medical literature focuses almost exclusively on painful sex (there's that use of the word sex as synonymous with intercourse) as the primary presenting symptoms of vulvar pain. [However, they added,] in real life, women who have the disorder report a complex array of physical symptoms that may be more important to them . . .." Interestingly enough in 1992 women took the problem into their own hands. They formed a grass roots organization: The Vulvar Pain Foundation. This foundation has three express purposes: 1) to end the isolation of women who have this problem, 2) to disseminate reliable information on treatment effectiveness (and to warn

against especially painful and invasive surgical methods that don't solve the problem) and 3) to promote scientific research to determine root causes.

In line with the PLISSIT model, I had assumed that she would improve her desire for sexual contact with the combination of treatment for the pain, behavioral change and solution focused problem solving. This did not turn out to be the case.

I was perplexed because all the standard treatments (medical and psychological) were not effective for helping her reach her goal. We could dismiss her as simply unwilling to see her own double bind, resistant to practicing new behaviors, or just plain blind to her own needs. I have seen too many women who present this kind of multi-causal puzzle to dismiss every woman like Jane. I find that many, many women in relationships are in double binds socio-culturally and are trying very hard to find a way to be in a relationship and feel good about their sexuality.

It is my perspective that every woman has a unique pathway of expressing sexual energy. As the laws of physics affirm, energy cannot be destroyed. Therefore, there is no true "lack" of sexual desire. The Sanskrit word for sexual energy is *Kundalini* meaning "the coiled one." In other words, sexual desire becomes dormant but is capable of being reawakened at any stage of life. Every woman who seeks help and truly wants an erotic life has a right to find her way to its expression. I prefer not to label any woman with yet another "wrong" message such as FSD. It simply exacerbates her bad feelings and is not effective in empowering her sexuality.

My overarching treatment model most closely resembles the paradigm of the Shamanic Journey, with the therapist as guide. For women to heal and enhance their sexual desire, we must tap into a source of genuine motivation towards self-discovery and sexual empowerment. In reframing self-healing as a journey to reawaken natural erotic energy, we have effectively opened up the door to possibility for any woman.

I have found that reframing healing in terms of *reawakening* sexual energy, appeals to feminine values. It validates the woman's own inner resources in collaboration with constructed knowledge from experts.

We have plenty of evidence from books such as In a Different Voice and Women's Ways of Knowing that women have a deep desire to integrate received knowledge with subjective insight. Women's wisdom has always been grounded in situational and contextual experience. Both the teachings of wise elders and personal experiences in the quest for self give an authentic voice to the woman's own embodied wisdom as a primary instrument of self understanding.

Since the biofeedback training helped Jane significantly reduce the vulvar pain but did not increase her motivation to have sexual contact with her husband, I have supported her to reframe her process as one of discovery and to reclaim her sexual energy in her own way**.**

I find it very helpful to educate women about their collective history, specifically the history of women's sexuality in the last 3,000 years. I have condensed much of it in my book, Reclaiming Goddess Sexuality, (*Psychology Today* called it easy to read). Women feel inspired by a new view of themselves. They are excited by the possibility

that there **is** a feminine sexual paradigm, derived from cultures that honored the divine feminine and where women were central to society.

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The psycho-educational component of the work illuminates the central tasks of each stage and the *optimal psychological sets and settings* for positive sexual development in each one. To the extent that there have been problems in any of these, we can rework the unfinished lessons and develop appropriate conditions in her current life. The central message of this work is: what was missed can be reclaimed.

The ancient women's societies divided women's lives based on the three blood mysteries: First Blood, Childbirth and Wise Blood. These continue to be powerful *psychological transformations* within all women. *They are universally transformational events for all women, everywhere and for all times.* There are great sexual lessons in each of these stages.

I helped Jane understand her psychosocial history within this developmental model. For the many women like Jane, with no severely traumatic background, this is a much more productive approach.

The particular sexual developmental issues for Jane were lack of internalized permission to explore her sexuality and an inability to discern readiness for specific sexual touch. Before her marriage, Jane relied on exciting dramatic meetings and long periods of yearning as powerful boosts to override her "good girl" inhibitions. She had never explored pleasure in the relatively safe setting of a continuously available and stable partner. Therefore, she had never felt comfortable enough to orgasm with a partner present. When she married a man who did not stir her lust or romantic longings, she had little sexual desire to motivate her to explore further**.**

One of the most difficult roadblocks in working with female sexual responsiveness is negative body image. For example, Jane was a naturally lovely woman, but did not have an internal sense of her own beauty. During touch exercises, she felt like a specimen on display rather than a woman enjoying receiving pleasure from a loving partner.

I suggested Jane record her experiences using several guided imagery sequences from my book: *The Secret Garden (*to strengthen personal boundaries), and *Womb Wisdom* (to listen to her own voice). These experiences helped her develop her Guardian and connect with her body wisdom. At home, she practiced the Yoni exercise in front of a mirror that helped her undo shame messages about her genitals. She also practiced cognitive affirmations that became a valuable source of self-validation.

Strengthening her Guardian self helped to discern her own wisdom from the judgmental introjects or negative voices of social conditioning. For Jane, this was especially helpful in eliminating judgment about her choice of erotic scenarios. She was able recognize and acknowledge her attraction to a female friend. She worked on accepting the images that she found truly erotic. Her husband proved very accepting as well. In couples' therapy, he was able to enthusiastically support her to use of fantasy,

which reduced a great deal of guilt. The fact that she was able to talk with her husband about her possible bi-sexual interest was a major turning point.

The second developmental issue was her inability to sustain body pleasure long enough to feel the heightened sense of readiness needed for pleasurable sex. The touch

exercises I had assigned as homework with her husband felt "creepy" and triggered impatient feelings. She wanted to stop after two minutes.

She practiced gentle, teasing self-stimulation to build her toleration for sustained body pleasure. Once she had internalized permission to use fantasy as part of her arousal, Jane was able to have an orgasm stimulating herself with her husband holding her. She is now working on gradually allowing her sexual readiness to build, using breathing and relaxation, with her husband.

Jane continues to work within her own process finding her way towards sexual wholeness. She is practicing various awareness exercises, couple communication and touch homework along with self-stimulation. She is still working on healing the good-girl/bad girl split in psychotherapy. She states that she feels encouraged to continue the journey because she knows that she has her unique path and she has no intention of giving up on herself.

The Shamanic journey model encourages the woman to draw on her own intuitive wisdom, listening for the message in the pain, aversion, or fear, and accepting only the constructed knowledge from external sources that resonate with her own sensibility. It requires a strengthening of the woman's Guardian self to protect healthy boundaries and encourage a relationship with her own body wisdom. The model is one of collaboration between the therapist as guide and the woman on her journey to reclaim her sexuality. The context of her relationship concerns is deeply imbedded in the process and never considered as an aside.

The guidance of a therapist is not imposed, especially when it is counter to the woman's inner knowing. The dominant model in healthcare is hierarchical. It calls for experts whose knowledge comes from outside the patient who is seen as an uninformed and lowly penitent. The external authority imposes an interpretation of what is wrong, offers a cure with little time spent listening to the patient's inner experience.

On the other hand, techniques such as guided imagery and visualization can consciously shape positive perceptions and guide her towards wholeness. With an alternative approach, we can encourage sexual enhancement. Women are inspired to seek higher levels of sexual self-actualization.

It is time that **"**high touch meets high tech" and we find the treatment equivalent to the blending of eastern and western philosophy that has become the hallmark of the last decade of mind-body awareness. The integrated approach that I have illustrated provides a framework for women to view themselves as whole persons. They are encouraged to attend to their own internal process as an important source of sexual self-knowledge. It also leaves a door open to expanding beyond the physical to levels of sexual enhancement that include concepts of spiritual sex. I hope to see a re-emergence of these life-affirming approaches to sexuality.