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in: Porst H. Buvat J. (Eds), ISSM (International Society of Sexual Medicine) Standard Committee Book, Standard practice in Sexual Medicine, Blackwell, Oxford, UK, 2006, p. 320-324

Chapter 21
Sexual aversion disorders in women

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Physical intimacy in a relationship is a dynamic process in which sexual motivation is the willingness to behave sexually with a partner [1]. This intimacy can be perceived as too frightening and can increase anxiety for some women to an overwhelming point of sexual avoidance [2]. Sexual desire and arousal is complex in women [3] and many factors can cause or contribute to sexual aversion disorder (SAD).

Sexual aversion may have a prominent *involuntary neurovegetative* basis, which is accompanied by symptoms and signs of anxiety-evoked sympathetic arousal. Or it may have a prevalent *cognitive, voluntary motivation*, when the woman perceives her exposure to sexual intimacy as frustrating and/or increasing her sense of sexual inadequacy.

Both components may be present in the individual woman. However, the term aversion is more pertinent to the phobic attitude, while avoidance better describes the voluntary motivation in the choice of non-exposing oneself to sexual intimacy. Although frequently used interchangeably they are not completely overlapping in meaning, nor in underlying pathophysiology.

Personal and family history can influence a woman's ability to be intimate and perceive this intimacy as a factor of vulnerability [1]. A family history of anxiety disorders and phobias is frequent [2]. Health conditions, such as diabetes mellitus, breast cancer and hyperprolactinemia to name a few [4,5,6] can also contribute to sexual avoidance, with different pathophysiologic mechanisms. Instances of female genital cutting or circumcision may cause women not to feel physical pleasure in sexual intimacy and thus want to avoid it [7,8]. Religious and cultural expectations regarding women's sexuality can influence women to inhibit their sexual desire and pleasure [9], and thus want to avoid physical intimacy. Aging and body image frequently play a significant role in women's ability to enjoy sexual pleasure [10,11]. The personal (and interpersonal) distress caused by this disorder can create a rift in the intimacy of the relationship and influence one member to seek treatment. In the early days of sex therapy women presenting with these symptoms and this disorder were referred to as "frigid" or "sexually unresponsive" [12].

Definition

Defined as "severe anxiety or disgust at the thought of sexual activity" [3, p.30], sexual aversion disorder has many, often interrelated, causes. Incest, molestation, rape and psychological abuse are often factors resulting in a woman developing complete avoidance of physical intimacy and revulsion

at the thought of sexual touch [13]. This anxiety can be severe enough to result in phobic and fear responses associated with dramatic physiological symptoms [14].

By definition, sexual aversion disorder [SAD] specifically describes the clinical picture that correlates with a neurobiologically based neurovegetative arousal with phobic characteristics, focused on or elicited by a sexual stimulus or context, which causes personal distress. It is not uncommon to see patients suffering from SAD who over time may develop post-traumatic stress disorder (PTSD) symptoms, with hypervigilence, flashbacks and panic attacks evoked by recurrent exposure to sexual stimuli. This comorbidity can be emotionally disturbing and further distressing to the patient and her partner.

Prevalence

This disorder is frequently a component of other diagnostic disorders, especially anxiety-based disorders. Hutchings and Dutton [15] demonstrated that 75% of sexually abused women had anxiety disorders versus 21% of non-abused women with anxiety disorders. Another study by Dinwiddie et al [16] demonstrated that the incidence of twins-either one or both-being sexually abused and developing any psychopathology over their lifetime was significantly increased when compared to non-twins and their psychopathology. The incidence of increased panic disorder was one of the most strongly correlated psychopathologies to childhood trauma or sexual abuse [16,17,18]. This hypothesis was initially linked to sexual aversion disorder by Kaplan [2] when she discussed clinical perspectives of intimacy and panic disorders.

Pathophysiology

The neurobiology of sexual aversion disorder is quite similar to that of other anxiety-based disorders, whether phobic or not. The sympathetic system initiates the fight or flight response causing the increase in epinephrine and norepinephrine to be released from the sympathetic nerve endings in the adrenal glands. This triggers a response in the brain to initiate neurotransmitter responses releasing hormones to respond to this anxious feeling and the sexual hormones, such as estrogen and adrenal androgens are reduced due to increased stress [20].

From a psychosexual perspective, women avoiding sexual intimacy could be described as having “emotional claustrophobia” [2]. Panic attacks can cause the increase in anticipatory anxiety. This escalating anxiety could be the result of genetic predisposition or memory of a traumatic event [2]. For example, childhood trauma could cause the individual to have depersonalization/derealization or dissociative symptoms in panic disorders [18]. Also, the woman’s sexual aversion disorder may not be disclosed or dealt with until her partner seeks treatment for his sexual dysfunction.

Co-morbidity with hypoactive sexual desire disorder ([HSSD) is frequent in women with SAD. The pathophysiology of this comorbidity is rooted in both the neurobiology of basic emotions contributing to and modulating sexual desire, and to psychosexual factors that may act as predisposing or precipitating factors for both conditions (see the sub-chapter on sexual desire) [21].

Clinical history

Patient issues

Women with a history of sexual trauma, such as molestation, incest or rape tend to develop inappropriate sexual behaviors [13] and some will act out with hyper-sexuality-the opposite of sexual aversion disorder-and others will act out with sexual aversion disorder. Many have post-traumatic stress disorder ([PTSD) symptoms and sexual avoidance from the experience. Frequently, symptoms of PTSD include increased anxiety, hypervigilence, flashbacks and avoidance of "cues" from the traumatic event [14]. *Clinicans should inquire about a woman's sex history, including childhood sexual exploration with such questions as "When was the first time you were aware of your body parts?" "Were you given any special names for your genital area?" "Did you ever play Dr with a family member or neighbor -what were your feelings about this experience?". It is best to address it "as if" they have already had this experience, because that is a more permission giving and accepting method to discuss this delicate topic.*

Women experiencing genital cutting, whether infibulation or clitoral circumcision and excision, can also have traumatic memories associated with their sexuality. It can also cause them to have difficulty receiving any physical pleasure from sexual intimacy [7,8] and thus want to avoid sexual intimacy. This procedure of female genital cutting is done on female infants within the first year or in the peripuberal years as a "rite of passage" for young women [9] (see the sub-chapter on Iatrogenic and posttraumatic FSD). *If a woman is from another culture, such as Africa, there is a strong likelihood that she may have either experienced genital cutting or witnessed it-which could also be traumatic for her. Again, address it as if it has happened and then she can correct your assumptions rather than probing and waiting for her to offer this information.*

Health conditions can play a role in women's sexual avoidance due to physiological changes with the disease, biochemical and neurological changes due to the disease or treatment chosen and psychological or emotional changes due to the nature of the disease or disorder. Women who have treatment for breast cancer often report a decrease in sexual function [5], which can result in voluntary avoidance of sexual intimacy. Depending on the treatment choice this could be caused by a change in body image due to a mastectomy, to lymphedema or due to lack of sensual response resulting from surgery, from the iatrogenic menopause secondary to chemotherapy, and or other treatment options [21] (see the sub-chapter on Iatrogenic FSD). Diabetes mellitus can cause women to have decreased genital sensation and lubrication and thus lead to female sexual disorders and eventually sexual avoidance. Neither age, duration of diabetes, glycemic controlnor complications predict the extent of sexual disorders in women [4]. However, age is an independent predictor of sexual disorders. Psychotropic medications, especially the serotonin-specific reuptake inhibitors ([SSRIs), tend to influence tactile sensation and decrease orgasmic response [19]. The decrease or even delay in orgasmic response can cause women to avoid sexual intimacy because it becomes unpredictable and requires a frustratingly longer sexplay. *Frequently, if the clinician is empathic and understanding of the woman's various health conditions, it is easier for her to talk about her loss of intimacy and closeness and open the hope and possibility of treatment.*

Religious beliefs can influence women's ability to enjoy sexual intimacy. Some religious doctrines do not allow women to experience their sexuality with pleasure and prefer to focus on rigid role expectations about sexual intimacy, which creates the "sex for procreation not recreation" mindset [9]. It is clear that if a woman has guilt about enjoying her sexual pleasure, which goes against her religious

beliefs, she will also experience high levels of anxiety and this can cause unsatisfactory physical symptoms resulting in sexual avoidance.

Partner-related issues

Aging and body image can have an impact on sexual function and levels of sexual desire or avoidance. Many older adults may have rigid expectations about their sexuality. Some may experience problems with their partner's physical and psychological state, their body image, health conditions, psychological well-being and social, cultural or religious beliefs, as well as levels of personal hygiene [10]. These partner-related conditions can cause various degrees of sexual function and disorders, and can lead to sexual aversion or avoidance. For older women, the most significant influences on their levels of sexual desire were attitudes about sexuality including age, importance of sex and education [11]. It is common for women to cease sexual interest and intimacy when their partner is experiencing a sexual difficulty, such as erectile dysfunction [11]. The anxiety caused by the vulnerability of physical intimacy can make some women very uncomfortable with their sexuality due to real or perceived body image problems, especially due to aging, health treatments or eating disorders. Some women see themselves as "physically unattractive" without their clothes on and thus avoid all aspects of sexual intimacy.

Sexual function and disorders are dynamic phenomena and reciprocal events. When women experience sexual aversion disorder, avoidance of physical intimacy can impact the quality of the relationship. With discrepancies of desire, one person in the relationship can get angry and act out against the other in non-sexual ways, creating a power struggle within the relationship. This can then set up the woman to use sex as her power in the relationship and completely avoid physical contact with her partner. It is not uncommon for couples to learn about the power of sex in the relationship and how to use it in their favor or against their partner [1]. Frequently, people in a sexual relationship confuse emotional intimacy with physical intimacy. Within the power dynamics of an intimate relationship, sexual aversion disorder can be the result of some deep psychological event or belief within the woman, a physical condition of the woman or her partner or a perceptual problem within the relationship. Regardless of the etiology, it can create a wedge within the relationship and become a source of distress for the woman and/or her partner. *Clinicians need to address the sexual history with the couple together and separately. Frequently, one person may reveal perspectives and experiences that may not come out in the conjoint session. Especially, if one person is really not turned on by the other for many reasons, it may be difficult to address this in front of their partner and yet it may have a profound impact on the woman's ability to engage in physical intimacy.*

Clinical evaluation

It is important to do a thorough history with the woman and her partner. She may need to have some of this information taken privately once she feels safe with the clinician. For trauma survivors, it may take some time for the patient to build a level of trust and safety to disclose deep personal and often shameful memories. When a patient has a medical etiology for their sexual aversion disorder or avoidant attitude, it may be more straightforward. However, the clinician needs to be mindful of the potential for secondary gain for keeping the problem. The clinician needs to be empathic and supportive of the patient to build the therapeutic rapport. Physical examination may be indicated when body-image related issues and/or negatively perceived outcomes of breast or genital surgery contribute to sexual avoidance (see the sub-chapters on Classification, etiology and key issues in FSD and Iatrogenic FSD).

Treatment

Integrative treatment

When available it has been shown that working in a collaborative manner can provide the most effective treatment choice because it involves both members of the relationship, and a sexual health professional team, which may include a physician, psychologist, sex therapist or physical therapist all working together for the benefit of the patient and her partner.

Medical

Depending on the etiology of the sexual aversion disorder, the medical treatment could include using drugs that reduce the phobic arousal or changing medications. Corrective surgery may be indicated when sexual avoidance is based on body image issues or secondary to negative outcomes of surgery or genital mutilation. Women who have had genital cutting may experience many complications to their urogenital functioning and need corrective surgery. Women who have had a mastectomy may need breast reconstruction to restore the visual component of their body image. However, loss of breast tactile and nipple erotic perception, which is total after mastectomy and partial after quadrantectomy, may remain a major issue in maintaining a breast focused sexual avoidance [22].

Psychologic

Couples therapy including communication, relationship, and negotiation skills, cognitive-behavior sex therapy with systematic desensitization and relaxation skills as a focal component and group therapy to teach sexual function skills, would be included.

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