Understanding Female Sexual Interest/ Arousal Disorder in the Ghanaian Context: Anxiety as a Risk Factor

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Abstract

Female Sexual Interest/Arousal Disorder (FSIAD) deprives humans of the natural pleasure they need to get from intimacy. It is prevalent but often not addressed by healthcare providers and patients. As clinicians, we need to move beyond our unease to adequately address our patients' sexual problems and implement appropriate treatment.

Introduction

Sexuality is a complex interplay of multiple facets, including anatomical, physiological, psychological, developmental, cultural, socialization and relational factors (Sadock & Sadock, 2003). All of these contribute to an individual's sexuality to varying degrees at any point in time and it is dynamic hence changing throughout the life cycle. By nature, the sexual response cycle of every human being comes in four systematic levels, the excitement, plateau, orgasm, and resolution (Masters & Johnson, 1966). However, the timing of these experiences differs; and the duration that each phase lasts varies. Kaplan (1979) asserts that, the individual must have a desire to engage in intimacy before responding to the phases of the sexual cycle, and in the absence of this desire, there may be problems with intimacy. These problems may include pain, lack of orgasm, sexual dissatisfaction, among others.

According to the Diagnostic and Statistical Manual of Mental Disorders (DSM V, 2013), Female Sexual Interest/Arousal Disorder (FSIAD) involves the fear of sexual intercourse and an intense desire to avoid sexual situations completely. It includes extreme anxiety and/or disgust at the anticipation of/or attempt to have any sexual activity (American Foundation for Urologic Disease, 1996). It can also be explained as the strong negative feelings associated with sexual interaction with a partner which produces sufficient fear or anxiety and sexual activity is avoided (International Classification of Mental Disorders, ICD-10).

Kaplan (1979) explains that the desire for intimacy drives one into the act. Thus, until an individual is ready and has fully prepared his/her mind, it becomes difficult enjoying sex and getting satisfaction. With FSIAD, the individual lacks or has lost interest in sexual activity and may not even respond when partner initiates. There is also the absence or reduced erotic thoughts or fantasies and this causes clinically significant distress to the individual. Some studies have identified age, level of education, psychological problems such as stress and mood disorders, and a history of sexual abuse as possible risk factors that may lead to sexual aversion disorder (Leiblum & Nathan, 2001).

Some studies have emphasized that anxiety plays an important role in sexual intimacy and it is a possible risk factor of FSIAD (Nobre & Pinto-Gouveia, 2009; Oliveira & Nobre, 2013). That is, sexual worries and fears seem to mar sexual arousal, and that affects one's response to any sexual activity. Extreme fear or worry results in tensed muscles which affect our daily functioning and may influence our desire for sex. Katz, Gipson and Turner (1992) highlight that one vital feature of FSIAD is recurrent fear and avoidance of genital

sexual contact in a person who otherwise desires sexual activity. This is in the sense that, FSIAD can be thought of as a fear of sex that may be as a result of fear associated with contracting a sexually transmitted disease, flashbacks of past sexual trauma, or feelings of personal non-readiness and inadequacy.

Literature review

Although sexual aversion disorder is an underdiagnosed condition, several studies conducted have thrown more light on its existence and prevalence. Some theories have also sought to explain the mechanisms involved in understanding sexual activity and why people may be averse to it.

Theoretical review

The psychoanalytic theory of Freud (1913) explains the development of anxiety produced from the ego. He describes anxiety as being neurotic, moral or realistic. According to him, the ego's dependence on the id can result in neurotic anxiety, which is a fear of unknown danger. Though this feeling of neurotic anxiety resides in the ego, it originally comes from desires of the id. Moral anxiety comes largely from the conflict between the ego and the superego, whereby anxiety exists as a conflict between actual needs and what the superego dictates. An example of this could include a child, who has recently developed a superego, feeling sexual temptations and believing them to be morally wrong at the same time. The third type, described as realistic anxiety, is an unpleasant feeling that could involve a real possible danger and this type of anxiety is similar to fear (Feist & Feist, 2009). Most of the time, anxiety is explained as an external emotional response that can cause danger (Parker, 2006). Freud explains how a traumatic event, which cannot be explained, can cause anxiety and that tends to disturb the victim. Some people may decide to repress the unpleasant event but it remains in their sub-consciousness. The implication of the repression is manifested through the person's behavior. The anxiety associated with a traumatic event can be life-altering, affecting the mindset of the individual and must be psycho-analyzed separately. Developing FSIAD may come about as a result of realistic anxiety, where the person involved perceives danger after engaging in the sexual activity and may, therefore, respond to the act negatively.

The main proponents of cognitive theory are Beck (1976) and Ellis (1962) and they argue that anxiety comes about due to maladaptive, faulty, irrational and distorted thinking about an event. According to them, a person's appraisal or interpretation of events determines the person's emotional response to it. When a person evaluates an event negatively or as a challenge, the person is most likely to be anxious and if the same event is appraised positively the person is most likely not to experience any form of anxiety. Epictetus (AD 55-135) summarises that it is not the event itself that causes the psychological distress but it is one's appraisal or interpretation of the event (Beck, Rush, Shaw & Emery, 1979). The appraisal of sexual activity influences either a person's participation or refusal (aversion).

Empirical review

Keith's (2008) review of the National Health and Social Life Survey found that 32% of women and 15% of men, between the ages of 18 and 59 years, lacked sexual interest for several months within the last year. A study was conducted by Roger and David (1999) on the relationship between worry, sexual aversion, and low sexual desire among college undergraduates. Using a quantitative approach, 138 participants were sampled with age range of 19-22 years, of which 56% were females. Results from the sexual aversion scale and the Penn State Worry Question (PSWQ, to test for one's proneness to worry) indicated that higher scores on the PSWQ showed extreme anxiety positively correlated with refusal to engage in sexual activity. There was a statistically significant relationship between generalized anxiety and sexual intimacy. Another study conducted by Bradford and Meston (2006) revealed that there is an association between a high level of anxiety in a non-clinical sample of women and their sexual arousal. They demonstrated that the impact of anxiety on sexual function may be more cognitive than physiological; and that the anxiety may be towards a specific thing and not the activity itself. Some experimental studies have shown a positive correlation between specific types of anxiety disorders and sexual arousal. Findings from studies using clinically diagnosed women with obsessive-compulsive disorders, generalized anxiety disorders, panic attacks, among others have revealed that they have poor sexual intimacy with their partners (Leiblum, Seehuus & Goldmeier, 2007;

Van Minnen & Kampman, 2000). Even though there are methodological differences in the studies reviewed, there seems to be a statistically significant correlation between anxiety and sexual relations. However, the level of significance at which this is likely to occur is unclear. Adopting a qualitative approach, this report therefore seeks to throw more light on the phenomenon, as in relation to the Ghanaian context.

A Case Study of a Client

A verbal consent was sought from the client prior to including this case study in the paper.

Initial Assessment

The client was referred by a physician for psychologist review, and so she walks in for a scheduled appointment. An initial intake assessment (history taking) was done.

A 35 year old female banker, who is married with one child, was referred by a physician as a result of a loss of interest in sexual activity/ libido. This is because the physician had done a thorough physical examination and perceived a psychological cause for client's sexual dysfunction. Client complains of being worried and disturbed because she cannot fulfill her sexual duties in her matrimonial home. She reports that, about a week to her wedding, she surprisingly found out that her husband had 2 children. She had gone to visit her soon-to-be in-laws in their house when she met the children. Her would-be sister-in-law introduced them to her as her fiancé's children. This information she claimed was heartbreaking but since her wedding was only a week away, she decided not to call it off but go ahead with the marriage. She, however, confronted her husband, who confirmed the news and apologized. Her trust for the man waned, but she stuck on with him, she added. Secondly, a year after her marriage, she found out that her husband had contracted HIV/AIDS when he travelled for work outside the country for a period of six months. Her husband could not tell her upon his return home, instead, he gave excuses whenever she made any move towards intimacy. After resisting her over a period, he agreed to get intimate provided they use protection (condom). This confounded her. Her husband eventually broke the news to her several months later when he invited her to his doctor's office. She has since lost interest in intimacy with her husband.

As exists in African cultures, she is being pressured by her extended family and her husband's extended family to have more children. Although her in-laws do not know about her husband's HIV status, her mother knows about it. Her mother also puts on the pressure for her to divorce her husband so she can remarry and have more children. She is under emotional blackmail from her husband, as he keeps threatening her with committing suicide should she divorce him. Out of distress, the woman finally breaks the news of her husband's HIV status to her in-laws. Per the culture of the client's husband, a wife is supposed to be married by her husband's brother (successor) when she is widowed. For this reason, the in-laws suggested that the client continues with the marriage but then, her husband's younger brother would have to get her to conceive another child. However, she refused this arrangement because, according to her, it goes against her moral values. Client has no significant past or medical history or psychiatric history. A mental status examination was done. The client was well groomed and cooperative. She made good eye contact, normal psychomotor activity with no tremors. She spoke fluently but with a quavering voice as though wanting to cry. She admitted to having a depressed mood, and this was congruent with her low affect, looking unhappy and worried. Her thought content was logical and coherent; and with a good memory, she was well oriented in time, place and person. She also had good insight into her situation with fair judgment of her presenting complaint.

Using the DSM V criteria, it was formulated that client has an anxiety disorder (specific phobia which is situational). This is because, client has deep fear or anxiety of being infected with HIV/AIDS (phobic stimulus) and also because of her husband's threats of committing suicide should she divorce him. Moreover, her fear worsens every time she and her husband would have to share a bed and especially during bedtime. The client actively avoids any physical contact with her husband, not even a handshake; and tends to be busy with house chores. Although many people may not intentionally risk their lives to contract HIV, the level of fear or anxiety exhibited by the client was out of proportion. In a typical Ghanaian setting, people living with HIV/AIDS are stigmatized and discriminated against. It is perceived that they acquired the virus

through promiscuous lifestyles. This client did not want to go through such an ordeal, even if she contracts it from her own husband. Likewise, she was also not ready to reveal her husband's medical status to any other person, and to her that meant she had no valid reason for a divorce. Nonetheless, she is under conflicting pressure from her mother and in-laws, but needs another child. These issues have been client's cause of distress for the past year, affecting her efficiency at her workplace.

Management of the client followed this outline:

- An intake assessment session resulting in the formulation of a diagnosis of FSIAD due to situational anxiety
- 6 therapy sessions (psychological education with its content, CBT, decision making and couple's therapy).

Client was seen on weekly basis at the out-patients' department (OPD) for six sessions. During those sessions, she received help through her state of confusion and education as to why she has lost interest in intimacy. In the first session, she was given insight (psychoeducation) into what was happening with her. Her loss of libido was as a result of fear of contracting the virus if she goes intimate with her husband. She did not have in-depth knowledge of HIV/AIDS and its transmission and so she held some misconceptions. Even though she was ready to engage her husband in active conversations and live a normal life with him, the misconceptions she had prevented her from doing so; and that yielded to severe anxiety, to the extent of avoiding any physical contact. Client was taken through anxiety reduction or desensitization process and taught breathing exercises and biofeedback. She was encouraged to practice it regularly.

Cognitive behavioural therapy (CBT) has been used to treat sexual desire disorders by focusing on dysfunctional thoughts, unrealistic expectations, partner behaviour that decreases desire in intercourse, and insufficient physical stimulation. In this case, cognitive restructuring technique was used to help the client reframe the irrational beliefs (misconceptions) that prevented her from having any physical contact (such as hugging) with her husband. Client was tasked to deeply reflect on all that had been discussed, and pen down what she makes of the discussion. This would help her come up with a decision that may be deemed appropriate in her current situation.

Couple's therapy (communication therapy) was held for the couple in order to help them understand that one partner (wife) has lost interest in sexual intimacy as a result of fear of being infected with the virus. They were, therefore, encouraged to reestablish open communication in their marriage so that they can freely express themselves to each other. However, husband was made to understand his wife's current situation and her reason for aversion.

Outcome: during the early stages of the therapy sessions, client had much difficulty coming to terms with reality, but her husband continually persuaded her for intimacy. However, after the second session, client exhibited better coping strategies because she had decided to stay married, for religious and moral reasons. She also understood her husband's distress and communicated her decisions to her mother, in-laws and her supervisor at work. Months later, she reported for psychological review but this time with a new decision to embark on separation (and not divorce). Generally, she looked better and her anxiety had reduced significantly. Client was discharged with the option to report whenever she found the need to, since she had resolved the matter at hand.

Discussion

The case study report highlights that; one's aversion to sexual intimacy can be explained by anxious thoughts. This client's fear of being infected with the HIV had accounted for her loss of libido. The psychoanalytic and the cognitive behavioural theories expound this assertion. This case concurs with findings by Bradford and Meston (2006) who found that aversion to sexual intimacy is as a result of fear of a specific thing and not the activity in itself. Findings from this case also agree with results from studies by Leiblum, Seehuus and Goldmeier (2007) and Van Minnen and Kampman (2000). Activating events lead to negative automatic thoughts which in turn result in disturbed negative feelings and dysfunctional behaviours. Anxiety cripples

the mind from responding positively to environmental stimuli and people may refuse sexual activities because they may perceive it as endangering to their health, progress or conflicting with their moral uprightness. It is obvious, from this case report that higher level of anxiety, which leads to stiffness of the muscles, impairs not only occupational functioning but one's readiness for action, including sexual activity.

Summary, Conclusions and Recommendation

Female sexual interest or arousal disorder is often progressive and rarely reverses spontaneously. Despite the difficulty in treatment, cognitive behavioural therapy is effective for managing FSIAD. Sexual desire disorders are under-recognized and under-treated disorders leading to a great deal of collapse in relationships (marriage). A thorough history is critical to a proper diagnosis and determination of underlying factors.

In conclusion, the psychology clinician works as part of a multidisciplinary team, which involves not only a collaboration of other professionals but also the integration and application of new knowledge, evaluation and subsequent modification of healthy practices; to ensure the highest level of care provided. The sociocultural context in which situations occur must be taken into substantial account since what may seem disquieting with one cultural group may be considered usual, or the norm in another. Hence, appropriate treatment is required to improve upon clients' sexual problems that may be resulting in marriage and relationship breakdowns. Furthermore, physicians should recognize that sexual dysfunctions could be solely psychological in origin and therefore make the necessary referrals. This report will also help the general public understand the role of the mind in intimacy. It will equip them with more knowledge on being prepared for sexual activity at all stages of their lives.

Recommendations

Based on this case study, it is recommended that continued research should be encouraged among clinicians, in this critical and sensitive, yet ubiquitous area of sexual dysfunction. By becoming more familiar with prevalence, etiology, and treatment of sexual desire disorders, clinicians can become more comfortable with issues pertaining to sexual intimacy. This will help them to adequately address patients' sexual problems and to implement appropriate treatment or refer to other disciplines with the expertise to help in the client's management. Psychologists must take cognizance of cultural issues that may lead to distress. Moreover, a biopsychosocial approach to healthcare is grossly encouraged to understand how these factors predispose to dysfunctions in sexual relations.

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Author's contribution

Both authors clerked the patient and reviewed her throughout her psychotherapeutic sessions. While the corresponding author is a clinical supervisor, the author was a clinical student as at the time the patient was attended to. The manuscript was put together by the author, and edited by the corresponding author.