



## HELP FOR FEMALE SEXUAL RESPONSE

It seems that the first thing to go if there is any sort of stress or illness in women is sex drive or libido. It also seems that in men, it's the last thing to go. I can imagine you nodding sagely as you read this article. We all know there is a libido gap between men and women generally, but what can be done?

There has been much research and discussion about men's hormones, especially testosterone, but not a lot about women and their sexual needs. At one time, it was all thought to "there, there, my dear, its all in your head". But now there is recognition that the female sexual response is indeed a complicated thing, as many men will tell you. It is wide reaching and multifactorial, involving psychology, social factors, brain neurotransmitters and hormones.

One definition of what is called Hypoactive Sexual Desire Disorder (HSDD) is that it is "a persistent and recurrent lack (or absence) of sexual fantasies and desire for sexual activity that causes marked distress or difficulty in interpersonal relationships". What they mean by that is you don't feel like it, you take longer to "warm up" and the response is not what it used to be. This makes sense, because its only a problem if it really worries you or causes problems.

Women can be reluctant to bring up the topic with their doctor, so the figures are estimates. Depending on your estimate, it can affect 20-50% of women. It affects 6% of premenopausal women and its higher at 16% of women who have had a surgical menopause (hysterectomy +/- ovaries removed) – this is because the ovaries are key producers of estrogen and testosterone.

In women aged 50-70 years, the rate is 9% if they have gone through a natural menopause and 12% if they have gone through a the surgical menopause. Generally the proportion of women with diminished sexual desire increases with age.

Getting into other age groups, in women aged 18-44years its 8.9%, aged 45-64 years its 12.3% and if aged 65 or older its 7.4%

### Symptoms

These women have little desire, little arousal and even sexual pain. These often are associated with negative feelings in relation to the sexual act as well as their physical and sexual satisfaction.

### Contributing factors

There are numerous factors that can contribute to the problem:

1. The relationship dynamics and its associations with sex. How the couple are communicating and how the relationship is progressing. Newer relationships have fewer problems. Women who have had relationships lasting over 20 years were more likely to have problems.

2. Mental illness in the woman. Depressed or anxious women communicate differently. Also likely is that the alteration of neurotransmitters ( brain chemical messengers) associated with their mental illness will be affecting their hormones.
3. Age. Reduction in hormone levels cause change in desire as well as sexual function. In older, post menopausal women, an atrophied vagina is dry because of reduction in estrogen levels.
4. Pregnancy is a special time when desire drops, especially during the third trimester. The drop can last for 3-6 months after delivery. Factors that influence this include lack of information, breast –feeding, painful vagina after the birth and post delivery pelvic dysfunction.

## Role of Sex hormones

Initial sexual stimulation causes release of blood vessel dilating substances like Nitric Oxide (similar to the male response). In addition, central nervous and spinal messengers might also be influenced by the Nitric Oxide (NO). In turn NO increases a substance called cGMP which is part of the response. Estrogen and testosterone are known to increase Nitric Oxide – this is where the hormones come in and women need a minimum amount of these hormones to get a sexual response.

## Causes of low testosterone levels in women:

- Age
- Removal of ovaries (testosterone is produced by ovaries and adrenal glands)
- Hypothalamic insufficiency – part of the brain that stimulates the pituitary
- Under active pituitary – normally stimulates all the endocrine glands like thyroid, adrenals, ovaries etc
- Adrenal insufficiency – from a tumour, disease or stress
- Synthetic steroid therapy
- Estrogen therapy – causes a rise in binding globulin which mops up testosterone
- Over active thyroid
- Depression
- Cancer

## Role of Neurotransmitters

Dopamine is the 'pleasure chemical' in the brain and increases sexual desire, the sensation of arousal and the desire to continue sexual activity once stimulation has begun. On the other hand, serotonin inhibits the sexual response. It is thought that there is a balancing effect carried out by the two neurotransmitters.

Both neurotransmitters are affected by stress and nutritional deficiency. They are both derived from protein foods. To break down protein in the stomach, there is a need to have adequate gastric acid which can decline with age and stress. To convert the protein breakdown products (amino acids) into the right neurotransmitters there is a requirement for adequate B vitamins, vitamin C etc. In addition, it is known that vitamin D which is obtained from sunshine and is often deficient, balances dopamine. Omega 3 fish oil also balances dopamine.

Selective serotonin reuptake inhibitors like fluoxetine influence serotonin in the brain as antidepressants but also affect sexual function and can slow it down.

Other neurotransmitters that affect sexual desire include oxytocin which is released during breast feeding and can be released during lovemaking – it increases a sense of bonding. Prolactin ( most often from breast feeding) and opioids (endorphin substances) in the brain can inhibit desire.

## Sexual dysfunction questionnaire for women

In the past, was your level of sexual desire or interest good and satisfying to you?

Has there been a decrease in your level of sexual desire or interest?

Are you bothered by your decreased level of sexual desire or interest?

Would you like your level of sexual desire or interest to increase?

Please mark all the factors below that you feel may be contributing to your current decrease in sexual desire or interest...

- An operation, depression, injuries, or other medical condition
- Medication, drugs or alcohol you are currently taking
- Pregnancy, recent childbirth, menopausal symptoms
- Other sexual issues eg pain, decreased arousal or orgasm
- Your partners sexual problems
- Dissatisfaction with your relationship or partner
- Stress or fatigue

## What can help low sexual interest or response:

1. Counselling, especially if there are relationship, social or stress issues.
2. Stress management, adequate sleep and rest.
3. A good diet with adequate protein and vegetables to supply the amino acids to make the neurotransmitters and vitamins to help them run properly. Adequate sunshine without sunburn from vitamin D. Fish for omega.
4. Correct hormone deficiency.
  - **Estrogen** is safer when given as patches and can be prescribed by a family doctor if this is deficient. Alternatively, pellets from a gynaecologist could be useful. This can be around the time of menopause or after surgical menopause.
  - **Testosterone** diminishes a little after menopause, but diminishes even more later on in menopause, so can need to be added in then. For women in New Zealand, it is available as pellets, so if necessary, they can be inserted under the skin along with the estrogen pellet. Otherwise, testosterone can be obtained as a bioidentical cream. Testosterone therapy for low sexual desire has been approved in some countries, and research in this area is still going and will become clearer in time. Overseas, Testosterone is also available as a patch and gel.
  - **DHEA** – short for Dihydroepiandrosterone. Although there is not much research, some suggests it can increase a persons assessment of sexuality. This is available only on prescription.

## Androgen therapy

This refers to treatment with DHEA or testosterone. My research suggests that it is considered safe to use. There is no increase in heart risk or changes in blood pressure. Androgens do not stimulate the lining of the uterus, although theoretically both DHEA and Testosterone can convert to Estradiol. This is why I recommend you see a gynaecologist, endocrinologist or a doctor who has an interest in bio identical hormones.

Androgens when taken to excess can cause increased hairiness, enlargement of the clitoris, acne and hair loss. IN this case, the dose can be reduced. Once again, if you wish to embark on this type of therapy, the advice of an experienced specialist is a good idea.

So, you have just read is what you already know. Its **not** all in your head. Its stress, too much work and fatigue, juggling many balls and just generally truing to be a Superwoman. On top of that its your nutrition and hormones, especially if you have been sick, on drugs, gone through menopause or just had gynaecological surgery. So make a quiet start now on the fundamentals like getting enough sleep, good diet and getting more support with home and work. The hormones are there is you need them.

Information about bio identical hormones like DHEA and Testosterone and doctors who can prescribe them can be obtained from compounding pharmacies. See below:

<http://www.pharmaceutical.co.nz/>

<http://www.optimushealth.co.nz/>

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