How Sex Works (and When it's not Working)

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Sex is one of the central aspects of the human condition and one of the driving factors of our evolution as a species. It is a necessary element of midwifery because, aside from modern medical-assisted reproduction techniques, there will be no pregnancies without sex.

Various publications have clarified that midwives need expertise—both skills and knowledge—concerning human sexuality. This chapter will broadly focus on how sex works and when sex is not working, both on an individual and couple level. Other chapters of this book will tackle sexuality and sexual health from a more biological, psychological or social perspective, concerning different parts of the midwife's field of practice—from pre-conception to young parenthood.

What makes sex work? Can we define parameters for promoting satisfying sexual experiences or understanding how sexual experiences can be disappointing or frustrating, e.g. when sex does not work?

This chapter strives to go beyond the mere description of models of sexual response [1] and aims to outline a simple to use '3-Conditions Framework', describing the necessary conditions that sexual experiences have to meet to be 'good'. 'Good' meaning pleasant, satisfying, fulfilling, bonding, fun or whatever one wants it to be.

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3.1 The 3-Conditions Framework for satisfying sexual experiences

We propose a simple framework for how sex works, outlining three more or less essential requirements for a satisfying sexual experience: (1) a sufficiently intact and functioning sexual system; (2) 'good enough' sexual stimuli and (3) a 'comfortable' context.

When one fully understands these three conditions, it enables the HCP to translate them towards diverse human sexual practices. They then can serve as a framework for exploring clients' sexual problems in counselling (e.g. by actively exploring these three conditions), as a mini-diagnostical tool (e.g. helping to understand which condition(s) are likely causing/maintaining the sexual problems) and as a framework for promoting sexual wellbeing (e.g. as a psycho-education tool).

This chapter will first explain the '3-conditions framework' and then successively address its use as a counselling tool, diagnostic tool and psycho-educational tool.

3.1.1 What Makes for Good Sex?

What does one need for good sex? What is the right way to stimulate women/men sexually? What is required to be sexually satisfied? If one tries to answer these questions factually, the result would likely be a useless list of sexual practices that might work for a given woman, her partner or a given couple. If we were to ask 100 people what they would need to have a good sexual experience, we would wind up with 100 personal sexual guide books. At best, one could read someone else's guide as a source of inspiration. In the margin of this chapter, this might be a personally enlightening exercise for each HCP in a committed relationship.

The question then becomes: what are the conditions for people to have pleasurable sexual experiences? We recommend approaching this on a meta-level to understand what is needed to make any sexual experience satisfying. The three most relevant conditions are the sexual system, the stimuli and the context.

3.1.2 An Intact and Functioning Sexual System

Sex requires activity in multiple brain regions. The hippocampus, hypothalamus and amygdala play a central role in routing and rerouting signals related to sexuality [2]. These signals travel through nerve bundles, connecting the brain with relevant erogenous zones (genitals, breasts, nipples, mouth, skin, neck, ears, feet, etc.) [3]. If one of the links in this chain of information-sharing is malfunctioning, the entire system can become stressed, sometimes even making certain aspects of sexual experiences impossible. A person's nervous system, endocrine system, genitalia, sensory organs, skin, hands, lips, tongue, etc. need to be intact and functioning, at

least up to a certain level. In other words: one needs to be able to register internal and external sexual stimuli (fantasies or desires, seeing a beautiful man/woman, feeling someone lightly brush your neck, etc.) and all internal systems and organs that play a part in the elicited sexual response need to be functioning enough.

One can immediately understand that any pathology or medical intervention that can impact the normal functioning of the nervous system, endocrine system or senses can influence how we experience sexuality. Think, for instance, of the negative effect high prolactin and low testosterone levels during breastfeeding can have on sexual desire and sexual arousability. Or think of the negative impact genito-pelvic pain caused by endometriosis can have on one's sexual experiences.

Still, it is important to note that the physical system does not have to be in pristine condition to enable people to have pleasurable sex. Many people continue enjoying sex despite e.g. being on anti-depressants, suffering from genital pathology, having a chronic disease, being blind, sitting in a wheelchair because of a spinal cord injury, etc.

One's sexual system does not have to be 100%, but it has to function sufficiently to allow people to experience what they want to experience.

3.1.3 Good Sexual Stimuli

Every system has its start-up requirements. Our sexual system is no different. It needs the input of sexual stimuli to get going and keep going. These stimuli can be internal (like memories, thoughts or fantasies) and external (like sound, touch, scents or just seeing someone you find attractive, hot or sexy). Both can do the job equally well. Most people have a general idea of which stimuli are the most valuable for themselves [4].

For most people in a stable relationship, the partner is an important source of various sexual stimuli. Partners can evoke erotic thoughts or fantasies, look really sexy when dressed in the right way (or not at all) or be the one who lights those lovely scented candles.

Stimuli are abundantly available. However, even when exposed to a potentially good stimulus, you still have to *experience it in a sexual way*. One's brain has to give sexual meaning and thus sexually validate a stimulus. In other words: allow oneself to interpret it sexually.

Whether or not this will occur will largely depend on one's personal background and frame of reference regarding sexuality. So the way people think about sex, their ideas and conceptions about sex, what is sexy, what is fun and so on, will largely determine if potential sexual stimuli will effectively become sexual stimuli for that person. So, the better you know your own and your partner's 'sexual frame of reference' (also called 'lovemap'), the easier it will be to find the proper stimuli to jump-start your sexual system or your partner's.

The bottom line is that we need stimuli to get our sexual system going, but we have to experience' them as sexual stimuli to have the desired effect.

3.1.4 A Comfortable Context

Even after fulfilling the first two conditions, one still needs the proper context for the situation to develop in the desired sexual way.

When people feel their physical sexual system is starting up, and desire and arousal are building, time and place have to be suitable for that person to actually do something with those feelings. And again, independent of whether time and place is in reality fit for sex, it has to feel right. Both the physical context, your surroundings, and one's internal context, in other words one's mindset need to be good enough to allow our brain to see stimuli as sexual. When your mind is elsewhere, occupied with non-sexual thoughts, or when your previous (negative) experiences or beliefs come into the mix, even potentially stimulating surroundings to act upon your desire could be transformed into 'not-comfortable-enough' to proceed to a satisfying sexual experience.

3.1.5 The '3-Conditions Framework' as a Communication Tool

For many midwives and other HCPs, sexuality is not an easy topic to address. Midwives might feel personal barriers and think it is inappropriate to ask actively about sexual wellbeing or fear invading the intimacy of the couple's relationship. Still, research shows that women and men expect the HCP to start a conversation about sexual health, as they too feel the challenge of addressing such a taboo-laden topic [5]. Chapter 26 will offer the midwife/HCP a step-by-step plan, the 'one-to-one method', for starting a conversation with the woman (or couple) on sexuality-related topics. The second step in that model is: '*Let her tell her own story*'. The woman can, for instance, be invited talk about sexuality by asking about her current situation's biological, psychological and social aspects or exploring her ideas, concerns and expectations relating to her sexual life. Here we can also use the '3-conditions framework' to enable the client to explain her current situation fully. By actively asking the client about her physical health in relation to sexuality, the presence of sexual stimuli and by exploring how their experiencing the context, the client and her partner start to already paint a broader picture of their sexual life at that moment in time.

3.1.6 The '3-Conditions Framework' as a Diagnostic Tool in Case of Sexual Problems

The midwife does not always have the skills and knowledge to diagnose the sexual problems of her client accurately. On the other hand, this is far from always necessary.

We can trace most sexual problems to a disturbance of one or more of the three conditions for pleasurable sex. Either the physical sexual system is impaired (e.g. hormonal changes during breastfeeding), or the stimuli are insufficient to trigger desire and arousal (e.g. perception of a partner as less attractive due to excess weight gain) or the context is not comfortable enough (e.g. fear that the baby will start crying).

By actively exploring the three conditions for pleasurable sex, the midwife can gain a rudimentary idea of what might be causing the sexual difficulties, which will help her decide on the strategy, provide the necessary psychoeducation or other interventions to help the couple tackle their problem or refer to another HCP for specialised treatment.

3.1.7 The '3-Conditions Framework' as a Psycho-Education Tool

The couples that remain sexually satisfied during pregnancy tend to have greater sexual and relational wellbeing during the challenging post-partum period. This is a solid argument for pro-actively addressing sexuality in pregnant couples and counselling on how to keep their sex life satisfactory, which is not an easy challenge in a changing relationship, with a changing body, etc. [6] (see also Chap. 6).

One way to do so is by already actively discussing the three conditions for satisfying sex with the couple early in pregnancy. That can make them aware of how various changes can affect their sexual relationship.

With enough stimuli available and regularly a context allowing them to act upon their sexual desire, the sexual response will probably follow. Helping couples in this way to actively think about their sex life can enhance mutual understanding, which e.g. can facilitate acceptance of differences in desire. Understanding why each partner behaves in a certain way can help the couple deal with tense and tricky situations and prevent developing frustrations. The midwife can lay the foundation for prolonged sexual and relationship happiness by enabling this, resulting in greater overall health and wellbeing during pregnancy and post-partum (and probably during later parenthood).

It is, however, essential to recognise that people's experiences might differ when their physical sexual system is not functioning optimally or when e.g. physical stimulation occurs in the 'wrong context', for instance a non-sexual, or even negative context.

3.2 When Sex Is Not Working

The '*3-conditions framework*', as described above, can help understand why people are experiencing sexual difficulties. Decades of research delineated various conditions making sex difficult or even impossible to enjoy. These so-called sexual dysfunctions have been officially adopted as clinical diagnoses in the DSM V and the ICD11, internationally used systems for diagnostic descriptions. The DSM V describes them as follows:

> *Sexual dysfunctions are a heterogeneous group of disorders that are typically characterised by a clinically significant disturbance in a person's ability to respond sexually or to experience sexual pleasure.*

For calling something a sexual problem, it should cause distress to the person and/or their partner.

The rest of this chapter will give an overview of known sexual dysfunctions, starting with problems of sexual desire, moving on to problems with sexual arousal, orgasm problems, sexual pain problems and finish with some sexual problems that deserve special attention. Each of the sexual problems will be linked to the '3-conditions model', explaining how the model could show the cause of that problem. We will also address the sexual problem's relevance to midwifery practice.

Clinical practice indicates that people sometimes have problems in their physical, sexual functioning but are still perfectly sexually satisfied. Labelling something as 'problematic' instead of 'dysfunctional' induces a mindset with the client that makes treatment more manageable, given that 'when one has a problem, we just have to find a solution', whereas labelling something as 'dysfunctional' gives the impression that something is 'malfunctioning' or even 'broken', which is often not the case when women or couples present with sexual distress. Hence we favour the term 'sexual problem' above the clinical term 'sexual dysfunction'.[1]

3.2.1 Problems with Sexual Desire

Problems with sexual desire can arise when people experience not enough or too much sexual desire. The logical question becomes: what is not enough or too much? At this point, the interpersonal distress aspect comes in. It will become a problem when a woman or her partner experiences distress because of a low level or even no sexual desire. In the same way, a high level of sexual desire can become a problem when it causes distress in the relationship. Culturally and clinically, too low desire levels are typically associated with women and too high desire levels with men. Still, it is essential to note that gender is not an absolute defining factor in sexual desire. Women can experience distress because of high levels of sexual desire too, just as men can experience problems because of low levels or no sexual desire. In a partner relationship, the discrepancy between the levels of sexual desire can cause problems if the difference is experienced as too large. Such problems with differences in sexual desire can occur at all points in life, including during pregnancy and post-partum. It is also worth noting that differences in sexual desire can also be about the nature of sexual desire.

Viewed through the lens of the '3-conditions framework' sexual desire problems can e.g. arise from lack or abundance of suitable sexual stimuli, from the idea that there is seldom a proper context, or that almost any context is seen as fit for a sexual experiences.

[1] Be aware: sexual and relational problems can coincide and be related but they do not have to be. Couples with a very good relationship can have very poor sex. And very exciting, satisfying sex happens also in people who barely have a relationship.

3.2.2 Problems with Sexual Arousal

Problems with sexual arousal can arise when the body has difficulties generating enough physical arousal. The cardiovascular system, numerous muscles and neurotransmitters have to cooperate to create general and genital arousal. Also, without sufficient subjective arousal, in other words enough feelings of arousal, lubrication or erection will fail.

In midwifery, think of the role sexual arousal plays in boosting one's chances of conception. Good vaginal lubrication is needed for proper movement and viability of the sperm cells, and a good erection is required for intra-vaginal ejaculation (see also Chap. 5).

A common mistake is to focus on the most visible symptom women experience when arousal is not always running smoothly. Lack of arousal often translates into a lack of vaginal lubrication and pain. So, when a woman presents with pain during intercourse, we have to address both feelings of arousal and physical arousal.

Erections can fail in several ways: no erections, erections disappearing too soon or not getting hard enough for penetration. This will only become a problem when causing (inter-)personal distress. A prerequisite for the body to start generating physical arousal is the presence of enough effective sexual stimuli, eliciting a sufficient level of 'feeling aroused' to get the physical sexual system to start up (see above).

Viewed through the lens of the '3-conditions framework' sexual arousal problems can be caused by each condition, separately or simultaneously. Be aware to distinguish between low female arousability caused by low testosterone levels during breastfeeding and so-called 'psychogenic arousal problems', often caused by a lack of proper stimuli or comfortable context. In the first case, it's transient.

Different causes will require different treatment approaches. The '3-conditions framework' can help the midwife discriminate the aetiology of the sexual arousal problem, leading to more targeted interventions or referrals.

3.2.3 Problems with Orgasm

Problems with orgasm can take many different forms. Men and women can climax too slow, sooner then desired or not at all.

What is the relevance of problems with orgasm in midwifery? Conceiving will become rather difficult if the man cannot ejaculate or always ejaculates before vaginal penetration. Besides, many men and women view the ability to orgasm as an essential aspect of their sexual wellbeing. Research repeatedly reports on the link between high sexual wellbeing, general psychosocial wellbeing and partner attachment during pregnancy and post-partum. For more information, see Chap. 4 on The Health Benefits of Sexual Expression.

Viewed through the lens of the '3-conditions framework', orgasm problems can be caused by all three conditions. Good in-depth anamnesis will be paramount to tailor treatment successfully.

3.2.4 Sexual Pain Problems

Women (and also men) can experience pain when having sex. In nearly all cases of sexual pain, there will be a physical factor that is (co)causing the pain. For women, the physical origins of sexual pain can vary widely from pathologies like endometriosis or vulvodynia to anatomical issues, birth trauma (see Chap. 13) or a hypertonic pelvic floor (see Chaps. 10 and 16). Apart from the possible physical cause of sexual pain, women often find themselves in a vicious circle where they have had several painful sexual experiences, leading them to expect pain beforehand the next time. The expectation of pain causes 'bracing' for the pain and unwillingly tightening her pelvic floor muscles, making penetration more difficult and painful. So the anticipation of pain is confirmed. In addition, fearing pain will distract from sexual stimuli, making good arousal and lubrication more difficult, which is another possible cause of pain. Breaking this cycle requires, among other things, good psychoeducation. Still just insight into what is happening is sometimes not enough. Good inter-disciplinary cooperation with a clinical sexologist and pelvic floor therapist is often needed.

Detailed anamnesis is a necessary precondition before proceeding to treatment. A clear picture of the type and location of the sexual pain can aid in diagnosing potential underlying pathologies (e.g. pain when entering the vaginal canal is more associated with e.g. birth trauma, whereas pain experienced deeper in the vaginal canal could indicate e.g. endometriosis).

The importance of awareness of sexual pain problems in midwifery practice seems evident. In the childwish-phase, sexual intercourse without pain is an important condition to continue to have pleasurable sexual experiences when trying to concieve. The post-partum period is also a well-known risk phase for developing sexual pain.

Viewed through the lens of the '3-conditions framework', sexual pain can be caused by all three conditions, in other words, by problems with the physical sexual system, a lack of good stimuli or lack of a comfortable context. In sexual pain problems, there will almost always be an impairment of the physical sexual system. The HCP should be aware that the initial physical cause of the pain might be gone when the client consults about her pain problem.

3.3 The Midwife's Job When It Comes to Sexual Problems

People experiencing sexual problems deserve good care and guidance. Not all professionals are qualified to deliver intensive sexual therapy. But, happily enough, only a few people need that.

In 1974, Jack Annon developed a model used for the assessment and management of sexual problems, coined the PLISSIT model [7].

This PLISSIT model (Fig. 3.1) shows that people with different sexual problems can have different needs. It is a stepped model in the form of a pyramid, consisting of four distinct levels.

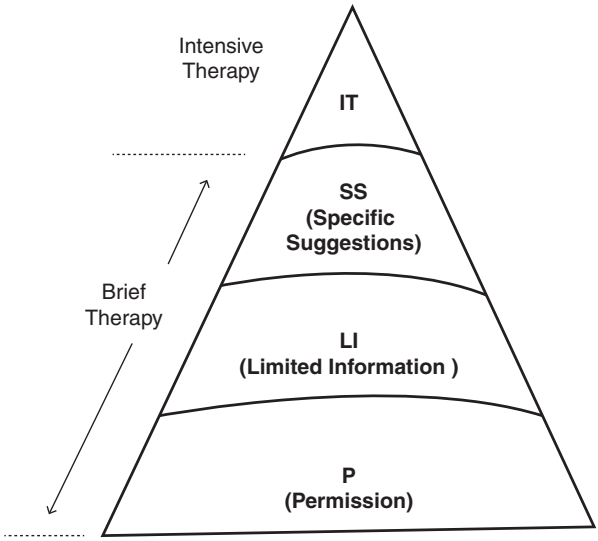

Fig. 3.1 The Plissit model. (Adapted from Annon)

The first level of the model, 'P', stands for *'permission giving'*. At the large base of the pyramid, the first client group represents all potential clients. All people can benefit from knowing that their HCP is open to discussing any issue about sexuality that they might be experiencing. So all HCPs—midwives, gynaecologists, sexologists, psychologists, physical therapists, nurses, etc.—should (be able to) create an environment where the client feels they can freely bring up sexual questions and worries. In addition to this, every woman and couple will benefit from a positive framing of sexuality. Being made aware by their HCP that it is okay to have sexual feelings, behave sexually and be sexual in a way that is not harmful to others can be an additional benefit that HCPs can create for their clients. In practice this translates to HCPs actively telling their clients 'if you ever have questions, concerns or problems with regards to sexuality, I'm always willing to listen'.

The second model level, 'LI', stands for *'limited information'*. Not all clients need information on sexual health, but a reasonably large group of people could benefit from such info. Think, for instance, of the midwife informing the client about the sexual side effects of hormonal contraception or explaining that it is perfectly safe to have penetrative sex during a physiological pregnancy. As the group of clients in need of this intervention become smaller, the group of HCPs which we expect to be able to deliver limited information on sexual health become smaller also. Aplied to midwifery practice one could argue that midwives should be able to deliver limited information with regards to sexuality during an active child wish phase, pregnancy and young parenthood.

The third model level, 'SS', stands for *'specific suggestions'*. A smaller group of clients are actually experiencing sexual problems and will need some professional

guidance to overcome these issues. Specific suggestions on how to handle the challenges they face can help them boost or regain their sexual wellbeing.[2]

Moving further through the levels the number of clients in need of this intervention becomes smaller. Also, fewer professionals will have the skills to provide such specific suggestions. Most healthcare curricula do not provide HCPs with the skills and knowledge they need to give this form of care. Often some additional training about sexual health is required. Such specialisation in sexuality or sexology is available for midwives in several countries. In some countries, the primary focus is on sexual health during the period of childwish, pregnancy and young parenthood. In other countries, midwives deal with the broader area of women's sexual health.

The final level of the model, 'IT', stands for *'intensive therapy'*. The group of clients who effectively need in-depth sexual therapy is tiny compared to those who need the previously described interventions. It follows that only a small group of highly trained and specialised professionals such as clinical sexologists or physicians, psychologists and psychiatrists with additional training in sexual therapy are capable of providing such care. Even a very experienced sexologist cannot correctly deal with all sexual problems. Therefore sexology has developed into various subspecialisations, 'reproduction sexology' being one of them.

The advantages of the PLISSIT model are that it allows professionals to position themselves in this model, thus deciding how far they can go in providing sexual health care for their clients. For midwives and gynaecologists, giving permission to talk about sexual concerns and providing clients with limited information on sexual health and wellbeing is a prerequisite. Those midwives and gynaecologists who find themselves working with client groups who often have real sexual concerns could seek some additional training to also become able to provide specific suggestions on sexual health and practice when needed. Still, if the HCP feels he is not the best person for addressing the client's questions and concerns on sexuality, it is important to stress that a good referral to a more specialised colleague is an equally good or sometimes better form of care than handling all issues by oneself.

In 2006, Taylor and Davis proposed a more nuanced version of this model, recreating it as the Ex-PLISSIT model [10]. Their additions updated the model with the healthcare norms and values of the new millennium. In the 1970s, health care had just started on the path to leaving paternalism behind. Autonomy as a value became much more central to health care, leading to client participation and a right to self-determination in matters of one's own health(care) becoming the new norm in healthcare. Today it is widely accepted that any therapeutic process has to be a process of co-creation, an interplay between HCP and client. We can see this value shift in the Ex-PLISSIT model, emphasising the importance of permission-giving

[2] Many exercises have been devised to help partners get to know just what works for their partner sexually (see, e.g. [8]). When selecting exercises that might help your clients to explore each other's sexual preferences, it is important to choose an exercise that is concise (not too time-consuming) and positively oriented (focussing on what works and previous good experiences, rather analysing what caused bad experiences). This way couples can learn 'what works and to do more of that' [9].

as the central element for any level of intervention, from permission-giving up to intensive therapy. The HCP should regularly check the client's current goals and, consequently, ask the client's permission to proceed in such a way that both HCP and client feel what is the best course of action to make their desire for change become a reality. Such a process of constantly focussing on the women/couple's desired outcome is essential in sexual health care. After all, cultural myths and taboos that exist in society about sexuality can easily cause the HCP to fill in what the client has not explicitly said because asking for detail would be 'uncomfortable' for both or 'too invading towards the client's intimate life'. By integrating permission-giving and a constant process of reflection, as elements of the model, it aims to keep the clients as co-pilots in the process, recognising them as the experts of both their own lives and their own problems, but also their own desired futures and the strengths they possess that can help get them to reach the goal.[3]

3.4 Conclusion

Sexuality, meant as a pleasurable and fulfilling form of human expression and bonding, can be a major source of physical, mental and social wellbeing. From trying to conceive till after childbirth, women and couples can, and many will, have sexual concerns and sexual problems. Thus, midwives and other HCPs should be aware of the necessary conditions to make sexuality a satisfying experience and thus a positive aspect of the couple's life. With the '3-conditions framework' of system, stimuli and context, this chapter offered an easy to use model to find out, together with the woman or couple, what might be causing the sexual problem and how to achieve a desired sexual future.

Providing good care also requires knowing one's strengths and limitations as an HCP. All midwives should be able to create a climate in which the woman and the couple feel safe to talk about sexuality and their sexual concerns or problems. We believe that every midwife should be able to give limited information on the effect of pregnancy, birth-related trauma, contraception, etc. on sexuality. Some midwives might even feel that they can proceed, with the tools presented in this chapter and this book, to take it one step further and give their clients specific suggestions on how to change their situations in their desired direction. Putting the client's needs and goals first will be the guiding principle towards helping women and couples 'making their sex work'.

Note: There will be books or blogs in most countries and languages to improve sexual communication and contact. We recommend the reader to look for good books or blogs in their own country/language area and integrate them into their midwifery and obstetric care.

[3] More practical guidelines for midwifes and other HCPs on how to ask questions and have a conversation with clients' as experts, focussing on their desired outcomes and strengths can be found in Geuens et al. [11].

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