



HERBAL MEDICINE FOR WOMEN

Unit 4 Lesson 48

Vaginal Dryness, Uterine Prolapse, Urinary Incontinence, and Low Libido

Learning Objectives

By the end of this lesson you will be able to:

1. Explain the physiologic changes that occur with menopause that can lead to vaginal atrophy, dryness, decreased libido, urinary incontinence, and sexual dysfunction.
2. Discuss the psychosocial and emotional causes and implications of sexual dysfunction on a woman's life, self-concept, sexual experience, and intimate relationships.
3. Understand the mechanics and possible treatments of uterine prolapse.
4. List and describe the characteristics of the most common botanical treatments for vaginal dryness, vaginal atrophy, and sexual dysfunction as presented in this lesson and the associated required reading.
5. Teach women ways to keep their vaginal tissue healthy, their creativity vibrant, and their sexuality alive and well.



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Required Reading

Botanical Medicine for Women's Health (Romm)

- Vaginal Dryness and Atrophy
- Low Libido and Sexual Dysfunction in the Perimenopausal Woman

Obstetrics and Gynecology at a Glance (Norwitz and Schorge)

- Urinary Incontinence
- Pelvic Organ Prolapse

Principles and Practice of Herbal Medicine (Mills and Bone)

- Review relevant herb monographs from Key Botanicals list below

Article: *Healing a Uterine Prolapse* (Romm)

Powerpoint and teleconference: *Botanica Erotica* (Romm)

Key Terms

Be sure to familiarize yourself with the definitions for all key terms. These can be found in the course resources or using free on-line resources.

Aphrodisiac	Dyspareunia	Orgasmic dysfunction	Stress urinary incontinence
Atrophic vaginitis	Estrogen	Pelvic floor exercises	Urodynamics
Chronic pelvic pain	Libido	Prolapse	Vaginismus
Cystocele	Lubrication	Phytoestrogen	

Key Botanicals for this Lesson

Students should be familiar with the botanical name, common name, actions, common uses, forms of use, general dosage ranges, side effects, and contraindications of the herbs in the following list. Ideally, you will also be familiar with taste. This information can generally be found in the course and accompanying required reading materials.

<i>Althea officinalis</i>	<i>Epimedium grandiflorum</i>	<i>Lepidium meyenii</i>	<i>Symphytum officinale</i>
<i>Asparagus racemosus</i>	<i>Ginkgo biloba</i>	<i>Linum usitatissimum</i>	<i>Theobroma cacao</i>
<i>Calendula officinalis</i>	<i>Glycine max</i>	<i>Medicago sativa</i>	<i>Tribulus terrestris</i>
<i>Cannabis</i> spp.	<i>Humulus lupulus</i>	<i>Panax ginseng</i>	<i>Trifolium pratense</i>
<i>Cimicifuga racemosa</i>	<i>Hypericum perforatum</i>	<i>Piper methysticum</i>	<i>Turnera diffusa</i>
<i>Dioscorea villosa</i>	<i>Lavendula officinalis</i>	<i>Ptychopetalum olacoides</i>	



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Introduction

Yoni: the sacred gate, the door of pleasure; the entrance to the universe.

Our bodies inevitably change with age. While we can be just as sexy at 45, 55, and older and we're way smarter and more sophisticated than when we were 20 and 30, for many women the actual physical matrix of the vaginal tissue is less full, plump and juicy than it was prior to menopause and this can lead to a frustrating and painful set of conditions as a result. Chalk it up to declining estrogen levels again!

This lesson is about keeping it juicy, vital, and keeping sexual energy flowing. It's also about conditions that commonly occur as estrogen declines after menopause – uterine prolapse, vaginal atrophy, sexual dysfunction, and urinary stress incontinence. As vaginal atrophy and sexual dysfunction are explained in *Botanical Medicine for Women's Health*, the explanatory text in this lesson emphasizes prolapse and incontinence. The assessment for this lesson covers all of these topics as covered in all of the required reading.

As women we are often better at taking care of everyone else – our kids, friends, partners, lovers, parents, siblings – better than ourselves. So this lesson is not only filled with ideas for helping our clients keep it juicy, but is also meant to serve as a reminder to us to take care of ourselves – either ahead of time if you are premenopausal, or starting right now if you are easing into the wisdom years. And some conditions, such as uterine prolapse and urinary incontinence don't just happen in later years; they can begin or occur even in one's 20s, for example, not uncommonly after giving birth! And loss of libido can be caused by depression, low thyroid, or other medical conditions. So this lesson applies to women of all ages.

As I write this my silver hairs are coming in, my fertile times of the month – well, they're still juicy but they're not as overflowingly fertile as they were in my 20s and 30s and even my moontimes are lighter and shorter. My creativity is more of a constant steady hum than a predictable monthly watershed of fertile, procreative energy that I could channel in any number of directions. I am past baby-making but I remind myself to nourish myself just as much as I would have nourished myself if I were growing a baby, be gentle with my body as I grow up, honor the gray and the wisdom. I also remind myself to not let the concept of age keep me from feeling young and being young, to let my sexiness show and enjoy knowing that it is now combined with elegance and self-knowledge, and to keep using it so I don't lose it!



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Key Symptoms

Women experiencing changes in the integrity, volume, or location of their pelvic organs and tissue are likely to experience any combination and number of the following symptoms:

- Vaginal dryness and thinning (atrophy)
- Vaginal itching and burning (vaginitis)
- A nagging, dragging feeling in the pelvis or the feeling that something is in the vagina (like a dry tampon in there sort of feeling), or that “Everything is just going to fall out.” Or something pink (vaginal wall; cervix/ uterus) actually protruding from the vagina!
- Urinary frequency; involuntary loss of urine (incontinence) when coughing, sneezing, or jumping
- Painful intercourse (dyspareunia)
- Slight bleeding after intercourse
- Increase in vaginal infections

The above symptoms are likely to make any woman less interested in having sex, and to complicate matters, hormonal changes around menopause decrease some women’s sexual desire. The old saying “if you don’t use it you lose it” is apropos when it comes to vaginal dryness – having a sexy sex life (even if circumstances or personal choice dictate an autoerotic life!) helps keep the vaginal tissue lubricated, helping to prevent the above symptoms. So it’s a vicious cycle.

Uterine Prolapse

Pelvic organ prolapse is the herniation (slipping down or “pooching out”) of one of the pelvic organs including the uterus, vaginal apex, bladder, rectum, and its associated vaginal segment from its normal location. Twenty-four percent of women in the US have some type of pelvic floor disorder. The Women’s Health Initiative reported 34 percent of women had anterior vaginal wall prolapse, 19 percent had posterior vaginal wall prolapse, and 14 percent had uterine prolapse on physical examination. Uterine prolapse ranges from mild to severe. Mild cases generally cause a small amount of annoyance whereas severe cases can be debilitating. They are described on a scale of 0-4, with 0 being no prolapse and 4 being a protrusion of the displaced part out of the vaginal introitus. Pelvic organ prolapse occurs as a result of ligament and muscle overstretching due to a number of possible factors from obesity to multiple pregnancies or vaginal birth of a large baby. Pelvic organ prolapse leads to over 200,000 procedures for surgical repair procedures each year with an annual cost (or profit, depending on how





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one looks at it!) of more than a billion dollars. While surgery is often beneficial in severe cases, it is done for mild and moderate cases as well. Surgery is associated with recurrence and re-operation rates are as high as 30 percent, with some surgical centers reporting re-operation in over 50 percent of cases.

Some Common Types of Pelvic Organ Prolapse

<i>Cystocele</i>	Hernia of the bladder with associated descent of the anterior vaginal segment.
<i>Uterine prolapse</i>	Descent of the uterus and cervix into the lower vagina, to the hymenal ring, or through the vaginal introitus.
<i>Vaginal vault prolapse</i>	Descent of the vaginal apex (following hysterectomy) into the lower vagina, to the hymenal ring, or through the vaginal introitus; often accompanied by enterocele.
<i>Rectocele</i>	Hernia of the rectum with associated descent of the posterior vaginal segment.

Urinary Incontinence

Urinary incontinence is the involuntary loss of urine. Using the definition of any urine leakage at least once in the past year, estimates of the rate of urinary incontinence range from 25 to 45 percent. Weekly urine leakage was reported in 10 percent of women aged 30 to 79 years, and the prevalence increases with age. In a large US survey of non-pregnant women, moderate or severe urinary incontinence (at least weekly or monthly leakage of more than just drops) was reported to affect 7 percent of women ages 20 to 39, 17 percent ages 40 to 59, 23 percent ages 60 to 79, and 32 percent age \geq 80 years. Only 45 percent of women who reported urinary incontinence occurring at least once a week sought care for their symptoms. Women with incontinence often live with unresolved physical, functional, and psychological challenges and diminished quality of life.

Types of Urinary Incontinence

<i>Stress</i>	Leakage of small amounts of urine during physical movement (coughing, sneezing, exercising).
<i>Urge</i>	Leakage of large amounts of urine at unexpected times, including during sleep.
<i>Overactive Bladder</i>	Urinary frequency and urgency, with or without urge incontinence.
<i>Functional</i>	Untimely urination because of physical disability, external obstacles, or problems in thinking or communicating that prevent a person from reaching a toilet.



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<i>Overflow</i>	Unexpected leakage of small amounts of urine because of a full bladder.
<i>Mixed</i>	Usually the occurrence of stress and urge incontinence together.
<i>Transient</i>	Leakage that occurs temporarily because of a situation that will pass (ie. infection, taking a new medication, colds with coughing).

Urinary incontinence can sometimes be an early sign of a serious underlying condition, for example, neurologic disease such as multiple sclerosis, or cancer. Therefore, the symptoms should never be dismissed simply as an age-related inconvenience.

Key Diagnostic Findings

Most of the “conditions” discussed in this lesson are diagnosed on the basis of history and clinical findings. Should menopausally-related symptoms occur in women who are not yet of expected menopausal age, then hormone testing is appropriate to assess for premature ovarian failure. Women experiencing loss of libido should be screened for hypothyroid as well as for depression. Younger women with uterine prolapse have more likelihood of reversion of the uterus to its normal position than do menopausal women as the tissue is more elastic premenopausally. On physical exam, atrophic vaginitis is recognizable by the thin and friable nature of the vaginal tissue; there may be fissure or small rent in the vaginal mucosa and digital or speculum vaginal exam may be painful or lead to a small amount of bleeding. The gloved finger or speculum should be well-lubricated and a small sized speculum may be used unless the woman is obese in which case a larger speculum may be necessary for an effective exam. Uterine prolapse is identified by digital vaginal exam by the location/distance of the cervix or uterus from the vaginal introitus.

Conventional Treatment

Conventional gynecologic treatment for atrophic vaginitis consists of hormone replacement therapy which is effective both taken orally and applied topically (usually vaginally) with the latter having fewer systemic effects and therefore slightly less cancer risk than oral HRT, and topical applications in the form of creams and lubricants. For urinary incontinence and pelvic organ prolapse women may be prescribed weighted vaginal cones which can be quite effective at helping women to isolate and exercise pelvic floor muscles, as well as surgery. Surgery can be very effective but often needs to be redone in as few as five and often ten years as the tissue, already weakened, will often re-prolapse. Further, sometimes surgery fixed the prolapse or the incontinence, but leads to chronic pelvic pain or abdominal pain, and sometimes even new problems with urinary incontinence or retention, bowel problems, nerve problems, and problems with sexual function, so the risks must be carefully weighed against the benefits on an individual basis. Women with only very mild uterine prolapse may choose to forego surgical intervention and use exercises to improve pelvic tone; simple devices such as pessaries can be used in women with moderate prolapse to provide mechanical support to the uterus. Surgery is optimally reserved for severe cases of prolapse. Care must be taken with constant use to avoid the development of rectovaginal or vesiculovaginal fistulas.



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Botanical Treatment Strategies

Botanical treatment relies on a number of strategies from the use of phytoestrogens to topical vaginal lubricants, vulneraries, adaptogens, aphrodisiacs, nervines, antidepressants, yin tonics, and antimicrobials for atrophic vaginitis, low libido, and sexual dysfunction. There are numerous factors that contribute to sexual dysfunction (See Box 1); the use of botanicals should be adjusted individually once the factors contributing to the client's underlying causes are identified, though some herbs may be included universally. While herbs may play some small role in the treatment of urinary incontinence and uterine prolapse, the role is really more supportive than directly therapeutic as these are mostly mechanical issues, however, when secondary to or accompanied by vaginal atrophy, the use of phytoestrogens may make a more important contribution. Botanical treatment strategies are presented in the accompanying and required reading and audio materials.

Perhaps one of the most important aspects of helping women with the conditions discussed in this lesson, and most significantly, sexual dysfunction, is creating a safe space for the woman to be able to openly discuss her sexual experience, fears, anxieties, embarrassment, concerns, and the impact of the problem on her life and relationships. Discussing the intimacies and intricacies of one's sexual experience is a very private affair. It can be awkward, and depending upon the age and background of the woman, quite foreign. Help the woman to find her own language, provide language if you need to help her express herself, use anatomical images to help her overcome her awkwardness, listen more than talk, and provide a



great deal of reassurance and encouragement. Assure her that the conversation is both safe and confidential. Let her know that her problems are not unique and that there are solutions. It is a great gift to teach women that they have a right to pleasure- at any age - and to safety at all ages, and that they are supported by a community of women around the world who have endured and overcome sexual and gynecologic problems. And remember, for some women, topics like masturbating are just out of the realm of their comfort zone but are still important to discuss with great sensitivity and perhaps save certain topics for subsequent visits after the initial consultation when a greater trust and ease has been established in the relationship.



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Box 1. Factors influencing Female Sexual Function

Biologic/physiologic factors

- Neurologic disease
- Cancer
- Urologic or gynecologic disorders
- Medications
- Endocrine abnormality

Psychological factors

- Depression/anxiety
- Prior sexual or physical abuse
- Substance abuse

Interpersonal factors

- Relationship quality and conflict
- Lack of privacy
- Partner performance and technique
- Lack of partner

Sociocultural factors

- Inadequate education
- Conflict with religious, personal, or family values
- Social taboos

Box 2. Risk Factors for Uterine/Pelvic Organ Prolapse

Vaginal parity

- Pregnancy
- Labor
- Vaginal birth
- Large baby
- Prolonged labor
- Forceps delivery

Race

- White women > Blacks and Asians

Age/Estrogen Levels

- Lower estrogen levels are associated with increased rates of pelvic organ prolapse

Chronic Conditions

- Constipation
- Standing for long periods of time on a regular basis
- Heavy lifting
- Chronic cough (i.e., COPD)

Connective Tissue Disorders

- Inherited conditions such as Ehlers-Danlos or Marfan syndromes
- Chronic steroid use



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Additional Treatment

- Pelvic floor exercises to improve tone, reduce prolapse and incontinence, and improve the intensity and quality of orgasms
- Essential fatty acids
- Zinc and vitamin C for tissue healing and integrity
- Weighted vaginal cones and biofeedback training for uterine prolapse
- Counseling/therapy/sex therapy for sexual dysfunction
- Masturbation to enhance or substitute for sexual activity with a partner to improve sexual function and keep the yoni lubricated and vital
- Yoga
- Tantra

Questions to Ask and Risks/Cautions

The main things to be aware of in the postmenopausal age group and with the symptoms that are likely to present – vaginal infections and bleeding – are cancer and HIV. Any postmenopausal woman with vaginal bleeding, other than the smallest amount of spotting in a woman with known atrophy which leads directly to some amount of tissue fissures that can bleed, should be evaluated for gynecologic cancer. Monogamous women over 65 are one of the fastest growing populations of HIV positive individuals in the US – exposure from partners who are clearly not monogamous or sexual relations with a partner with HIV who does not know he (or less likely she) has the virus. So don't dismiss the need for an HIV test in women with recurrent vaginitis, candida infection, or other recurrent infectious symptoms in this population and don't assume a marriage is monogamous even after 45 years of "monogamous" marriage for both partners! All women experiencing sexual dysfunction should be screened for thyroid problems, depression and anxiety, and for domestic or relationship abuse.



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Select the best answer for the following multiple choice questions.

1. The most common form of urinary incontinence is _____.
 - a. overflow incontinence
 - b. detrusor overactivity
 - c. stress incontinence

2. Pelvic floor exercises can _____.
 - a. improve pelvic tone
 - b. increase sexual sensation
 - c. improve urinary incontinence
 - d. all of the above

3. Damiana is a traditional aphrodisiac and Mexican liquor. It is also commonly used as a part of the botanical treatment of _____, especially when associated with _____.
 - a. stress incontinence; cystocele
 - b. depression; sexual dysfunction
 - c. uterine prolapse; depression

4. Which of the following nervines was specifically used by the Eclectics for low libido due to debilitated nervous energy (sexual neurasthenia)?
 - a. kava kava
 - b. passionflower
 - c. milky oats



5. A combination of *muira puama* and ginkgo may be specifically useful in the treatment of _____.

- a. vaginal dryness
- b. vaginal atrophy
- c. orgasmic dysfunction

6. Your client tells you that she has a tremendous amount of anxiety that is causing her both difficulty relaxing sexually and also causes her to experience a nervous bladder with frequent urination. She recently went to her primary doctor for an exam and was told that she does not have a urinary tract infection. Which of the following herbs is the most specific for her?

- a. ashwagandha
- b. ginkgo
- c. kava kava

7. Carla is a 54-year old postmenopausal woman who has been happily married for 27 years. She has had recurrent vaginal candidiasis for the past 6 months. She also reports more frequent cold symptoms. You emphasize the importance of her first _____.

- a. cutting down on her sugar consumption
- b. getting an HIV test
- c. taking daily echinacea and garlic to boost her immune system
- d. doing all of the above

8. Saralyn is a healthy 33-year old woman. Since the birth of her baby 4 months ago she has had a subtle nagging sense of having a tampon in her vagina, though she is not using tampons—she's not even started menstruating yet since the birth. Her midwife told her she has a stage 1 uterine prolapse and refers her to a gynecologic surgeon for a consultation. Saralyn asks you whether you consider surgery appropriate for a stage 1 uterine prolapse. You tell her that _____.

- a. surgery is not generally recommended for a stage 1 prolapse and that given time and her age and good health, pelvic exercises would be the most appropriate first line course for treatment
- b. surgery is entirely appropriate if she is chronically uncomfortable and is usually effective with long-lasting effects
- c. you cannot comment on this matter as you are not a gynecologic surgeon (unless of course, you are one!)



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9. An essential element of the definition of sexual dysfunction is _____.

- a. lack of orgasm
- b. sense of personal distress about the dysfunction
- c. lack of desire for one's partner

10. Two of the proposed mechanisms of action of ginkgo in improving sexual dysfunction include _____.

- a. improved pelvic blood flow and nerve transmission
- b. improved mood and increased estrogen
- c. improved memory and cognitive function

11. A woman tells you that she has not felt much sexual desire since her baby was born 4 months ago; she is breastfeeding full time, also has 4-year old and 2-year old children at home and has not been sleeping much. She does not mind waiting until she has more energy to resume an active sex life, but right now she's just tired at the end of the day. Do you think she has sexual dysfunction?

- a. Yes, this would be categorized as sexual dysfunction and she should receive treatment and counseling.
- b. No, this is not definitely a case of sexual dysfunction; she may simply be an exhausted mom with small young children
- c. This is not likely to be sexual dysfunction, and she may just be a tired mom of young children, but sexual dysfunction is high on your differential diagnosis.

12. Your client is a 58-year old postmenopausal woman who has been married for 30 years and is in a very loving relationship. Since menopause she has experienced persistent vaginal dryness as well as insomnia. She was recommended ERT by her gynecologist but prefers a natural approach and is concerned about the long-term risks of estrogen therapy. Which is of the following herbs is both a nervine and may have estrogenic activity, and might be included in a formula for her complaints?

- a. *Passiflora incarnata*
- b. *Scutellaria lateriflora*
- c. *Humulus lupulus*



13. In perimenopausal women, ginseng is most likely to be helpful with _____.
- a. depression, low libido, vaginal dryness
 - b. low libido, insomnia, hot flashes
 - c. insomnia, hot flashes, depression
14. Which of the following might be used topically for atrophic vaginitis and internally for depression?
- a. *Calendula officinalis*
 - b. *Hypericum perforatum*
 - c. *Humulus lupulus*
15. Comfrey is one of our most reliable vulneraries and emollients. The German Commission E warns that care must be taken with extended topical use due to risks of _____ from prolonged absorption of PAs.
- a. liver disease
 - b. heart disease
 - c. kidney disease
16. The following combination may actually increase vaginal epithelial thickness, according to one study.
- a. soy and flax
 - b. vitex and black cohosh
 - c. calendula and comfrey
17. Used topically to relieve inflammation and for pain, this herb also imparts a soothing scent to herbal products.
- a. comfrey
 - b. yarrow
 - c. lavender



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18. Gemma is a single-mother considering divorce after 18 years of marriage. She reports that she is able to achieve an orgasm, but ever since she found out that her husband had an affair last year, she just doesn't experience relaxation after it. The cause of her inability to achieve _____ is likely due to _____.

- a. arousal, psychoemotional conflict
- b. orgasm, low estrogen
- c. resolution, psychoemotional conflict

19. In TCM, the following "organ(s)" are believed to be in a deficient state when there is low sexual vitality.

- a. Liver
- b. Adrenals
- c. Kidneys

20. Your client, Michelle, is a 38-year old woman experiencing some nervous exhaustion, sexual dysfunction, and menstrual complaints. She and her husband are trying to get pregnant. Which of the following European herbs would be an aphrodisiac that they could both take, and that, based on traditional use, is a pro-fertility agent useful for fatigue and low general stamina?

- a. maca
- b. tribulus
- c. ginseng

Fill-In the Blank

21. Stress incontinence is the involuntary loss of urine due to weaknesses in urethral _____ structures.

22. Orgasm initially causes strong contractions of the _____ muscles followed by contractions of the _____ and _____.

23. Pelvic floor exercises are also called _____ after a man who popularized them. YAY for him, but let's call them pelvic floor exercises!

24. We'd prefer our kids not to smoke it, but cannabis products are a powerful _____. (I encourage you to see the Meryl Streep film "It's Complicated" for a hilarious cannabis scene!)



25. Cinnamon and ginger are examples of _____ that can be used to enhance sexual desire.
26. _____ and _____ are vulnerary, anti-inflammatory herbs that can be used to heal irritated, inflamed vaginal tissue, enhance cell regeneration, and fight infection.
27. The botanical name for flax seed is _____.
28. Vitamin _____ is commonly included in topical skin products and can be included in vaginal suppositories to help reduce _____.
29. _____ is a widely used Peruvian aphrodisiac and pro-fertility herb that can be used by men and women.
30. Stimulating LH in men increases _____ production; LH stimulating in women increases _____ production.
31. Topical _____ application can relieve vaginal dryness and atrophy, and thus may help with dyspareunia.
32. Due to its ability to promote tissue repair and prevent infection, _____ is an important mineral to consider for women with atrophic vaginitis.
33. Your client had lab work that showed elevated _____. This is suggestive of hypothyroidism.
34. A woman with fertility difficulties is using tribulus for low libido. If she were to become _____ she should _____ (stop/ continue) using tribulus.
35. _____ and _____ are the common names for two herbs commonly used in the treatment of symptoms associated with hyperthyroidism, including anxiety, agitation, and heart palpitations.
36. The chemical constituent in tribulus, believed to be the most active pharmacologic agent in the plant, and found in highest content in Bulgarian tribulus is _____.
37. Vitex may play a role in improving sleep. In one clinical trial _____ levels were found to be higher in a group taking vitex. However, one limitation of this study that may limit its value for women is that the study was conducted with healthy _____ subjects.
38. Since approaching menopause, your client has been experiencing an increase in her migraine headaches as well as worsening seasonal allergies. In addition to looking for underlying causes, you mention that she might consider feverfew for headache prevention as well as quercetin and freeze-dried stinging _____ to reduce her seasonal allergies via a reduction in histamine reaction.
39. Slight bleeding after intercourse in a woman with vaginal dryness is most likely due to vaginal _____, the shrinkage of tissue that occurs with a decline in estrogen.
40. While you are working on improving the integrity of her vaginal tissue, you mention to your client that taking capsules of _____ juice, extract, or concentrate can help to prevent her risk of recurrent UTIs.



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CASES, FORMULAS, and REFLECTIONS

Short Answer

1. List five psychosocial factors that can interfere with erotic response.
2. List five menopausal factors that can have an impact on optimal sexual functioning and pleasure.
3. List 5 medical conditions that can cause loss of libido.
4. What three classes of pharmaceutical drugs can lead to diminished libido?
5. List 5 possible causes of dyspareunia.
6. List three herbs that might be used to treat female anorgasmia.
7. Why is sexual dysfunction commonly overlooked as a diagnosis? (Briefly give 2 reasons.)
8. You suspect your client has hypothyroidism causing low libido. List 3 additional symptoms that caused you to consider low thyroid.
9. List 5 clinical applications for the use of motherwort throughout a woman's life from postpartum through menopause.
10. By what mechanism(s) do pelvic floor exercises most likely increase sexual response?

Hands-On/Clinical

Lara is a 57-year old single woman. She has 2 grown children, is a successful non-profit administrator and owns a successful small herb business providing culinary herbs to local fine restaurants. She is, by any standards, an intelligent and attractive woman who has kept herself in good shape and good health. She has a self-deprecating but good sense of humor and seems a little nervous talking about sex. She was divorced 3 years ago after several years of sexual debility in her marriage. Since menopause at age 50 she'd had a difficult time achieving orgasms with her husband and had difficulty with lubrication and her husband left her for one of his colleagues. She now has tremendous anxiety about entering into a sexual relationship with the man she's been dating for a few months. They've been friends for years and have been going slowly with transitioning into a sexual relationship so she's been able to "put things off." She experiences occasional stress headaches, mild constipation, and insomnia. Create a comprehensive herbal plan for her that will maximally address her issues and describe your rationale for all of the herbs you include in any formula(s) you recommend. Also, list some of the things you say to her to help her address her dilemma.