

Assessment and Treatment of Female Sexual Dysfunction in Primary Care

Pretest

1. Which of the following is true?
 - a) Rates of sexual dysfunction are higher among men than women.
 - b) Rates of sexual dysfunction are higher among women than men.**
 - c) Men and women have about equal rates of sexual dysfunction.
2. Which of the following is true?
 - a) Most women experiencing sexual problems will seek medical consultation for their concerns.
 - b) About half of women experiencing sexual problems will seek medical consultation for their concerns.
 - c) Most women experiencing sexual problems will not seek medical consultation for their concerns.**
3. Which of the following is the most common sexual dysfunction among women?
 - a) Dyspareunia
 - b) Hypoactive sexual desire disorder**
 - c) Orgasmic disorder
 - d) Sexual arousal disorder
 - e) Sexual aversion disorder
 - f) Vaginismus
4. Vaginismus is classified as a
 - a) sexual arousal disorder
 - b) sexual desire disorder
 - c) a sexual pain disorder**
 - d) all of the above
5. Which of the following statements best characterizes women's levels of sexual desire during pregnancy.
 - a) Typically during pregnancy sexual desires decrease progressively from the first through second and third trimesters.
 - b) Typically during pregnancy sexual desires increase in the first trimester and then decrease in the second and third trimesters.
 - c) Typically during pregnancy sexual desires decrease in the first trimester and then increase during the second trimester and then decrease in the third trimester.**
 - d) Typically, sexual desires are unaffected by pregnancy.
 - e) There are no typical patterns of sexual desire during pregnancy.
6. Which of the following plays a role in regulating female sexual function.
 - A) Testosterone
 - B) Estrogen
 - a) A
 - b) B**
 - c) A & B
 - d) None of the above

7) Which of the following antidepressants is associated with orgasmic difficulties among some women?

- a) Fluoxetine
- b) Fluoxetine & Imipramine
- c) Fluoxetine, Phenelzine, & Imipramine
- d) Clomipramine
- e) **All of the above**

8) Asking a female patient if she is able to have an orgasm through self-stimulation (masturbation) can yield useful information for which of the following reasons?

- A. A “no” response by the patient is a definitive indication of a sexual desire disorder.
- B. A “no” response by the patient is a possible indication of a generalized orgasmic disorder.
- C. A “yes” response is a definitive indication that the patient does not have an orgasmic disorder.
- D. A “yes” response is a possible indication of a situational orgasmic disorder.

- a) B
- b) C
- c) A & B
- d) **B & D**

9) Which of the following is **not** a recommended treatment for Dyspareunia?

- a) **Use of vaginal dilators.**
- b) Anxiety reduction behaviour modification.
- c) Use of lubricants
- d) Experimentation with different sexual intercourse positions.
- e) Medication to treat chronic pain.

10) Estrogen replacement therapy can be helpful for the treatment of which of the following sexual dysfunctions.

- A) Hypoactive sexual desire disorder
- B) Sexual aversion disorder
- C) Sexual arousal disorder
- D) Dyspareunia
- E) Vaginismus

- a) A
- b) A & B & C
- c) C
- d) **A & C & D**
- e) All of the above

Learning Objectives

- 1) Become aware of the importance and role of the physician in screening for and treating female sexual dysfunction.
- 2) Develop the skills to screen female patients for sexual dysfunction.
- 3) Determine the prevalence, etiology, and manifestations of common female sexual dysfunctions.
- 4) Determine appropriate treatment strategies for common female sexual dysfunctions.

Quick Reference

Prevalence, women aged 18 - 59: Lack of desire; 33%. Lack of arousal; 18%. Anorgasmia; 24%. Pain during sex, 14%, Vaginismus; 1%.

Implications: There is a strong association between sexual dysfunction and impaired quality of life including significantly reduced individual psychological health and well-being and quality of couple relationships.

Risk factors/predictors: Poor physical and/or psychological and well-being are associated with the occurrence of sexual dysfunction. A wide variety of medical conditions including breast cancer, gynecological conditions and cancer, diabetes, multiple sclerosis, and depression constitute risk factors for the development of sexual dysfunction among women.

Diagnostic criteria: Hypoactive sexual desire disorder: Persistent absence of sexual fantasies or receptivity to sexual activity causing personal distress. Sexual arousal disorder: persistent inability to attain sufficient sexual excitement causing personal distress. Orgasmic disorder: persistent absence or delay in attaining orgasm causing personal distress. Dyspareunia: Persistent genital pain associated with sexual intercourse. Vaginismus: persistent involuntary spasm of the musculature of the outer third of the vagina that interferes with vaginal penetration causing personal distress.

Screening: Brief questions to evaluate the phases of the female sexual response cycle and the experience of pain during sexual activity. Routine gynecological examination. If indicated, the Female Sexual Function Index. If indicated, laboratory tests.

Treatment: Level 1 – all patients: screening for sexual dysfunction and provision of information. Level 2 – patients with sexual dysfunction: provision of least invasive treatment and brief psychosexual counselling. Level 3 – patients with poor treatment outcomes: progression to more invasive treatment, referral to medical specialist, referral for sex therapy.

Introduction: The Physician's Role in Addressing the Sexual Function of Primary Care Patients

Primary care physicians routinely ask their patients about sexual behaviour with respect to risk behaviours for sexually transmitted infections and for issues related to conception and fertility. Some physicians, however, are less likely to ask about sexual function. If these issues are not raised by the physician, it is unlikely that these issues will be addressed at all. A survey of adults aged 25 and older found that 85% would like to discuss a sexual problem they might have with a physician but 68% were reluctant to ask a physician about sexual problems and 71% thought that their physician would dismiss sexual concerns¹. A survey of Canadian women found that although 67% reported that they would be comfortable asking their doctor about sexual issues, only 39% had done so². A study examining the prevalence of sexual dysfunction in the United States found that of women with sexual dysfunction, only 20% had sought medical consultation for their sexual problems³.

The need for direct inquiry by the physician about women's sexual concerns is clear. For example, one study of women attending an outpatient gynecological clinic found that adding two simple questions regarding sexual function to the medical history exam increased the incidence of patients reporting sexual

concerns from 3% to 19%⁴. In addition to improving the health and well-being of patients, screening for sexual dysfunction often uncovers previously undiscovered medical conditions. A study conducted at a general medicine outpatient department found that taking a sexual history uncovered new and important medical information in 26% of patients and resulted in changes to medical treatment in 16% of these patients⁵. In sum, it is not only appropriate and necessary for physician's to raise sexual health issues with their female patients, but it is also clear that women with sexual concerns will appreciate physician leadership in routinely inquiring about sexual function⁶. Patients are much more likely to discuss sexual problems when the physician inquires directly.

Primary care physicians, skilled in the treatment of medical and psychological disorders sometimes feel uncertain (often due to a lack of medical school training in the area of sexual dysfunction) about addressing patients sexuality related concerns. However, the physician's basic skills and procedures combined with supplementary information specific to sexual dysfunction can be effectively used to address patients sexuality concerns. This includes conducting a physical examination, obtaining a complete patient history, application of basic treatment strategies, providing education and reassurance, and referral to an appropriate medical specialist or sex therapist when indicated⁷.

The Impact of Female Sexual Dysfunction

Sexual dysfunction can have a major impact on a women's quality of life. Impairment of sexual function can have damaging effects on a women's self-esteem, sense of wholeness, and her interpersonal relationships. It is often emotionally distressing. A population based representative sample study conducted in the United States found significant associations between the major categories of sexual dysfunction and lower feelings of physical and emotional satisfaction as well lower feelings of general well-being among women with sexual sexual dysfunctions⁸.

Meeting Patient Concerns About Sexual Function with Information and Practical Suggestions

Many women enter the physician's office with anxiety or concern about their sexual function that is rooted in a lack of accurate information or unrealistic expectations regarding normal female sexual function. Thus, many patient sexual concerns and problems can be effectively addressed by providing basic information, correcting misconceptions and by making practical suggestions for modifying behaviour. Physicians are in a unique position to provide authoritative information on sexual function that will help to alleviate patient concerns. For example:

- 1) Many women lack basic information on female sexual response. For example, it is common for some women to assume that it is expected and normal for a women to experience orgasm during penile-vaginal intercourse (Most women require direct clitoral stimulation to have an orgasm).
- 2) Many women benefit from information on the psycho-social determinants of sexual response. For example, clarifying the interaction of general relationship functioning and sexual functioning can be helpful.
- 3) It is reasonable for middle-aged and elderly women to continue to engage in and enjoy sexual activity. Nevertheless, physicians can help patients understand how the aging process and life events (e.g., pregnancy, menopause) affect levels of sexual desire and physiological sexual response.
- 4) Many common medications, for example SSRI antidepressants, can impair sexual function. It is important for physicians and their patients to assess how medications a patient is taking may have sexual side effects and how these interactions can be managed.
- 5) Women with medical conditions (e.g., diabetes, multiple sclerosis, heart disease, breast, gynecological and other cancers, spinal cord injury, arthritis ect.) often lack information on how their conditions can affect sexual functioning and what steps can be taken to address the sexuality related issues that may result.
- 6) There are many lifestyle modifications that women can take to improve sexual function. For example, improving cardio-vascular conditioning, quitting smoking, reducing alcohol intake, and reducing stress can all have a beneficial impact on sexual function.

Table 1: Levels of Intervention in the Assessment and Management of Female Sexual Dysfunction

Level 1. All Patients

Screening for sexual dysfunction
Provision of information

Level 2. Patients with Sexual dysfunction

Provision of least invasive treatment
Brief psychosocial counselling

Level 3. Patients with Poor Treatment Outcomes

Progression to more invasive treatment
Referral to medical specialist (e.g., endocrinologist, psychiatrist)
Referral for sex therapy

Basic Classifications and Etiologies of Sexual Dysfunction

At the most basic level, sexual dysfunctions can be classified as **lifelong** or **acquired** and **generalized** or **situational**. These classifications are important factors in determining the etiology and treatment of sexual dysfunctions.

Table 2: Basic Classifications of Sexual Dysfunctions

Lifelong (also known as "primary")	Any sexual dysfunction that has always been present; e.g., a woman who has never had an orgasm.
Acquired (also known as "secondary")	Any sexual dysfunction that follows a period of adequate sexual function; e.g., a woman who develops pain during intercourse following menopause.
Generalized	A problem with sexual functioning that occurs in all sexual situations; e.g., a woman who does not experience sexual arousal in any context whether alone or with a partner.
Situational	A problem with sexual functioning that occurs only in certain situations or with certain partners; e.g., a woman who is able to experience orgasm during masturbation but not when in engaged in sexual activity with her partner.

Female Sexual Dysfunction: The Likelihood of Multiple Etiologies

It is important in the assessment and treatment of female sexual dysfunctions to recognize that there is often a considerable overlap between dysfunctions where problems in one sexual function domain (desire, arousal, orgasm, pain) affect functioning in another domain^{9 10}. For example, a woman experiencing decreased desire, perhaps due to hormonal disturbances, medication side effects, or stress, may also very likely experience difficulty becoming aroused (e.g., insufficient lubrication) which subsequently leads to pain during sexual activity. Conversely, a woman who is regularly experiences discomfort or pain during sexual activity is quite likely to experience, over time, a decrease in her desire for sex.

In most cases, a sexual dysfunction may begin with a particular biological or psychological factor, or life event. However, by the time the patient has become cognitively aware of the problem and brought it with her to the physician's office, the sexual dysfunction is likely to have multiple etiologies. For example, a sexual problem that is initiated by biological changes (e.g., onset of a medical condition, menopause ect.)

can quickly take on a psychological and/or social/relational component depending on how the biological change impacted on her sexuality. In sum, women's experiences with sexual dysfunction are often complex and this underscores the importance of a complete and thorough assessment of sexual function when a patient expresses a sexual concern during routine assessment. Table 3 presents basic contextual and biopsychosocial factors involved in female sexual dysfunction.

Table 3: Etiology of Sexual Dysfunctions: Contextual and Biopsychosocial Factors

Contextual Factors

- | | |
|-------------------------------|--|
| 1. Predisposing | Prior life experiences (e.g., Childhood sexual trauma)
Inherited characteristics (e.g., diabetes) |
| 2. Precipitating (triggering) | Life events associated with initial onset (e.g., job stress, divorce ect.) |
| 3. Maintaining | Ongoing life circumstances or physical conditions that contribute to sexual dysfunction |

Biopsychosocial Factors

- | | |
|-----------------------|--|
| 1. Biological/medical | Vascular, hormonal, neurological, pharmacological |
| 2. Psychological | Cognitive, affective |
| 3. Social/relational | Sociocultural influences (e.g., religious background, sex role)
Communication, relationship factors |

Conceptualizing and Defining Female Sexual Response and Dysfunction

Female sexual dysfunction is highly prevalent, affecting up to 40% of women in the adult general population¹¹. However, until recently, little research has focused on the study of female sexual function. As a result, medical knowledge of the anatomy, physiology, and psychology of female sexual response and of the effective treatment of female sexual dysfunction is relatively limited, at least in comparison to our understanding of male sexual function and dysfunction. Nevertheless, the study of female sexual function and dysfunction is gradually evolving and the state of the art is sufficient to provide physicians with the tools to effectively assess and assist women with sexual dysfunction¹².

A number of definitions for both sexual function and sexual dysfunction are available in the medical-sexological literature. For the purposes of screening for sexual dysfunction by the primary care physician a basic conceptualization of these terms will suffice. There is a general consensus that adequate sexual functioning consists of three basic stages: desire, arousal, and orgasm. Thus, sexual dysfunction can be defined as an impairment or disturbance in one of these stages¹³. The American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders*(DSM-IV)¹⁴, the most widely adopted diagnostic scheme for classifying sexual dysfunctions, is based on the desire, arousal, and orgasm stages of sexual response. Recently, a consensus panel of experts in female sexual dysfunction revised and expanded existing classifications, including that of the DSM, to produce a more comprehensive system for defining and classifying female sexual dysfunction¹⁵. Table 1 provides the basic classifications of female sexual dysfunction. The definition, assessment and treatment of each of these dysfunctions are discussed in more detail below.

Table 4: Classification of Female Sexual Dysfunction¹⁶

1. Sexual desire disorders:
 - A. Hypoactive sexual desire disorder
 - B. Sexual aversion disorder
2. Sexual arousal disorder
3. Orgasmic disorder
4. Sexual pain disorders:
 - A. Dyspareunia
 - B. Vaginismus
 - C. Other sexual pain disorders

Sexual Dysfunction Verses “Normal” Sexual Response: The Importance of Considering Levels of Personal Distress in the Assessment of Patient Sexual Functioning

It is important to recognize that a major criteria for the diagnosis of a sexual dysfunction is that the condition causes the patient personal distress¹⁷. For example, there are no universally definitive or objective standards for how intensely or frequently a woman should desire sex or how easily or how often she should have orgasms. Although it is very useful to use behavioural and physiological indices to assess sexual function, it is necessary to interpret the findings in terms of the woman’s subjective needs, experiences, and priorities¹⁸. The expert consensus panel on female sexual dysfunction cited above emphasizes the importance of the personal distress criterion and suggests that unless personal distress is present, a clinical diagnosis of sexual dysfunction should not be made.

Clinical assessment of personal distress involves querying the patient about the level of dissatisfaction or bother concerning the sexual difficulty. For example, a woman who seldom reaches orgasm may report that it does not bother her particularly and that she is still able to enjoy sexual relations with her partner. Similarly, some women do not view low sexual desire as a personal problem. In these instances a diagnosis of sexual dysfunction would not be given due to the absence of personal distress on the part of the patient. The reaction of the sexual partner may be a cause of concern or bother to the patient but is insufficient as a basis for diagnosis. For instance, if a woman reports that her partner is dissatisfied with her lack of orgasm but that it does not bother her personally, a specific diagnosis would not be given. Counselling may still be recommended in such cases due to conflict or incompatibility in expectations regarding adequate sexual functioning¹⁹.

Screening for Sexual Dysfunction

Screening for sexual dysfunction combines physical examination with direct inquiry about sexual function.

Physical Examination

The patient’s routine physical examination is a key aspect of the screening process to detect possible sexual dysfunction. As routine examination identifies general medical conditions (e.g, gynecologic abnormalities or disease, arthritis, diabetes, ect.), the physician can note the potential sexuality implications of these conditions as a precursor to discussion with the patient. The physical examination also provides an opportunity for the physician to educate the patient about anatomy and sexual function and to reproduce and localize pain that the patient may be experiencing during sexual activity²⁰.

Incorporating Sexual Health Questions into the General health History

Primary care physicians should have clear procedures for inquiring about sexual function as a routine part of primary health care. This includes:

- A. Developing standard questions to ask patients with respect to sexual function;
- B. Integrating sexual function questions into a general health history.

As indicated in Table 5, there are a number of steps that physicians can take to ensure that inquiry about a patient's sexual is effective and comfortable for both the physician and patient.

Table 5: Tips for Inquiring About Sexuality Issues

- Inform patient that you will ask about sexuality.
- Assure patient that the discussion is confidential.
- Inform patient that questions about sexuality are a standard part of assessment.
- Use precise, clear and easily understood terminology (not slang)
- Maintain a nonjudgemental attitude and tone.
- When asking a patient about sexuality, respond to their answers with affirmation and information.
- Start with general, less sensitive questions and proceed to more detailed, more sensitive questions.

To put patients at ease, some physicians may wish to preface questions about sexual function by noting that such questions are standard and by asking permission to inquire about sexuality. For example,

“I have been asking you questions about different aspects of your health. As part of this, I ask all my patients about their sexual health. So I am going to ask you some questions about sexuality. Is that OK with you?”

General Introductory Questions

An assessment of sexual function can begin with some general questions that will allow the patient an initial opportunity to articulate in their own terms sexual concerns that they may have. For example,

“Many of my patients have questions or concerns related to sexuality. I wonder what your concerns might be?”

or

“Many people have questions or concerns about sex. Are there any questions about sex that you would like to ask?”

Such questions can help to quickly identify patient concerns and areas that need to be focused on. Nevertheless, it is important to specifically and systematically screen the patient for possible problems in each of the four major categories of female sexual dysfunction. This can be done with a few standard questions, as illustrated in Table 6.

Table 6: Basic Screening Questions for Female Sexual Dysfunction

<u>Category</u>	<u>Questions</u>
Desire	"Are you interested in sex?" "Do you have sexual thoughts or fantasies?" "Have you become less interested in sex lately?"
Arousal	"Do you have trouble becoming sexually aroused (turned on) during sexual activity?" "Does your vagina become lubricated (wet) when you are having sex?"
Orgasm	"Do you have difficulty having an orgasm?" "Are you able to have an orgasm when you are with your partner?"
Pain	"Do you experience discomfort or pain during sexual activity?" "Do you ever have discomfort or pain after sex?"

If patient responses to one or more of these basic questions indicating a sexual problem or concern, a minimum assessment by the physician should include further discussion to precisely clarify the issue(s) of concern and the patient's beliefs about the cause(s), identification of any previous intervention for this concern and the results, and the patient's wishes and expectations for treatment²¹. If, from initial questioning, a sexual concern has been identified, the next stage in the assessment process entails more precise, focused questioning to more clearly identify the problem and its extent. In this case, the use of a standardized questionnaire can be helpful. Physicians may wish to have the patient fill-out a standardized pencil and paper questionnaire or use the questionnaire as a guide for further questioning.

The *Female Sexual Function Index* (FSFI) is a brief questionnaire designed to measure sexual functioning in women with a specific focus on sexual arousal, orgasm, satisfaction, and pain²². It has been shown to have high reliability and psychometric and clinical validity²³. Although the FSFI can be very useful in assessing key dimensions of female sexual dysfunction, it should not be used as a substitute for a complete assessment of sexual function which includes a medical examination and a dialogue between physician and patient. However, when initial assessment reveals a sexual concern, administering the FSFI (or an equivalent set of questions) can help both the physician and patient assess the nature and severity of the problem as well as identify an appropriate course of treatment. Below are the 19 questions and response categories contained in the FSFI. A complete downloadable, ready to administer FSFI questionnaire, instructions, and scoring algorithm is available at www.FSFIquestionnaire.com.

Female Sexual function Index (FSFI)²⁴

Question

1. Over the past 4 weeks, how **often** did you feel sexual desire or interest?
 - Almost always or always
 - Most times (more than half the time)
 - Sometimes (about half the time)
 - A few times (less than half the time)
 - Almost never or never

2. Over the past 4 weeks, how would you rate your **level** (degree) of sexual desire or interest?
- Very high
 - High
 - Moderate
 - Low
 - Very low or none at all
3. Over the past 4 weeks, how **often** did you feel sexually aroused (“turned on”) during sexual activity or intercourse?
- No sexual activity
 - Almost always or always
 - Most times (more than half the time)
 - Sometimes (about half the time)
 - A few times (less than half the time)
 - Almost never or never
4. Over the past 4 weeks, how would you rate your **level** of sexual arousal (“turn on”) during sexual activity or intercourse?
- No sexual activity
 - Very high
 - High
 - Moderate
 - Low
 - Very low or none at all
5. Over the past 4 weeks, how **confident** were you about becoming sexually aroused during sexual activity or intercourse?
- No sexual activity
 - Very high confidence
 - High confidence
 - Moderate confidence
 - Low confidence
 - Very low or no confidence
6. Over the past 4 weeks, how **often** have you been satisfied with your arousal (excitement) during sexual activity or intercourse?
- No sexual activity
 - Almost always or always
 - Most times (more than half the time)
 - Sometimes (about half the time)
 - A few times (less than half the time)
 - Almost never or never

7. Over the past 4 weeks, how **often** did you become lubricated (“wet”) during sexual activity or intercourse?
- No sexual activity
 - Almost always or always
 - Most times (more than half the time)
 - Sometimes (about half the time)
 - A few times (less than half the time)
 - Almost never or never
8. Over the past 4 weeks, how **difficult** was it to become lubricated (“wet”) during sexual activity or intercourse?
- No sexual activity
 - Extremely difficult or impossible
 - Very difficult
 - Difficult
 - Slightly difficult
 - Not difficult
9. Over the past 4 weeks, how often did you **maintain** your lubrication (“wetness”) until completion of sexual activity or intercourse?
- No sexual activity
 - Almost always or always
 - Most times (more than half the time)
 - Sometimes (about half the time)
 - A few times (less than half the time)
 - Almost never or never
10. Over the past 4 weeks, how **difficult** was it to maintain your lubrication (“wetness”) until completion of sexual activity or intercourse?
- No sexual activity
 - Extremely difficult or impossible
 - Very difficult
 - Difficult
 - Slightly difficult
 - Not difficult
11. Over the past 4 weeks, when you had sexual stimulation or intercourse, how **often** did you reach orgasm (climax)?
- No sexual activity
 - Almost always or always
 - Most times (more than half the time)
 - Sometimes (about half the time)
 - A few times (less than half the time)
 - Almost never or never

12. Over the past 4 weeks, when you had sexual stimulation or intercourse, how **difficult** was it for you to reach orgasm (climax)?

- No sexual activity
- Extremely difficult or impossible
- Very difficult
- Difficult
- Slightly difficult
- Not difficult

13. Over the past 4 weeks, how **satisfied** were you with your ability to reach orgasm (climax) during sexual activity or intercourse?

- No sexual activity
- Very satisfied
- Moderately satisfied
- About equally satisfied and dissatisfied
- Moderately dissatisfied
- Very dissatisfied

14. Over the past 4 weeks, how **satisfied** have you been with the amount of emotional closeness during sexual activity between you and your partner?

- No sexual activity
- Very satisfied
- Moderately satisfied
- About equally satisfied and dissatisfied
- Moderately dissatisfied
- Very dissatisfied

15. Over the past 4 weeks, how **satisfied** have you been with your sexual relationship with your partner?

- Very satisfied
- Moderately satisfied
- About equally satisfied and dissatisfied
- Moderately dissatisfied
- Very dissatisfied

16. Over the past 4 weeks, how **satisfied** have you been with your overall sexual life?

- Very satisfied
- Moderately satisfied
- About equally satisfied and dissatisfied
- Moderately dissatisfied
- Very dissatisfied

17. Over the past 4 weeks, how **often** did you experience discomfort or pain during vaginal penetration?

- Did not attempt intercourse
- Almost always or always
- Most times (more than half the time)
- Sometimes (about half the time)
- A few times (less than half the time)
- Almost never or never

18. Over the past 4 weeks, how **often** did you experience discomfort or pain following vaginal penetration?

- Did not attempt intercourse
- Almost always or always
- Most times (more than half the time)
- Sometimes (about half the time)
- A few times (less than half the time)
- Almost never or never

19. Over the past 4 weeks, how would you rate your **level** (degree) of discomfort or pain during or following vaginal penetration?

- Did not attempt intercourse
- Very high
- High
- Moderate
- Low
- Very low or none at all

Hypoactive Sexual Desire Disorder (HSDD)

Hypoactive sexual desire disorder is defined as a “persistent or recurrent deficiency (or absence) of sexual fantasies/thoughts, and/or desire for or receptivity to sexual activity, which causes personal distress”²⁵.

In most cases, HSDD results from either psychological/emotional factors or is secondary to physiological problems such as hormonal deficiencies and medical or surgical procedures²⁶. For example, a woman who is experiencing prolonged emotional distress due to conflict with her primary relationship partner may find that her overall desire for sexual activity is reduced. Prolonged stress due to work-related issues and/or the burdens of child rearing can have similar effects on levels of sexual desire. Sexual assault or sexual abuse as well as low self-esteem or poor body image can also play a role in low desire. A wide variety of psychiatric conditions including depression, anxiety disorders, post traumatic stress disorder, and eating disorders have also been found to be associated with low desire²⁷.

In addition, disruptions to the hormonal milieu resulting from natural menopause, surgically or medically induced menopause, or endocrine disorders can result in reduced sexual desire²⁸. The precise role that hormones play in influencing female sexual desire is unclear. For women with pronounced HSDD, particularly those who have passed through menopause, assessment of hormone levels can be instructive in determining etiology.

It is clear that commonly prescribed SSRI antidepressant medications can have a negative impact on levels of sexual desire among women²⁹. Tricyclic antidepressants, monoamine oxidase inhibitors, lithium, and some antipsychotics are among the medications reported to result in reduced sexual interest³⁰.

In sum, primary and generalized HSDD tend to be related to traumatic sexuality related events occurring early in life or a highly sex negative upbringing, whereas acquired and situational HSDD tends to be associated with medical or relationship factors³¹.

Studies investigating the prevalence of a lack of sexual desire among women have yielded a wide range of results depending on how the problem is defined. In general, however, it appears that a large number of women report a lack of sexual desire, suggesting that HSDD is the most common sexual dysfunction among women. In a national study of Canadian women aged 18 to 44, 39% reported that “My sexual desire is often much lower than I would like it to be”³². Married women were significantly more likely than unmarried women to report diminished desire (53% vs. 21%). A U.S. population-based study of women aged 18 to 59 found that approximately 30% reported lacking interest in sex³³. A study of postmenopausal women found that 46% had HSDD³⁴. As is the case with many other sexual dysfunctions, a relatively low level of sexual desire should only be considered a sexual dysfunction requiring treatment if it causes distress to the patient. Nevertheless, low sexual desire is the most common sexual problem presented to primary care physicians³⁵.

Sexual Aversion Disorder (SAD)

Sexual aversion disorder is defined as “the persistent or recurrent phobic aversion to and avoidance of sexual contact with a sexual partner, which causes personal distress”³⁶.

In most cases, sexual aversion disorder is rooted in psychological or emotional factors³⁷. Causes include physical or sexual abuse or childhood trauma. Growing up in a family environment that is extremely negative or punitive with respect to sexuality could contribute to sexual aversion.

Although it is considered a qualitatively distinct diagnostic entity from HSDD, SAD and HSDD can be viewed as points along a continuum of low desire. What distinguishes SAD from HSDD is that SAD is primarily characterized by a pronounced fear and determined avoidance of sexual activity whereas HSDD is more likely to be typified by patient distress about a decline in sexual desire³⁸. For example, a patient with SAD is more likely to actively avoid having sexual fantasies whereas a patient with HSDD is more likely to wish she had more of them. In general, SAD can be conceptualized as a specific form of phobic disorder³⁹.

There are no reliable estimates on the percentage of women who have SAD in part because they are often encompassed by the broader category of HSDD. Unless the physician feels comfortable and qualified to address the psychological dimensions of SAD, referral to an appropriate mental health specialist is warranted. Exposure-based intervention, effective in treating other phobias, may be helpful⁴⁰. However, it is important proceed slowly with exposure exercises in order to avoid re-traumatization. An important initial step in addressing SAD is to clearly identify if there are specific aspects of sexual activity that are perceived by the patient as threatening (e.g. certain sexual behaviours, the genitalia, particular partners, ect.) or if it is generalized to all types of sexual stimuli.

Sexual Arousal Disorder

Sexual arousal disorder is defined as “the persistent or recurrent inability to sufficient sexual excitement, causing personal distress, which may be expressed as a lack of subjective excitement, or genital (lubrication/swelling) or other somatic responses”⁴¹.

Sexual arousal disorder can manifest itself in a number of ways including lack of or reduced vaginal lubrication, decreased clitoral and labial engorgement, and lack of vaginal smooth muscle relaxation⁴². Sexual arousal disorders are associated with a wide range of psychological or social factors. These include mood states such as anxiety, depression, and anger, relationship issues such as problems with couple conflict, poor communication, or lack of attraction to one’s sexual partner, as well as personal history factors such as the occurrence of sexual victimization, or persistently negatives messages about sex from parents

and family⁴³. However, many cases of sexual arousal disorders among women are due to medical or physiological factors such as reduced blood flow to the vagina and/or clitoris, pelvic trauma, pelvic surgery, or medications (e.g., serotonin-reuptake inhibitor antidepressants)⁴⁴. Hormonal variations, particularly decreased estrogen, can lead to vaginal dryness⁴⁵. There is also some evidence that the use of oral contraceptives may adversely affect sexual arousal in some women⁴⁶.

With respect to prevalence, in a population-based study in the United States, 18% of women aged 30-39, 21% aged 40-49, and 27% aged 50-59 reported that they had difficulty with lubrication (the best available indicator of sexual arousal) in the previous 12 months⁴⁷. In a study of women attending a health centre, 14% of women reported a lack of lubrication on 50% or more of their sexual interactions and 52% of women over the age of 50% reported at least occasional problems with vaginal dryness⁴⁸.

It is often difficult for the patient and the physician and patient to differentiate between a problem related to desire and a problem related to arousal⁴⁹. Thus, it is helpful to determine which problem occurred first and which is the most troubling to the patient.

Some women experiencing difficulties becoming sexually aroused, particularly with respect to a lack of lubrication, are estrogen-deprived and therefore estrogen supplementation can be an effective treatment⁵⁰. However, it should be noted that regular, orally delivered estrogen can result in a reduction of bioavailable testosterone which may impair sexual desire further compounding the arousal problem. Over the counter lubricants can assist in problems related to vaginal dryness.

Currently, research is investigating the potential role of phosphodiesterase inhibitors in the treatment of female sexual arousal disorder. Vasoactive agents such as sildenafil citrate (ViagraTM) may increase clitoral vasocongestion and adrenoceptor agonists such as phentolamine and yohimbine may augment general vasodilation⁵¹. However, it should be noted that while these approaches may help to increase vasocongestion and lubrication, they may not have a significant impact on a woman's subjective, psychological feelings of sexual excitement.

The potential role of androgen supplementation in treating sexual arousal disorders in women is under investigation. When a deficiency of estrogen or androgen is clearly linked to a lack of genital response to physical stimulation, hormone replacement can be beneficial but physicians considering the use of pharmacological agents to treat sexual arousal problems should carefully consult the medical literature concerning their use for these purposes⁵².

In many cases, sexual arousal difficulties are psychologically based. For example, reduced sexual and/or emotional attraction to a partner or boredom with routine sexual activity with the partner can result in problems with arousal and desire. In addition, negative emotions such as guilt, shame, anxiety, anger, or resentment can interfere with sexual arousal. Preoccupation with life events or increased stress can also play a role. For example, mothers of young children often reported that they are too distracted to focus on sexuality and are thus mentally disengaged from the process of sexual arousal⁵³.

The physician can suggest a number of strategies to patients to address the psycho-sexual aspects of problems with sexual arousal. For example, many women, as they grow older, do not become aroused as spontaneously or as quickly as they did when they were younger. Encouraging the patient to communicate with her partner about sexual activities that she finds pleasurable and about the pace of sexual activities can be helpful in facilitating arousal. Activities that reduce anxiety or distraction such as taking a warm bath prior to sexual activity can also be helpful⁵⁴. The introduction of erotica and sexual aids (e.g., vibrators) can be suggested for women who comfortable with their use⁵⁵. If the physician determines that an arousal disorder is due to persistent individual inhibitions or interpersonal conflicts that are resistant to brief psychosexual counselling, a referral for couple's counselling or sex therapy is recommended.

Orgasmic Disorder

Orgasmic disorder is defined as “the persistent or recurrent difficulty, delay in or absence of attaining orgasm following sufficient sexual stimulation and arousal, which causes personal distress”⁵⁶.

Primary orgasmic disorder (i.e., the woman has never had an orgasm) can result from prior emotional trauma or sexual abuse or a medical condition⁵⁷. A number of biological factors have been implicated in difficulty achieving orgasm in women. For example, any disease, injury, or disruption that affects the sympathetic or parasympathetic nervous systems can impair the ability to have an orgasm⁵⁸. Atherosclerotic vascular disease may also be a common cause of orgasmic disorder⁵⁹. Women with diabetes, multiple sclerosis, and hypothalamo-pituitary disorders have higher than normal rates of orgasm disorder⁶⁰. Common antidepressants (e.g. Imipramine, Phenelzine, Clomipramine, Fluoxetine) are associated with orgasm difficulties in some patients⁶¹. High levels of alcohol consumption have also been found to impair female orgasmic response⁶².

In a representative sample survey of sexual behaviour, about 25% of women aged 18-59 reported that in the previous year they were unable to achieve orgasm⁶³. A study of women attending a gynecological out-patient clinic found that for post-menopausal women, 35% reported that they often had difficulty reaching orgasm⁶⁴. Unfortunately, epidemiological studies have not examined the prevalence of primary versus secondary orgasmic disorder although secondary orgasmic disorder is thought to be relatively more common.

Among the first steps in the assessment and treatment of orgasmic disorders is to ascertain the extent to which the problem is secondary to a desire or arousal disorder. Treatment of underlying medical conditions and adjustments to antidepressant medications can effectively address physiological impairments to orgasm.

Cognitive-behavioural strategies, similar to those used to address arousal disorders (see above) can help to address the psycho-sexual aspects of orgasm difficulties. Some women with orgasmic disorder lack sufficient knowledge of their own sexual response. In these cases, directed masturbation where women are provided with information related to sexual response and techniques followed by encouragement to explore their bodies and responses has been shown to be effective with some women experiencing either primary or secondary orgasmic disorder⁶⁵. Generalized versus situational.

Dyspareunia

Dyspareunia is defined as “the recurrent or persistent genital pain associated with sexual intercourse”⁶⁶.

The exact prevalence of Dyspareunia is difficult to ascertain as population based studies have yielded wide ranging estimates. Recent studies have provided estimates ranging from 3% to 18%⁶⁷. A population-based study from the United States, 21% of women aged 18-29, 15% aged 30-39, 13% aged 40-49, and 8% of those aged 50 –59 reported that they experienced pain during sex in the previous 12 months⁶⁸.

A physical examination is an important component of the assessment and treatment of Dyspareunia in order to identify anatomic sites and abnormalities that may be causing pain. Physiological factors associated with Dyspareunia that can be addressed with medical or surgical treatment include scar tissue, PID, vaginal stenosis, and endometriosis⁶⁹. Other potential physiological factors include urinary tract infections, pelvic tumours, prolapsed ovaries, vulvar vestibulitis, and vulvar or vaginal atrophy perhaps associated with decreasing estrogen levels postmenopausally⁷⁰. Dyspareunia can result from vaginal dryness and the use of lubricants may in some cases alleviate discomfort.

Psycho-sexual counselling can include suggestions for less painful intercourse positions, suggestions for noncoital sexual expression (i.e., oral sex, mutual masturbation), and in more severe or resistant cases, the use of medication to treat chronic pain, and the use of anxiety reduction-behaviour modification techniques⁷¹.

Vaginismus

Vaginismus is defined as “the recurrent or persistent involuntary spasm of the musculature of the outer third of the vagina that interferes with vaginal penetration, which causes personal distress”⁷².

Although limited population-based data suggests a prevalence rate among women of about 1%, several studies of women presenting to sex therapy clinics have found rates as high as 17%,⁷³ it has been suggested that the actual incidence of vaginismus is under-reported⁷⁴. It should be noted that vaginismus and dyspareunia often occur simultaneously resulting in a “mixed sexual pain disorder”⁷⁵.

A variety of factors can contribute to vaginismus. It is often a conditioned response to painful or traumatic sexual experiences⁷⁶. In addition, traumatic pelvic examinations and misinformation about pain and bleeding associated with the rupture of the hymen may play a role in the development of vaginismus⁷⁷. Psychologically, these factors lead to an intense fear of vaginal penetration.

Regardless of the etiology, the most common treatment for vaginismus includes the gradual insertion of objects (e.g., fingers, dilators, tampons) into the vagina. In relaxed conditions under the woman’s control, the size of the objects is gradually increased. This is generally combined with systematic desensitization exercises where the woman visualizes the insertion of objects of gradually increasing size including, eventually, a penis⁷⁸.

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