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About the Author

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Dr. Laurie Betito is a clinical psychologist with a specialty in sexual wellness and has been a practicing psychotherapist for over 35 years. For the last three decades she has been doing radio and television, dispensing sex and relationship advice. For 22 years she was the host of the nightly Canadian syndicated show *Passion*. She is a regular contributor to various magazines, newspapers and television shows. Dr. Laurie is also President of the Sexual Health Network of Quebec and Past President of the Canadian Sex Research Forum. She is the author of *The Sex Bible for People Over 50* and the Director of the Pornhub Sexual Wellness Center, an online sexual health information platform. Dr. Laurie has also done two TEDx talks on the subject of sexuality. Her weekly podcast "Passion with Dr. Laurie and Jon Pole" is available on all platforms.

Understanding Female Sexual Dysfunction

Laurie Betito, PhD

Introduction

Sexuality is an integral part of our human existence. It is more than a source of pleasure—it is a source of fulfillment, emotional connection, intimacy and empowerment. Unfortunately, for many women worldwide, a satisfying and fulfilling sex life is thwarted by sexual dysfunction. Female sexual dysfunction (FSD) is an all too common and often very distressing condition that encompasses a wide range of difficulties, and affects women of all ages and backgrounds. This condition is characterized by a persistent or recurrent inability to achieve sexual satisfaction, causing the woman distress. This is a complex issue as the causes can be quite varied and sometimes elusive. The contributing factors we evaluate include physical (hormones, chronic illnesses, medication side effects), psychological (anxiety, depression, stress, relationship issues) and social (cultural or religious beliefs). Women who experience FSD are often distressed, experiencing relationship strain as a result, and their overall quality of life is impacted. This is a topic that is still shrouded in shame and stigma, leaving many women unable to discuss or uncomfortable discussing their difficulties even with healthcare professionals. We need to empower women with knowledge, encourage them to discuss their sexuality, and provide help and support. As health professionals, we need to play our part in the destigmatization and normalization of sexual wellness.

Evaluating Female Sexual Dysfunction

Evaluating FSD involves a comprehensive assessment of the physical, emotional, relational and psychological factors that may be contributing to the dysfunction. In addition to a medical history and a physical examination, healthcare providers can use standardized questionnaires to understand and diagnose the particular area of difficulty.[1,2]

The Female Sexual Function Index (FSFI) is the most widely used tool for assessing sexual health in women, and for readers of this article in e-journal format, the FSFI can be found here. It is a self-reporting measure that asks questions about desire, arousal, lubrication, orgasm, sexual satisfaction, and pain.[2] This tool is a great beginning to initiating the conversation about sexual wellness and evaluating the specific areas of distress. If time is a constraint, focusing on the

following elements will provide an overview of the problem and will help you refer the patient to the appropriate healthcare professional:

1. **Sexual activity:** Is the patient sexually active (self or partnered)?
2. **Response:** Do they have desire? Do they experience arousal and/or orgasm? Do they experience pain?
3. **Onset:** Is it lifelong/acquired? Is it gradual or sudden?
4. **Pattern:** Is it situational or global?
5. **About the partner:** Any sexual concerns or problems in the partner?
6. **Impact of the problem** on patient's life/relationship
7. **Previous intervention:** Has the patient received treatment for the problem? If so, was it effective?
8. **Motivation for seeking help now?**

Using this index systematically during a wellness checkup is recommended and lets the patient know that the provider is open to discussing sexual issues.

Categorization

FSD can be categorized following the human sexual response cycle[3]: desire disorders, arousal disorders and orgasmic disorders. Pain disorders should also be included.

Hypoactive Sexual Desire Disorder (HSDD) is now categorized in the DSM-54 as Female Sexual Interest/Arousal Disorder. This is a common sexual dysfunction, defined by a complete lack of or significant reduction in sexual interest or/and arousal. Symptoms to investigate include the absence of interest in sex; the absence of sexual thoughts; lack of initiating partnered sex; little or no sexual excitement or pleasure during sexual activity; little to no arousal to sexual cues; and a lack of genital sensation during sexual stimulation. The symptoms must persist for a minimum of six months and result in distress for the patient. This last element of distress is a vital component in the assessment of FSD (in fact, this was only added in the DSM-IV in 1994).[5] It is also important to note that traditional models typically posit that sexual desire is spontaneous. However, this framework often fails to align with the experiences of many women regarding their sexual response. As a result, definitions of desire dysfunctions tend to presuppose a baseline of spontaneous sexual desire, which has led to many women being erroneously labeled as dysfunctional.

Sexual arousal disorder is characterized by persistent difficulty in becoming sexually aroused or maintaining arousal during sexual activity resulting in distress to the patient. It is important to assess the context by asking if this is specific to certain sexual situations (partnered sex, solo sex) or specific partners; if this is a new condition, and if so, what else is occurring in the person's life (or relationship) that may be contributing to the issue. Assessing changes in the patient's psychological state (including stress, anxiety, trauma) that may also contribute to the issue is important as is the societal/cultural context the patient is influenced by. We also want to assess if lack of arousal is due to low desire and/or sexual pain.

Orgasmic disorder, also known as anorgasmia or inhibited orgasm, is characterized by the difficulty or inability to achieve orgasm despite adequate sexual stimulation and arousal, causing the patient distress and frustration. Orgasmic disorders may be due to psychological factors such as anxiety, body image issues, stress, history of trauma, and relationship issues. It may also be a result of prescription medications.

Sexual aversion disorder is a much less common sexual dysfunction, characterized by a strong aversion to or avoidance of sexual activity altogether. The etiology may be very similar to that of the other dysfunctions discussed above.

Treatment for the above disorders depends on their etiology, which is why it is crucial to conduct a thorough evaluation of the person's medical history; trauma history; relationship dynamics; cultural context; belief system; and degree of sexual knowledge/experience. It is also important to assess if the problem is global or situational, primary or secondary. For example, if the problem only occurs in certain situations, it is most likely a psychological/relational issue rather than a medical issue. If it is secondary (developed over time), we must assess changes in the patient's life, relationship or medical situation.

Treatment often involves a combination of approaches including psychotherapy, sex therapy,

lifestyle changes, or medication in certain cases. Therapy can include "prescriptions" such as exploring sexual techniques; sensate focus exercises such as self-stimulation (often with clitoral stimulators) to get to know one's body; working on body image issues; psychotherapy with a focus on healing trauma; treating underlying anxiety or depression; couple therapy to address relationship issues; teaching mindfulness techniques to learn how to be present sexually and others. If the problem is hormonal, hormone replacement therapies should be considered (estrogen or testosterone replacement). If the problem is due to a medication side effect, we would consider changing the medication to one with less sexual side effects (for example, adding Wellbutrin to a patient on an SSRI may counter the side effect of low desire).[6]

Unfortunately, to date, there are few efficient medications for the treatment of low desire or arousal disorders. There is still quite a bit of controversy over the use of such medications considering that female sexuality is quite complex, with multiple factors at play that cannot be remedied by medication alone, especially concerning desire. Filbanserin is an oral medication that is FDA and Health Canada approved for the treatment of hypoactive sexual desire disorder (HSDD) in pre and postmenopausal women. It is thought to work by affecting neurotransmitters in the brain. However, there are many reported side effects and its efficacy is questionable.[7] At the present time, testosterone replacement therapy is sometimes used off label as a treatment for FSD. However, it is not approved by either the FDA nor Health Canada for this use due to the uncertainty around both efficacy and long-term safety. Furthermore, there does not seem to be any consensus on what constitutes androgen insufficiency in women. For these reasons, it is not further explored in this article.[8,9]

Sexual pain disorders are conditions that cause pain during sexual activity. They can involve pain during intercourse (dyspareunia), persistent genital pain (vulvodynia) and vaginismus.

Dyspareunia is a condition marked by persistent or recurring genital pain that occurs before, during or after sexual intercourse. It can originate from factors like inadequate lubrication; injury; inflammation; infection; skin conditions; structural issues or vaginismus.

Vaginismus is a syndrome characterized by involuntary spasms of the vaginal muscles that hinder penetration, or make it completely impossible for the insertion of even a tampon or finger.

Vulvodynia is a pain condition whereby women experience sensations of burning and soreness in the vulval area, especially when the area is touched, even lightly. It is considered a form of localized, provoked vulvodynia when it is specific to touch. When the pain is continuous it is considered unprovoked vulvodynia. The pain is often described as burning; irritation; stinging; rawness; soreness; or sharp, knife-like pain. It can be felt in a very specific spot (like the vestibule), the clitoris or the entire genital area.[7]

Female sexual pain disorders can greatly affect a woman's health, self-esteem, relationships, quality of life, and work productivity. It is uncertain if sexual pain should be classified as a sexual disorder, a pain disorder or both.[10] The causes of these disorders vary from straightforward anatomical issues or infection to intricate biopsychosocial factors. Identifying the exact cause of pain can be difficult as a woman may experience more than one underlying cause.

Avenues to explore in determining the etiology of genital pain include: skin conditions; sexually transmitted infections; yeast or bacterial infection; vulvar growths; and genitourinary syndrome of menopause. Unfortunately, sometimes the exact cause is difficult to determine as there may be no visible sign. One line of thinking is that there is damage or irritation to the nerves that transmit pain from the vulva. Researchers also consider an increase in nerve fibre density in the vulvar vestibule as a potential factor.[11]

Therapies for sexual pain disorders may include topical hormone therapies for GSM; pelvic floor physiotherapy which has robust, evidence-based support and is considered a first-line treatment[12]; local anesthetics for temporary relief; nerve block injections to the area; pain management therapies such as biofeedback, talk therapy and sex therapy (individual/couple); or surgery of the vestibule tissue.

Needless to say, treatment strategies should be tailored to address each patient's unique requirements and may involve a combination of approaches.

Conclusion

FSD is an often distressing condition that encompasses a wide range of difficulties. It affects women of all ages and backgrounds, with significant physical and psychological repercussions. It is incumbent on healthcare professionals to provide women with FSD information and knowledge, encourage them to discuss their sexuality, and provide them assistance and support. Healthcare professionals have an important role to play in destigmatizing and normalizing sexual wellness.

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Financial Disclosures

None declared.

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