Female sexual health complaints range from lack of desire for sexual activity to an inability to orgasm, pain during sexual intercourse, not finding sex pleasurable, and experiencing a lack of vaginal lubrication (arousal). Collectively, these complaints are known in the medical literature as female sexual dysfunction (FSD) and represent a common problem in the United States. According to two of the most widely quoted US studies—the National Health and Social Life Survey comparing 1,749 women to 1,410 men and the PRESIDE study of 31,581 women—43% of women complain of some type of sexual dysfunction. The Association of Reproductive Health Professionals (ARHP) convened a multidisciplinary panel of sexual health experts in 2009 to identify the top 10 things front line health care providers need to know about FSD to talk knowledgeably about the subject with their patients and initiate treatment.

1. Hypoactive sexual desire dysfunction (HSDD) is the most common female sexual dysfunction.

Low desire was present in 39% of women in the PRESIDE study and approximately 30% of women in the National Health and Social Life Survey. The disorder has been defined by sexual experts gathered by the American Foundation of Urologic Disease as “absent or diminished feelings of sexual interest or desire, absent sexual thoughts or fantasies, and a lack of responsive desire.” The reasons for becoming sexually aroused are few and far between or absent, and “the lack of interest is considered to be beyond a normative lessening with life cycle and relationship duration,” and causes distress to the woman. Sexual health is an important quality-of-life issue and has a profound effect on intimate relationships; an adage states that “bad sex” has a much greater impact on ruining a relationship (up to 70%) than “good sex” has on improving it (15%).

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Several therapies have been effective in treating low desire. Some women may respond to testosterone supplementation, but this treatment is presently not FDA-approved and is controversial due to unclarified risks (e.g., cardiovascular and breast cancer implications). A breakthrough non-hormonal agent is presently under investigation, with Stage 3 clinical trials showing promise for the treatment of HSDD in premenopausal women.

2. Female sexual response may be influenced by neurotransmitters and other chemicals in the brain.

Neurotransmitters in the brain such as dopamine and norepinephrine interact with sex hormones and their receptors and have been identified as playing a “prosexual” role in a woman’s sexual response. According to anthropologist Helen Fisher, PhD, elevated levels of dopamine can produce many of the sensations (e.g., intense focus, exhilaration, sleeplessness, loss of appetite) associated with sexual ardor and fueling libido. Functional magnetic resonance imaging (fMRI) scans demonstrate increased activity in the ventral tegmental area of the brain (a primary dopamine pathway) in people experiencing feelings of romantic love. Elevated levels of norepinephrine, which is derived from dopamine, and low levels of serotonin may also play roles in the female sexual response.

Orgasm leads to the release of a variety of chemicals such as oxytocin and endorphins, which foster feelings of attachment and relaxation. Sexual intercourse also can lead to elevated levels of testosterone, which in turn prompts production of more dopamine.
3. Medications and diseases can both have profound effects on sexual function.

A number of physical and medical problems can interfere with a woman’s ability to enjoy sex and feel pleasure. Chronic health conditions (e.g., diabetes, hypertension, and high cholesterol) and pelvic surgeries (e.g., hysterectomy) can damage and narrow blood vessels and prevent the flow of blood to genital tissues, thwarting arousal. An underactive thyroid gland can hinder sex drive, Genital and urinary tract infections can cause discomfort in the reproductive tract leading to painful sex. Neurologic diseases such as multiple sclerosis and spinal cord injuries can affect the nerves in the pelvis and impact arousal and orgasm. Many drugs can also interfere with sexual response. For instance, while some women may experience a sense of freedom from worrying about pregnancy when using hormonal contraception, decreased libido and changes in vaginal secretions can be a problem for some women; this may include vaginal dryness and accompanying discomfort during intercourse. Because of the many types of medications that may have sexual side effects, providers should be certain to pursue this line of inquiry when assessing problems with sexual response.

4. Depression and its treatment commonly affect sexual function.

Depression is common in women—the average lifetime prevalence of major depression in women is approximately 20%—and can dampen sex drive and affect the global sexual response cycle. Antidepressants—and particularly selective serotonin reuptake inhibitors (SSRIs)—can also lessen desire and affect the ability to orgasm, either delaying it or preventing it entirely. It is important to screen patients for the concurrent diagnosis of depression when you are considering FSD, as they often coexist.

5. Anger/resentment may be an underlying factor in sexual dissatisfaction and disorders.

When a woman is unhappy, angry, or disappointed with her partner, her sex life may suffer. Research shows that relationship issues can underlie a lack of desire: How a woman feels about her partner may have more of an impact on her sexual response than even hormones that drive libido.

6. Vulvovaginal atrophy is common and can be treated.

The loss of estrogen production associated with menopause and other conditions (e.g., postpartum) leads to atrophy of the vulva, vagina, and urinary tract over time. Decreasing estrogen levels are also associated with vaginal dryness and loss of elasticity, which can make sexual intercourse uncomfortable and result in tears in delicate, thinning vaginal tissue and increased risk of vaginal infections. The use of vaginal lubricants and moisturizers can ease vaginal dryness and make intercourse comfortable again but does not reverse atrophy. Minimally absorbed, locally applied topical estrogen therapy (creams, tablets, and rings) and systemic oral estrogens can effectively treat vaginal dryness. (Unopposed estrogen is not recommended in women with a uterus due to the risk of endometrial cancer.)

7. Most women want their health care provider to bring up the topic of sexuality during a visit.

Surveys consistently show that women want to talk about their sexual issues with health care providers—but are reluctant to bring up the topic first. For instance, one study of 3,807 healthy volunteers found that 40% of women who participated in an online survey said they did not talk to a clinician about a sexual problem, but over half of them wanted to. This and other studies indicate that women don’t seek help because they are embarrassed, worry the clinician will be embarrassed, fear the problem may be minimalized or classified as being “all in their head,” or that there are no treatments for their problem.

8. Often, one open-ended question takes the same amount of time as several closed-ended questions.

Eliciting “yes/no” answers may be unhelpful in determining the character and scope of a sexual problem and can lead to provider and patient frustration. It can be far more helpful in homing in on a diagnosis and treatment plan to use open-ended questions such as “Have you had any sexual concerns that you’d like to talk about?” “How does your sexual concern affect your life and your relationships?” or “What have you tried so far to manage your problem?” A panel convened by the American Foundation of Urologic Disease and led by Dr. Rosemary Basson suggests that if a patient indicates she has a sexual issue but is not distressed about it—which was the case for half of women with a sexual problem in the PRESIDE study—it may not be necessary to pursue the line of inquiry further.

9. Use of the PLISSIT model for history-taking and therapy can be helpful when working with women who have sexual dysfunction.

The PLISSIT Model of Intervention for Sexual Problems, developed by psychologist Jack Anon, will streamline the history-taking process.

- Give the patient permission to talk about her sexual concerns by bringing up the subject and reassuring her that her experience is normal and acceptable. You can help patients feel more at ease by creating a comfortable office environment for the medical examination, asking appropriate questions, and having a warm, welcoming office staff.
• Provide Limited Information. Address whatever topics you can in the limited time you have available and consider encouraging the patient to make a follow-up appointment to focus solely on her sexual health concerns. Correct myths and misinformation and educate her and her partner about female sexual function and disorders. (See the ARHP What You Need to Know fact sheet, Female Sexual Response [www.arhp.org/FSR].)

• Offer Specific Suggestions to treat the complaint. Complete a detailed sexual history to define the problem and determine an appropriate treatment course. (See the ARHP Sexual Health Fundamentals fact sheet, Talking With Patients About Sexuality and Sexual Health [www.arhp.org/SHFTalking] for tips on taking a sexual history.) This includes addressing comorbid conditions and medications that alter sexual function, and offering suggestions that are in line with the patient’s sexual health goals.

• For Intensive Therapy, most primary care providers will want to refer a patient to qualified specialists, such as sex therapists and sexual health care providers.11,12 (Refer to point #10 below for more information about referrals.)

10. It’s important to refer appropriately.

If you decide to refer a patient, use appropriate language such as: “Your problem is very important and deserves some specialized treatment, and I know just the person who can help us with this.” This language validates the patient’s concern and reassures her that she is not being passed off to another clinician, but will be coming back to you for follow-up.22

For more information on this topic, refer to the other Sexual Health Fundamentals fact sheets, Talking with Patients About Sexuality and Sexual Health [www.arhp.org/SHFTalking] and Sex Therapy for Non-Sex Therapists [www.arhp.org/SHFTherapy].

Sexual Health Fundamentals is a publication of the Association of Reproductive Health Professionals (ARHP) for health care professionals, educators, and researchers working in the field of reproductive health. This fact sheet is part of the Sexual Health Fundamentals for Patient Care Initiative [www.sexualhealthfundamentals.org], which was guided by principles established by a consensus committee of renowned experts in female sexuality, led by co-chairs Michael Krychman, MD, and Susan Kellogg Spadt, CRNP, PhD. The goals of this initiative are to assist “frontline” members of the reproductive health care team with expert, evidence-based guidance on sexual function, health, and wellness, and to provide freely available needs assessment tools for professional societies to customize for their specific constituencies. Sexual Health Fundamentals are available at www.arhp.org/factsheets.