# Female Sexual Dysfunction

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**KEYWORDS**

• Female sexual dysfunction • Hypoactive sexual desire disorder
• Testosterone therapy • SSRI-induced sexual dysfunction • Atrophic vaginitis

**KEY POINTS**

- Ask patients about their sexual health and explore their concerns: broad categories of female sexual dysfunction include decreased desire, difficulty with arousal, delayed or absent orgasm, and pain with intercourse.
- Evidence supports the use of topical testosterone to treat hypoactive sexual desire disorder; although the magnitude of the benefit was small, there is a lack of long-term safety data, the studied testosterone replacement preparations are not available in the United States, and it is not approved by the Food and Drug Administration.
- Selective serotonin reuptake inhibitor–induced female sexual dysfunction can be treated with addition of bupropion or use of sildenafil.
- Topical estrogen is the most effective treatment for atrophic vaginitis, which is a common cause of pain with intercourse.

## INTRODUCTION

The topic of female sexual health and dysfunction is a challenging one for health care providers. Discomfort with the topic, inadequate training, and insufficient clinical time with patients to discuss in-depth sexual histories and limited treatment options hinder providers' desire to address this issue. Academically, before the 1950s, this topic was rarely discussed. In the 1950s, Kinsey[1] introduced landmark literature addressing the sexual lives of women and their sexual practices in the United States. In the 1960s, Masters and Johnson[2] introduced a model of the female sexual response cycle, defined as the linear progression of 4 distinct physiologic phases, including excitement, plateau, orgasm, and resolution (**Fig. 1**). In the late 1970s, Kaplan[3] modified

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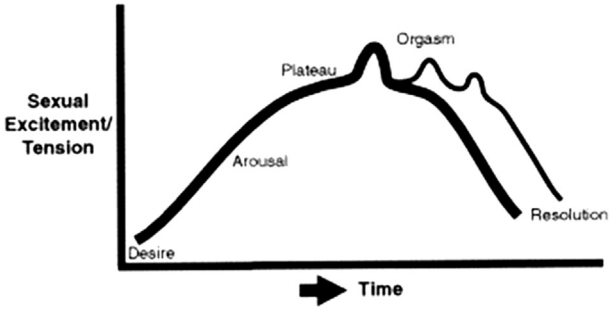


**Fig. 1.** Traditional sexual response cycle. (*From* Basson R. Female sexual response: the role of drugs in the management of sexual dysfunction. Obstet Gynecol 2001;98(2):351; with permission.)

this to a 3-phase model, including desire, arousal, and orgasm. In both of these genitally focused models, orgasm was considered essential for sexual fulfillment and the importance of intimacy and the emotional aspects of sexuality were not addressed. Basson[4] significantly modified this linear model of female sexual response. She proposed a cyclical model incorporating intimacy, relationship satisfaction, and sexual stimuli. In Basson's model,[4] the stages of female sexual functioning occur in a nonlinear fashion and orgasm is not essential for sexual fulfillment (**Fig. 2**).

It is important to realize that the Diagnostic and Statistical Manual of Mental Disorders-IV-text revision (DSM-IV-TR) criteria for female sexual dysfunction is based on the traditional linear model, which we have learned may not represent the most accurate pattern of sexual functioning for most women.[5] However, many women still believe normal sexual functioning to be the traditional desire-arousal-orgasm process. As a provider, some brief education about alternative theories and the importance of intimacy and emotionality and not just orgasm can go far in decreasing women's distress about their sexual health.

Not surprisingly, numerous biopsychosocial factors impact sexual function. Multiple medical and mental health conditions and medications can impact sexual health.

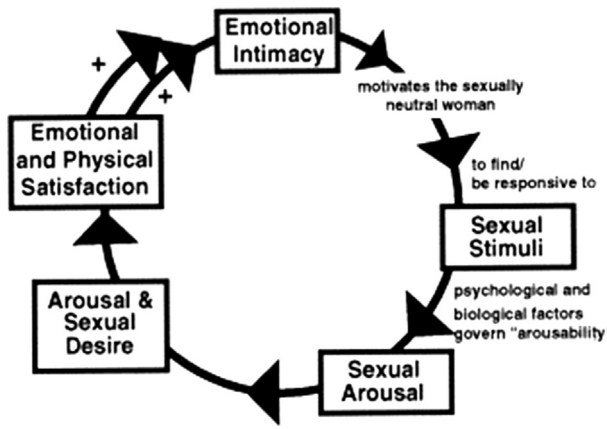


**Fig. 2.** Cyclical sexual response cycle. (*From* Basson R. Female sexual response: the role of drugs in the management of sexual dysfunction. Obstet Gynecol 2001;98(2):351; with permission.)