Women's Sexual Desire and Arousal Disorders

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ABSTRACT

Introduction. A committee of five was convened to update the chapter on women's sexual dysfunctions from the perspective of diagnostic issues, pathophysiology, assessment, and treatment.
Aim. To review the literature since 2003 and provide recommendations based on evidence.
Methods. Research databases, conference proceedings, and articles in press were read for relevant new data on these topics for hypoactive sexual desire disorder (HSDD), female sexual arousal disorder (FSAD), female orgasmic disorder (FOD), and persistent genital arousal disorder (PGAD).
Main Outcome Measures. Recommendations by five experts from five countries were formulated with associated grades.
Results. The definitions of HSDD, FSAD, and FOD in the Diagnostic and Statistical Manual of Mental Disorders, 4th Edition, Text-Revised are imperfect and have been criticized over the last decade. Proposed new criteria that take into account empirical findings and the diversity across women are recommended. There has been a flurry of new epidemiological studies on women's sexual dysfunction; studies also assessing distress consistenly find a much lower prevalence of dysfunction if distress is considered. Assessment of sexual difficulties is best achieved through a biopsychosocial clinical interview of the woman and her partner (if possible); though laboratory investigations, a physical examination, psychophysiological measurement, and self-report questionnaires can often supplement the interview information. There are currently no approved pharmacological treatments for women's sexual dysfunction in North America, though a number of promising agents have been studied. Evidence for the efficacy of psychological treatments is based on limited studies. There is an urgent need for more data on the assessment, etiology, and treatment of PGAD.
Conclusions. Specific recommendations for the assessment and treatment of women's desire, arousal, and orgasm disorders are forwarded; however, more research into these domains is needed. **Brotto LA, Bitzer J, Laan E, Leiblum S, and Luria M. Women's sexual desire and arousal disorders. J Sex Med 2010;7:586–614.**

Key Words. Female Sexual Dysfunction; Hypoactive Sexual Desire Disorder; Female Sexual Arousal Disorder; Female Orgasmic Disorder; Persistent Genital Arousal Disorder; Assessment; Pathophysiology; Treatment; Diagnosis

Part I: Diagnostic Issues

Women's sexual desire, arousal, and orgasm disorders have traditionally been conceptualized, studied, assessed, and often treated from a perspective which compartmentalizes them. However, despite the common finding in recent population-based epidemiological studies in which low sexual desire is the most prevalent of concerns relating to women's sexual functioning, women's sexual complaints are rarely experienced as discreet entities. The four Diagnostic and Statistical Manual of Mental Disorders, 4th Edition (DSM-IV) categories pertaining to lack of desire, arousal, orgasm problems or to sexual pain, are not independent, and in clinical practice, classification is

Table 1 Diagnostic criteria for women's sexual dysfunctions according to the Diagnostic and Statistical Manual of Mental Disorders, 4th Edition, Text-Revised (DSM-IV-TR) [10] and American Urological Association Foundation (AUAF) [11]

	DSM-IV-TR	AUAF
Desire	Hypoactive sexual desire disorder: Persistently or recurrently deficient (or absent) sexual fantasies and desire for sexual activity. The disturbance causes marked distress or interpersonal difficulty	Sexual interest/desire disorder: Absent or diminished feelings of sexual interest or desire, absent sexual thoughts or fantasies, and a lack of responsive desire. Motivations (here defined as reasons/incentives) for attempting to become sexually aroused are scarce or absent. The lack of interest is considered to be beyond a normative lessening with life cycle and relationship duration.
Arousal	Female sexual arousal disorder: Persistent or recurrent inability to attain, or maintain until completion of the sexual activity, an adequate lubrication-swelling response of sexual excitement. The disturbance causes marked distress or interpersonal difficulty. The sexual dysfunction in not better accounted for by another Axis I disorder (except another sexual dysfunction) and is not due exclusively to the direct physiological effects of a substance (e.g., a drug of abuse, a medication) or a general medical condition.	Subjective sexual arousal disorder: Absent or markedly diminished feelings of sexual arousal (sexual excitement or sexual pleasure) from any type of sexual stimulation. Vaginal lubrication or other signs of physical response still occur. Genital sexual arousal disorder: Absent or impaired genital sexual arousal. Self-report may include minimal vulval swelling or vaginal lubrication from any type of sexual stimulation and reduced sexual sensations from caressing genitalia. Subjective sexual excitement still occurs from nongenital sexual stimuli. Combined genital and subjective arousal disorder: Absent or markedly diminished feelings of sexual arousal (sexual excitement or sexual pleasure) from any type of sexual stimulation as well as complaints of absent or impaired genital sexual arousal (vulval swelling, lubrication).
Orgasm	Female orgasmic disorder: Persistent or recurrent delay in, or absence of, orgasm following a normal sexual excitement phase. Women exhibit wide variability in the type or intensity of stimulation that triggers orgasm. The diagnosis of female orgasmic disorder should be based on the clinician's judgment that the woman's orgasmic capacity is less than would be reasonable for her age, sexual experience, and the adequacy of sexual stimulation she receives. The disturbance causes marked distress or interpersonal difficulty. The orgasmic dysfunction is not better accounted for by another Axis I disorder (except another sexual dysfunction) and is not due exclusively to the direct physiological effects of a substance (e.g., a drug of abuse, a medication) or a general medical condition.	Women's orgasmic disorder: Despite the self-report of high sexual arousal/excitement, there is either a lack of orgasm, markedly diminished intensity of orgasmic sensations, or marked delay of orgasm from any kind of stimulation.

often based on the way in which complaints are presented [1]. Studies find comorbidity between desire and arousal [2–5]. In part, this may be because women express difficulties differentiating desire from subjective arousal [5–7]. Also, some women report their experience of desire to precede arousal whereas for other women, desire appears to follow arousal [6], as women do not seem to follow one universal sexual response cycle [8]. As such, there has been notable criticism of the DSM-IV-Text-Revised (TR) classification of sexual dysfunctions in women [7–9].

Definition of Hypoactive Sexual Desire Disorder (HSDD)

A critical look at existing definitions of the female sexual dysfunctions is warranted given that they have a direct and profound impact on instrument development, epidemiological studies, treatment protocols, etc. The DSM-IV-TR [10] diagnosis of HSDD focuses on "persistently or recurrently deficient (or absent) sexual fantasies and desire for sexual activity" which causes marked distress or interpersonal difficulty (Table 1). This definition has been criticized as overpathologizing women on the basis that women themselves may not necessarily consider sexual fantasies and desire for sexual *activity* to be an index of their sexual desire [5] and that some women may deliberately evoke fantasy as a way of boosting their sexual arousal. Moreover, in two large recent prevalence studies of older women, 70% reported desiring sex less than once a week but the majority (86–89%) were at least moderately to extremely emotionally sexually satisfied [12]; and in the second study, the majority (71.2%) of women with low desire were happy with the relationship [13]. There is also desyn-