Female Sexual Dysfunction

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KEYWORDS

• Female sexual dysfunction • Hypoactive sexual desire disorder
• Sexual arousal disorder • Female sexual pain disorder

KEY POINTS

- Diagnostic categories for female sexual disorders are discussed as well as a review of the clinical utility and current categories, including the *International Classification of Diseases, Eleventh Revision*; the *Diagnostic and Statistical Manual of Mental Disorders* (Fifth Edition); the International Consultation on Sexual Medicine; and other nomenclature systems.
- Definitions of sexual dysfunctions in women and epidemiologic data of female sexual dysfunctions currently available are discussed.
- Evidence-based diagnosis and treatment supported by the literature, other clinical guidelines and principles and experts' consensus recommendations are reviewed.

The aim of this article is to discuss the different types, classifications, causes, and treatment modalities of female sexual dysfunction (FSD). The topics of discussion include

- Nosology of FSD
- Classification systems and nomenclature in the field, including the International Consultation in Sexual Medicine (ICSM), International Society for the Study of Vulvovaginal Disease (ISSVD), *Diagnostic and Statistical Manual of Mental Disorders* (Fourth Edition) (*DSM-IV*) and *Diagnostic and Statistical Manual of Mental Disorders* (Fifth Edition) (*DSM-5*), and *International Classification of Diseases, Tenth Revision* (*ICD-10*) and the proposed *International Classification of Diseases and Related Health Problems* (*ICD-11*)
- Overview of FSD, differential diagnosis, and management

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CHANGES IN DIAGNOSTIC CATEGORIES

In 2013, changes to diagnostic categories were proposed for FSDs in the new version of the *DSM-5*. The changes include

- The previous categories of female hypoactive sexual desire disorder (HSDD) and female sexual arousal disorder (FSAD) were combined into a new category called female sexual interest/arousal disorder (FSIAD).
- The separate diagnoses of dyspareunia and vaginismus were merged into a single diagnosis of genito-pelvic pain/penetration disorder (GPPD).
- Sexual aversion disorder, a diagnosis thought by the *DSM-5* committee to have limited empirical support and with more similarities to anxiety disorders and phobias, was eliminated.[1]
- Frequency and severity criteria were included in diagnostic criteria with potential to enhance clinical research.[2]
- Diagnoses are sex specific.

Overall the changes in *DSM-5* represent a departure from nosology based on presumed cause to a condensation of diagnoses based on groups of conditions with common symptoms or syndromes. Unfortunately, comorbidity of diagnoses does not mean the diagnoses are the same (eg, major depressive disorder and anxiety disorders have 50% comorbidity but are not merged in *DSM-5*).

All of these new classifications have duration and severity criteria with the exception of substance/medication-induced sexual dysfunction. The subtypes of lifelong versus acquired, generalized versus situational, and due to psychological factors versus combined factors have also been changed. Sexual dysfunction due to a general medical condition and the subtype due to psychological versus combined factors were eliminated.

It is unclear whether these changes represent a simplification from the previous *DSM-IV-TR* (Text Revision) version or if they accurately represent a common etiologic root for these disorders. Proponents of the new criteria have pointed out that *DSM-IV-TR* was based on a linear model of the human sexual response cycle based on the work of Masters and Johnson[3] dating from 1966 and that the human sexual response is not always linear (~5%–25% of men and women report a nonlinear model of sexual function as representative of their sexual response).[4–6] The phases of the sexual response cycle previously used may, therefore, be artificial for some individuals (eg, desire vs arousal).

Both *DSM-IV-TR* and *DSM-5* classification systems have limitations. There is a high level of false negatives. Both systems fail to identify most individuals who report sexual difficulties.[7] Use of a check-box template and lumping of diagnoses as in *DSM-V* reduces diagnostic specificity/precision.[8] Additionally, there are no data to support physiologic differences in sexual function between the sexes (except for physical/genital manifestations of arousal). Because of these limitations, experts in sexual medicine have proposed a revision of the current criteria, arguing that improved definitions and criteria encompassing all models of sexual response and across both sexes would better address issues related to accurate identification of individuals with sexual dysfunction and be useful to investigators for research purposes.

Challenges in identification and treatment of FSD include women's discomfort with the topic, reproductive-focused cultures, inadequate clinician training, and limited available time to elicit an in-depth sexual history. Clinicians must be able to differentiate between sexual disorders and transient states secondary to situational factors,