Female Sexual Dysfunction
Frequently Asked Questions

- **I see much higher rates of FSD in my office. Your numbers seem low. Do you know why?**

  The PRESIDE study surveyed over 31,500 women over the age of 18 years. Rates for individual practices will vary based on the patient demographics. For example, according to the PRESIDE data, FSD rates are greater among women aged 45-64 years.[1] Several studies indicate that FSD is more prevalent among older women. [1,2] The BACH study found that sexual problems tended to be greater among White patients compared to Black and Hispanic women; however, FSD can affect all women, regardless of race or age.[2]

- **Are there specific signs/symptoms that would indicate I should explore a diagnosis of FSD further?**

  There are many factors that may affect sexual function. These factors can overlap and sometimes are interrelated, so there is no one factor a provider can look to in order to determine the causes of FSD. Women who have FSD distress frequently have distress in other domains, such as bodily pain, mental health, vitality, and social functioning. Sometimes patients' lifestyle can change and there will be changes in a patient's mood or disposition. It is important to ask about what is going on in the patient's life to see if there are any life events that may cause a change in mood and affect sexual response. Dramatic weight changes or changes in waist circumference may indicate changes in a patient's psychosocial disposition.

  Other factors that may affect sexual function include including mood disorders[3], anxiety disorders[4,5], and psychotic illness[6]. General health factors may also negatively impact sexual function, such as hypertension[7], neurological disorders[8], diabetes[9], rheumatoid arthritis[10], psoriasis[11], and breast cancer[12]. Urological problems[13], sexual transmitted diseases[14], or post-partum[15] may also be of concern. These issues may cause loss of libido or distress. Of note, numerous medications, including antipsychotics[16], SSRIs[17], tricyclic antidepressants[18], chemotherapeutic agents[19], and other agents[20-29] are also associated with sexual side effects.

- **What is the best way to differentially diagnose HSDD and FSAD?**

  The DSM-IV-TR defines hypoactive sexual desire disorder (HSDD) as the deficiency or absence of sexual fantasies and desire for sexual activity. HSDD is categorized as sexual desire disorder.[30] Female sexual arousal disorder (FSAD) is categorized as a sexual arousal disorder and is defined as persistent or recurrent inability to attain, to maintain until completion of the sexual activity, an adequate lubrication-swelling response of sexual excitement.[30] HSDD is related to desire, while FSAD is related to arousal. There are several tools that have been developed to quantitatively measure sexual related distress in women. The Female Sexual Distress Scale-Revised (FSDS—

R)[31,32], the Decreased Sexual Desire Screener (DSDS)[33] and the Female Sexual Function Index (FSFI)[34,35] are validated to assess sexual function. The DSDS is specifically designed for HSDD.[36] The DSDS has 5 questions and takes on average 15 minutes.[37]

- **How can I explain the mechanisms involved in FSD to my patients?**

There are multiple theoretical models of sexual response. Sexual response can be understood through the concepts of desire, arousal, orgasm, and resolution.[38] However, there are an infinite variety of responses within this model and there is no "normal" response. These stages of sexual response may be experienced in a linear fashion, but arousal may precede desire for some women.[39] The response may be analogous to going to the gym: you may not have any desire to go to the gym, but once you are there and have begun working out, the desire to be there emerges. It is alright not to have the initial interest. If the desire never emerges, then there can be a problem.

There are also other factors that contribute to the female sexual response. These include biology or basic physical health, neurobiology/psychology, sociocultural factors, and interpersonal factors.[40,41] These are influenced by the balance between excitatory and inhibitory factors, which are regulated by hormones, sex steroids, and neurotransmitters.[42-59] These factors will vary between woman to woman and even within the same woman at different times.

- **What types of educational resources can I share with my patients?**

Providers can refer patients to the International Society for the Study of Womens' Sexual Health (www.isswsh.org) and the Association for Reproductive Health Professionals (www.arhp.org). Patients may also want to check bookstores and libraries, which may contain good resources for patients with different backgrounds or religious denominations.

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