Female sexual dysfunction: reality or disease-mongering?

Sexual medicine physicians with an interest in female sexual dysfunction are once again bracing themselves for a wave of attacks implying that their chosen specialty is built on sand. As the 'Myth or Malady' headline in a *Time* magazine article on the subject suggests (Elton, 2009), doubts are again being cast over whether women's sexual problems should be 'medicalized' or even treated at all.

The reason for this latest surge in interest is that the next edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM) is expected to change the definitions and criteria under which female sexual dysfunction is diagnosed.

Writing in the *Archives of Sexual Behavior*, members of a working party for the American Psychiatric Association, which produces the DSM, recommended merging the current diagnoses of hypoactive sexual desire disorder and female sexual arousal disorder into a single diagnosis of sexual interest/arousal disorder in women (Brotto, 2010). According to Dr Brotto, this new diagnosis will give greater recognition to the relationship context of women's sexual difficulties and avoid a 'normal reaction to a problematic context' being 'pathologised'.

Of course, we have been here before.

Disease-mongering

Seven years ago the *British Medical Journal* published an article in which medical journalist Ray Moynihan (2003) questioned the commonly cited prevalence figure of 43% (Laumann et al, 1999) for female sexual dysfunction and effectively accused the pharmaceutical industry of inventing the condition as a way of selling more drugs. Similar accusations of 'disease mongering' have been made elsewhere (Tiefer, 2006).

These claims are easy to make and difficult to refute. If female sexuality is a complicated subject then its dysfunction is more complicated still. It does not fit neatly into the medical model, nor is it always amenable to medical intervention. But pathologized or not, there is no doubt that the significant distress caused by female sexual dysfunction can often be alleviated by properly trained and well-equipped sexual health professionals. The patients helped in this way are poorly served by arguments over whether their distress is caused by myth or malady.

Complex aetiology

No-one would deny that the aetiology of female sexual dysfunction is difficult to deduce. It may have its origins in co-morbidities such as depression, diabetes mellitus, neurological damage, or endocrinological disease such as disorders of the sex steroids, prolactin and thyroid disease (Laurent and Simons, 2009). Sometimes the condition is related to the psychological and physical effects of childbirth, which can have a lasting impact on a woman's sexual function (Botros et al, 2006). Other psychological causes include exposure to violence or previous trauma and abuse. Sexual dysfunction may be related to alcohol abuse or drug use, either prescription (particularly antidepressants) or recreational.

There are also a number of undeniably 'non-medical' causes of female sexual dysfunction such as work stresses, environmental factors, insufficient sexual satisfaction and communication problems within interpersonal relationships. One of the most common 'causes' of female sexual dysfunction cited by women themselves is the poor technique and performance of their partner (Safarinejad, 2006).

It is also true that sexual dysfunction is not always perceived as a problem by the woman affected by it (Bachmann, 2006). Clearly, if the dysfunction is causing no distress and does not signal a more serious problem, then there is little reason to treat it. Nevertheless, a significant number of women are distressed by female sexual dysfunction and seek help actively from a number of sources, including physicians.

Sexual distress

In the PRESIDE study, which received over 31 000 responses from 50 000 women, 8.9% of those aged 18–44 years reported that lack of sexual desire caused them distress. In women aged 45–64 years, this figure rose to 12.3% (Shifren et al, 2008). In another study of over 10 000 women with low sexual desire, 27.5% reported they were suffering sexual distress (Rosen et al, 2009).

It is unlikely that many of these women are particularly worried about the exact wording of the DSM diagnostic criteria or whether or not their condition is pathologized. They are distressed by their condition and are looking for relief.

Fortunately, most sexual health professionals are well aware of the complexities surrounding female sexual dysfunction and will explore both the medical and non-medical components in seeking to alleviate it. Both diagnosis and management of the condition will incorporate a full examination of the woman's physical, endocrinological, psychosexual and relationship status.

Hypoactive sexual desire disorder is the most common presenting female sexual dysfunction, affecting around 1 in 10 women (Clayton et al, 2009). It is defined as the chronic or recurring deficiency (or absence) of any sexual thoughts upon sexual activity, causing distress. The current diagnostic criteria for hypoactive sexual desire disorder demand that the biological, motivational (emotional and affective matters and the need for intimacy) as well as the cognitive components (wishes and fears about sexual behaviour) of the condition are determined before it is diagnosed. Thus sexual health questionnaires such as the Female Sexual Function Index, the Sexual Satisfaction Scale for Women and the Decreased Sexual Desire Screener are commonly used to assess the severity of the condition and the level of distress it is causing.

Multidisciplinary management

The treatment and further management of female sexual dysfunction also takes a multidisciplinary approach, with non-drug techniques to the fore.

The use of sexual and couples psychotherapy as well as devices and aids may all offer direct or adjunct value to any pharmacological agents. The evidence for the use of these methods is mainly observational (Wylie, 2007). Psychotherapy can be used both on an individual basis and with couples. Information and advice on sexual arousal and function is used to help couples achieve a more rewarding sex life and sex therapy, including sensate focus, can be beneficial. Mindfulness may offer opportunities for change in some women.

In arousal disorder, patients are offered advice on pelvic floor exercises and the use of aids and vibrators. Lubricants and vaginal moisturizers are recommended if vaginal dryness is causing pain.

Cognitive behavioural therapy is particularly useful in orgasmic disorder in promoting changes in attitudes to sexual thoughts. Advice is also given on self-exploration with desensitization and guided sexual self-stimulation. Vaginismus is usually treated using sexual therapy and vaginal trainers and dilators.

There is also a place for drug therapy in the treatment of female sexual dysfunction (Wylie and Malik, 2009). The treatment options available depend on the type of sexual dysfunction identified. Although hormonal therapy is the mainstay of treatment, other pharmacological agents have been recognized as potential treatment options, including phosphodiesterase-5 inhibitors, dopaminergic agonists, prostaglandins and melanocortin agonists (Brown et al, 2007). Oestrogen therapy is commonly used as a treatment of sexual dysfunction that arises as a result of declining levels of the hormone that occur during the menopause (Wylie and Malik, 2009).

Testosterone has an important role in female sexual arousal, genital sensation, orgasm and libido. Davis et al (2008) demonstrated that testosterone therapy has some beneficial effect for the treatment of hypoactive sexual desire disorder in postmenopausal women, even though they are not on additional oestrogen therapy but the use of androgen therapy may result in masculinizing side effects so further studies are needed to evaluate the long-term effects. The transdermal testosterone patch is a potentially viable and safe treatment option for surgically menopausal women already on oestrogen replacement suffering from hypoactive sexual desire disorder (Wylie and Malik, 2009).

The phosphodiesterase-5 inhibitor sildenafil has been investigated as a potential agent for female sexual dysfunction as phosphodiesterase-5 is present in clitoral tissue. Berman (2005) showed that more women with symptoms of arousal disorder experienced improvement of their sexual function with sildenafil than did women in the placebo group, although to a lesser extent. Women with hypoactive sexual desire disorder in the study did not report any improvement. Results from studies to date suggest that further investigation, in larger groups of women, needs to be done to ascertain the efficacy of sildenafil as a viable treatment option for female sexual dysfunction. There are limited data on the use of prostaglandins to treat female sexual dysfunction but the success of their use to treat male sexual dysfunction suggests a basis for further investigation. Studies of the use of dopamine agonists have produced inconsistent results in terms of improvement of sexual desire and frequency of sexual activity in women. A number of other molecules are under investigation as treatments for female sexual dysfunction including flibanserin, a $5HT_{1A}$ agonist and $5HT_{2A}$ antagonist with weak partial agonist activity at dopamine D4 receptors.

Conclusions

Female sexual dysfunction is a common problem that requires integrative therapy both medically and psychologically. To suggest that female sexual dysfunction is a myth is to deny thousands of women access to interventions that can improve the quality of their lives and their relationships. Many women suffer these distressing conditions and sexual health professionals can provide a valuable service in helping these women find solutions for their problems. BJHM

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KEY POINTS

- Female sexual dysfunction is a poorly understood collection of clinical diagnoses.
- A new diagnosis of female sexual dysfunction should give greater recognition to the relationship context.
- Female sexual dysfunction is complex and can cause significant personal and inter-relational distress.
- Hypoactive sexual disorder is the most common presenting condition within the female sexual dysfunction spectrum.
- Female sexual dysfunction can benefit from both a medical and psychological approach to treatment.