Female Sexual Dysfunction: Barriers to Treatment

Melissa Feldhaus-Dahir

Sexuality is a fundamental and important part of the human life cycle. When the sexual cycle is interrupted, the development of personal identity, health, and well being is hindered, causing a sexual dysfunction. Contrary to beliefs, female sexual dysfunction is a highly prevalent condition that affects nearly 50 million American women (Laumann, Paik, & Rosen, 1999).

Female sexual dysfunction is defined as disorders of sexual desire, arousal and orgasm, and pain, which lead to personal distress (Aslan & Fynes, 2008). According to The Women’s Sexual Health Foundation (n.d.), there are seven classifications of female sexual dysfunction. These classifications include hypoactive sexual desire disorder, sexual aversion disorder, sexual arousal disorder, orgasmic disorder, dyspareunia, vaginismus, and noncoital sexual pain disorder. It is important to know that each of these conditions must be persistent or recurrent, and cause a woman personal distress in order to be classified as a female sexual dysfunction disorder (see Table 1).

The World Health Organization (1992) describes sexual dysfunction as the multiple ways in which a person is unable to participate in a sexual relationship as he or she wishes. Defining sexual problems in women can be difficult because it is subjective and depends on the values, religious beliefs, and sexual knowledge of the woman and her part-

Table 1. Types of Female Sexual Dysfunction

<table>
<thead>
<tr>
<th>Condition</th>
<th>Description</th>
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<tr>
<td>Dyspareunia</td>
<td>Genital pain associated with sexual intercourse.</td>
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<tr>
<td>Hypoactive Sexual Desire Disorder</td>
<td>Absence of sexual fantasies and/or desire or receptivity to sexual activity.</td>
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<tr>
<td>Non-Coital Sexual Pain Disorder</td>
<td>Genital pain that is induced by non-coital sexual stimulation.</td>
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<tr>
<td>Orgasmic Disorder</td>
<td>Delay or absence of achieving orgasm despite sufficient sexual stimulation and arousal.</td>
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<tr>
<td>Sexual Arousal Disorder</td>
<td>Inability to attain or maintain sexual excitement.</td>
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<tr>
<td>Sexual Aversion Disorder</td>
<td>Phobic aversion and avoidance of sexual contact with a partner.</td>
</tr>
<tr>
<td>Vaginismus</td>
<td>Recurrent involuntary spasm of the outer third vaginal musculature which interferes with vaginal penetration.</td>
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Urologic Nursing, pp. 81-86.

Key Words: Sexuality, female sexual dysfunction, sildenafil (Viagra®), sexuality curriculum, urologists, primary health care providers, patient perceptions, ageism, societal stereotypes.

Objectives
1. Define female sexual dysfunction.
2. List and discuss barriers to the treatment of female sexual dysfunction.
3. Identify treatment options for female sexual dysfunction.

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Note: Objectives and CNE Evaluation Form appear on page 86.

Note: The author disclosed that she is on the Consultant Presenter Bureau for Medtronic, Inc.

Editor’s Note: A new column on female sexual dysfunction will be published in Urologic Nursing later this year.
ner (Burr & Nicolson, 2003). Female sexual dysfunction is a multicausal and multidimensional condition that combines biological, psychological, interpersonal, and sociocultural factors (Basson et al., 2000). For this reason, women are more complex than men and often experience overlapping conditions related to their sexual functioning.

There are many factors that can contribute to female sexual dysfunction, which may be due to psychogenic, physical, mixed, or unknown causes (The Women’s Sexual Health Foundation, n.d.). Psychogenic factors include a lack of knowledge regarding one’s body and the sexual response cycle, religious beliefs, social pressures, sexual abuse, negative sexual experiences, unrealistic expectations, relationship conflict, or resentment toward a partner. Physical factors include medications (including birth control pills and antidepressants) and chronic health conditions (such as diabetes mellitus, atherosclerosis, cancer, hypothyroidism, and depression). Other physical factors associated with female sexual dysfunction are spinal cord injuries, hysterectomy, childbirth, and hormonal imbalances. These psychogenic and physical factors are frequently associated with sexual dysfunction, which is often under-reported and under-diagnosed (Alder, Bitzer, Platano, & Tschudin, 2007).

It is evident that a strong need for the treatment of female sexual dysfunction exists. Female patients usually want to hear that other women have similar issues to validate their concerns and be reassured that they are not alone. Researchers have found that the number of women who seek medical treatment for sexual dysfunction is lower than those who actually have a sexual dysfunction. In fact, women are more likely than men to seek professional help. A study by Laumann et al. (1999) found that 5 out of 10 women seek medical attention for sexual problems compared to only 1 out of 10 men. How can health care professionals treat such a prevalent medical disorder despite the existence of many barriers? These barriers include lack of research, treatments, knowledge, and education. Failure of the provider to address or assess sexual issues in patients and stereotypes, such as ageism, are also existing barriers for many women.

**Barriers to Treatment**

**Lack of Compelling Research And Treatments for Women**

Pfizer launched sildenafil (Viagra®) in 1998 as the first oral medication to treat men with erectile dysfunction (ED). Television ads featured commercials of former Senator Bob Dole encouraging men with health conditions, such as prostate cancer, to talk to their physician about treatment options for ED. Suddenly, primary care physicians and urologists were bombarded with men inquiring about Viagra – the magical little “blue pill.” This was a huge step toward breaking the barrier for middle-aged men with chronic diseases, such as diabetes mellitus, who had suffered from ED for years. The blockbuster success of Viagra for men propelled a strong medical interest in female sexual dysfunction to find the magical “pink pill” for women. Viagra was trialed for women, but internal studies were discontinued due to inconclusive results and a lack of statistical significance. To date, very few studies have addressed the psychological and physiological underpinnings of female sexual dysfunction since there are not as many treatments available for women as there are for men (Basson et al., 2000).

**Lack of Knowledge**

The National Institute of Health’s (NIH) Consensus Statement on Impotence reported that most health care professionals are either uninformed or misinformed about sexual problems, and therefore, fail to deal with them candidly. In order to improve knowledge, NIH recommended human sexuality courses for all health care professionals in graduate school, which would emphasize a detailed sexual history as part of the medical history. Other recommendations included offering continuing education courses that focused on the diagnosis and treatment of sexual dysfunction and an interdisciplinary approach utilizing resources, such as physical therapy and sex therapy when treating patients (National Institute of Health Consensus Conference, 1993). Although the consensus statement was focused on ED, it is now known that sexual dysfunction is more prevalent in women than men. Data from the National Health and Social Life Survey suggest 43% of women suffer from some type of sexual dysfunction compared to only 31% of men (Laumann et al., 1999).

**Lack of Education**

Inadequate clinical habits may develop when a student’s education and experience does not teach sexual health as an important part of medical history and examination. These habits will often carry over into how they practice for the remainder of their career. This often contributes to a cycle of misunderstanding and poor patient/health care provider communication patterns (McCarthy, Peterson, Pinkerton, Keller, & Clayton, 2003). A Cumulative Index to Nursing and Allied Health Literature (CINAHL) and MEDLINE search was performed to review the curriculum of nursing and medical students to see how they were prepared to care for female patients with sexual dysfunction. Unfortunately, there were no studies available regarding the importance or teaching of
female sexual dysfunction during nursing school, suggesting a greater need for education and curriculum development. The following studies obtained from the search focused on medical school preparation.

In 1999, a survey of North American medical schools was conducted to assess how well physicians were prepared to treat sexual problems. Less than half of the schools surveyed offered clinical programs focused on treating patients with sexual dysfunction. A majority of the medical schools (54.1%) offered 3 to 10 hours of education related to human sexuality, psychiatry being the most involved discipline in teaching those courses. Not only was that a small part of the curriculum, but it is quite possible that those hours were embedded in other courses related to infertility, reproduction, contraception, and sexually transmitted diseases (Ernst et al., 2003).

The American Board of Obstetrics and Gynecology required sexual functioning as a topic for those with specialized training in pelvic medicine and reconstructive surgery. To further evaluate how physicians address female sexual dysfunction, Goldenhar et al. (2005) conducted a study to evaluate the practice patterns of members of the American Urogynecologic Society. They discovered that the majority of respondents (69%) had under-estimated the prevalence of female sexual dysfunction. In this same study, 59% of respondents had received post-residency training in urogynecology. Of this group, an astounding 50% reported that their training in female sexual dysfunction was unsatisfactory, while only 8% were very satisfied. In addition, the screening practices of the urogynecologists were evaluated. They qualified as “screening” patients for female sexual dysfunction if they asked at least one question about sexual activity during the history intake. Even with this minimal requirement, only 22% of urogynecologists reported screening all the time (Goldenhar et al., 2005). The author surmised that this may have been due to a lack of time, which is a legitimate concern, but could have been addressed in a follow-up appointment.

Failure to Address Sexual Issues With Women Patients

When a woman experiences sexual distress and decides to seek help, she will most likely discuss it with a health care provider she trusts. Berman and colleagues (2003) surveyed a group of women regarding their experiences of seeking help for sexual dysfunction. In this study, the largest group (42%) sought help from their gynecologist. Other specialties approached for help included general practice (24%), psychiatry (12%), urology (3%), endocrinology (8%), and other (8%). Forty percent of women did not seek help; reasons included that they were too embarrassed (22%), thought their physician could not help (17%), or had never thought of seeking medical help for sexual dysfunction (12%). Of these women who did not seek help, 54% said they would have liked to do so (Berman et al., 2003).

Unfortunately, most health care providers are not comfortable or competent to appropriately manage these women patients. Some providers choose to not identify sexual concerns among their patients, which contributes to the perception of sexual health as being unimportant. As a result, many patients generally have low expectations regarding their providers’ capability to treat sexual dysfunction (McGarvey et al., 2003). A study by Marwick (1999) reported that 75% of patients believe their doctor would dismiss their sexual complaints, and 68% of patients were worried that they would embarrass their doctor. Rosenqvist and Sarkadi (2001) confirmed research by Marwick (1999) and found that primary health care providers did not initiate discussions of sexual health with their patients due to a lack of time, limited ability to refer for secondary care, patient embarrassment, lack of knowledge, and inadequate training and skills due to lack of education.

Berman et al. (2003) investigated women’s satisfaction with their physician’s evaluation and treatment of their sexual complaint. Less than half of the women felt that they were thoroughly examined by their physician. It is even more disconcerting that less than a quarter of these women felt their physician performed appropriate medical tests, made a diagnosis, developed a treatment plan, and actually followed up with the patient.

Ageism

There is little known about older adults who experience sexual dysfunction in the United States despite the aging population (Laumann et al., 2007). Historically, research in sexual medicine has been focused on younger populations. Some health professionals view ageing and sexual problems as normal and irreversible. Others believe sexual problems are not a severe health problem, but rather, a “life pleasure” that is not serious nor damaging to your health. A study by Goldenhar et al. (2005) found that 20% of urogynecologists did not screen for female sexual dysfunction because most of their patients were elderly, and therefore, did not warrant screening. It is important to understand that sexual health is important throughout the lifespan, not just during the reproductive years. Older adults are often stereotyped as “asexual,” and those societal beliefs cause feelings of shame, embarrassment, and fear that hinder them from seeking treatment for sexual disorders (Berman et al., 2003).

Laumann et al. (2007) reported the prevalence of sexual activity, behaviors, and problems of
men and women aged 57 to 85 years of age. Of the women surveyed, 43% experienced low sexual desire, 39% had difficulty with vaginal lubrication, and 34% were unable to achieve orgasm. In the oldest group, ages 75 to 85 (including men and women), 54% of sexually active individuals reported having sex at least two to three times per month, and 23% reported having sex once a week or more. Overall, 22% of women reported that they had discussed sex with a physician since the age of 50. The study concluded that although many older adults are sexually active, many experience sexual problems that are infrequently discussed with their health care providers.

Gott and Hinchliff (2003) interviewed 22 women and 23 men regarding barriers to seeking treatment for sexual problems in primary care. They found that adults aged 50 to 92 felt most comfortable seeking treatment for sexual health disorders from their general practitioner because most participants were not aware of other resources for help. Subjects also preferred to consult a general practitioner of a similar age and gender to reduce embarrassment since they may have had similar experiences. Seven of the 22 women interviewed experienced problems with vaginal lubrication. The women reported decreased lubrication as a “symptom” of menopause that made intercourse difficult or impossible (Gott & Hinchliff, 2003). This study indicated that older adults are not receiving information about sexual issues from their general practitioner. Although patients wished to discuss sexual concerns during consultations, they generally felt uncomfortable initiating the conversation. Results also indicated that the general practitioner did not discuss risks or side effects when a patient was diagnosed with a medical condition and given a medication that was known to directly impact sexual function.

In addition, general practitioners often saw this generation as viewing sex as a private subject and did not want to cause offense.

### Conclusion

Numerous therapies for male sexual dysfunction have resulted in an increased number of women seeking treatment for sexual dysfunction. However, for many women, sexuality remains to be a taboo subject that further creates physical and emotional disruption. Female sexual dysfunction can also cause a societal burden, which has been reflected in divorce, domestic violence, single parent families, quality of life, and problems with future relationships (Aslan & Fynes, 2008). Therefore, it is important for clinicians to be aware of the barriers women encounter when seeking treatment for female sexual dysfunction.

Health care professionals, regardless of specialty, must proactively screen and inquire about each patient’s sexual functioning. It is not professional or compassionate to wait for patients to ask questions about sexual functioning, which can leave them feeling uncomfortable or anxious, and they may even resist treatment. A gynecologic examination is a common intervention in women’s health care and would be a great opportunity to start a dialogue regarding their sexual health. The open dialogue can allow the patient to ask questions about her sexuality, letting her know that sexual health concerns can be discussed in the future (Hellstrom, 1998).

Health care providers are usually able to recognize sexual issues, but they may fail to recognize their own cultural biases. Most clinicians have no problem talking to patients about bowel movements, but they often avoid discussing topics of a sexual nature, which may prohibit total disease management (Shell, 2007). To become more comfortable initiating a dialogue regarding sexuality, clinicians can practice by role playing with a colleague, partner, or an existing patient. Health care providers can help screen patients for sexual dysfunction by becoming more knowledgeable about sexual functioning and resources that are available for patients and clinicians (see Table 2). Becoming a certified sexuality educator through the American Association of Sexuality Educators Counselors and Therapists (AASECT) is another option to increase competence in sexual dysfunction (www.aasect.org). AASECT certification would offer the opportunity for patient education and informal counseling. In addition, psychotherapists can become AASECT certified as sexuality therapists, and nurse practitioners, physician assistants, or physicians can become AASECT certified as sexuality counselors.

Health care providers must also work toward the international standardization and training of all health care professionals to competently treat patients who present with sexual disorders (Aslan & Fynes, 2008). More

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**Table 2. Female Sexual Dysfunction Resources**

<table>
<thead>
<tr>
<th>Organization</th>
<th>Website</th>
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<tbody>
<tr>
<td>American Association of Sex Educators, Counselors, and Therapists</td>
<td>(<a href="http://www.aasect.org">www.aasect.org</a>)</td>
</tr>
<tr>
<td>International Society for the Study of Women’s Sexual Health</td>
<td>(<a href="http://www.isswsh.org">www.isswsh.org</a>)</td>
</tr>
<tr>
<td>National Vulvodynia Association</td>
<td>(<a href="http://www.nva.org">www.nva.org</a>)</td>
</tr>
<tr>
<td>Nurse Practitioners in Women’s Health</td>
<td>(<a href="http://www.npwh.org">www.npwh.org</a>)</td>
</tr>
<tr>
<td>Sexual Medicine and Wellness Center</td>
<td>(<a href="http://www.methodistsexualwellness.com">www.methodistsexualwellness.com</a>)</td>
</tr>
<tr>
<td>The International Pelvic Pain Society</td>
<td>(<a href="http://www.pelvicpain.org">www.pelvicpain.org</a>)</td>
</tr>
<tr>
<td>The Sexual Health Network</td>
<td>(<a href="http://www.sxualhealth.com">www.sxualhealth.com</a>)</td>
</tr>
<tr>
<td>The Women’s Sexual Health Foundation</td>
<td>(<a href="http://www.twehf.org">www.twehf.org</a>)</td>
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research is needed to optimize care for women using evidence-based treatments. To date, there are no medications approved by the Food and Drug Administration (FDA) to treat female sexual dysfunction. In April 2000, the FDA approved the Clitoral Therapy Device for the treatment of sexual arousal and orgasm disorders. The NuGyn™ Eros-CTD is a handheld, battery-operated device that improves blood flow to the clitoris and genitalia, and may enhance the ability to achieve orgasm. It is only available by prescription. One potential obstacle of the Eros-CTD is the cost. It retails for $395, and insurance companies are reluctant to reimburse for the device unless it is considered a medical necessity (Eros Therapy, 2009).

A foundation for understanding female sexuality among health care professionals can be achieved by reading textbooks and journals that focus on sexual anatomy and physiology, psychosexual development, the sexual response cycle, aging, and sexual functioning, as well as cultural, religious, and ethical implications (Byers, DeLamater, & Hyde, 2001). In addition, nurses and other health care providers can increase their knowledge by attending conferences and joining organizations specifically devoted to women’s sexual health (see Table 2). It is important to remember that the causes of female sexual dysfunction are multifactorial and require a multidisciplinary team composed of a physician, nurse practitioner or physician assistant, nurse, psychotherapist, and physical therapist, and which should be tailored according to the patient’s needs (Aslan & Fynes, 2008). An educated, competent, and compassionate health care team is crucial in the effort to break down barriers for women patients seeking information and treatment for sexual dysfunction.

**References**


