The Silent Epidemic:

Female Sexual Dysfunction

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Introduction

Sexual intercourse is the human's innate ability to reproduce. It is responsible for extraordinary things in the human race. Sex strengthens intimacy amongst couples; relieves a number of human ailments ranging from burning calories to alleviating mental stress; satisfies religious enlightenment; provides pleasurable for most; and the most important, produces offspring. Sex is one of the most primal instincts that has not evolved much since the evolution of human beings. It does not discriminate amongst gender, race, age, origin, and sexual preference. However, issues can arise for men and women in this aspect of their lives. Sexual dysfunction is an epidemic that plagues 52% of men and 43% of women. Current society has become very knowledgeable and vocal regarding male sexual dysfunction, however progress for female sexual dysfunction has been slower moving. Female sexual dysfunction plagues more women than is reported to and by the medical community. Women have had ongoing issues openly discussing and/or identifying issues existing in their intimate lives. Inadequate public awareness for female sexual dysfunction is a problem that needs to be addressed to offer women a better quality of life for themselves and their families.

Sexual Intercourse

The differences between how males and females experience sex is a topic that has intrigued the minds of all. Majority of the male species have penises and females have vaginas. AskMen.com has noted the chemicals present during male sexual arousal that can also be found in female, but ones that are not found during female arousal. The hormone prolactin is responsible for relieving men from sexual arousal after orgasm and it disengages men from sex. This hormone is not present in female arousal. Oxytocin stimulates the prostate, causes muscle contractions and sensitizes nerves, also known as 'cuddle hormone'. This hormone is shared by both sexes. These chemicals and many more makeup the biological foundation of what men feel when they experience sex. It also explains how they behave and respond to act of sex.
Females share many chemicals associated with male sexual arousal. According to Firstresponse.com and Harvard Health, the hormones are listed as follows, 1. Gonadotropin-releasing hormone (GnRH)- significant influence in the neurons that affect emotions and sexual activity 2. Luteinizing hormone (LH)- released in conjunction with FSH to create and controls sex steroid production. 3. Androgens- catalyst for puberty, growth of pubic and underarm hair in women, and converting female hormones to estrogen, however produced in small amounts in women 4. Estrogen (pertaining to intercourse)- moisture in the vagina, boosts sexual libido. Unfortunately, there is not a large variety of research that specifically discusses unique hormones present in females during female sexual arousal and/or activity. This listing does not begin to encompass the complexity of what is involved in the physiological aspect of sexual intercourse. Although women may share in some of the biological chemical makeup with men, the dosage that is experienced by women differs. The general understanding of female behavior before and after sex differs entirely from how men behave. The physical and emotional differences in chemical makeup signifies a daunting task the medical community faces in understanding how women's bodies operate, especially when it comes to sex.

The physical and emotional aspects of sex play a significant role in the everyday operations of humans. The main role of sexual intercourse is the production of offspring. As humans have evolved, they have developed an insatiable urge that links the need to satisfy their own and their partners’ sexual needs, often lending itself to the fulfillment of the emotional requirements of the relationship. This sexual urge has led to major discussions in specific roles of sexual intercourse in the everyday lives of people. Sex is arguably one of the most important and complex topics in human existence.

**Facts and Risk Factors Female Sexual Dysfunction**

Female Sexual Dysfunction (also known as FSD) is an epidemic that plagues a reported 43% of the female population. This percentage is not accurate due to the sensitivity women face discussing this topic. This sensitivity is often caused by societal, religious, or personal reasons. In the last two decades,
FSD is categorized in its own disease category. The research about FSD is still in its infancy stage. All women, regardless of age, nationality, sexual orientation and/or lifestyle choice, can be afflicted by FSD. According to the Mayo Clinic, the definition of FSD is, “Persistent, recurrent problems with sexual response or desire — that distress you or strain your relationship with your partner — are known medically as female sexual dysfunction.”(1). Although this definition is quite vague, there are other guidelines that can assist in the diagnoses of FSD.

Symptoms associated with FSD are, but not limited to: lack of sexual desire, sexual arousal disorder, inability to achieve orgasm, low estrogen levels, pain experienced during intercourse, sexual disorders, lack of sexual fantasy, inability to have any emotions, and/or negative emotions towards sex. These key symptoms aid specialists to diagnose and treat FSD. Currently, there has been a consensus reached among researchers that women, who are: single, divorced, widowed, separated, never received a high school diploma, has emotional or stress related issues, stress financially, low self esteem, or have been a victim of sexual violence, are at higher risk than the average woman of being diagnosed or developing FSD. This consensus encompasses every woman that has faced some type of tribulation in her life at one point or another.

FSD can have a determinant effect on the everyday existence of a woman. Her relationship with her partner becomes stressed. It depresses her self esteem, leading to personal difficulties in everyday relationships. The physical pain experienced from FSD during sex hinders the physical aspect of sex responsible for the onset of orgasmic activity. The internal chemical balance, not at equilibrium, also causes the rise of other physiological and psychological issues for her. Research is still being conducted to gain a better understanding of these risk factors and the effects it has on women affected by FSD.

**Understanding the Female Orgasm**

The female body is a very complex entity. The early understanding of a female orgasm was characterized as a form of female sexual dysfunction. In the 19th century, the medical community
defined the onset of female sexual desire as hysteria. Doctors told their patients they would have 100% cure rate for hysteria. Today, the female orgasm has been come an elusive icon in society. Each female experiences her own unique orgasm. No female orgasm can be experienced in the same way as another woman's. It can be stimulated manually, orally, or with sex toy devices. In order for a woman to experience an orgasm, her brain has to be in a specific mental condition that will allow her body to warrant the orgasm. The amygdala and hippocampus decreases in activity as a woman prepares to experience an orgasm. The amygdala is responsible for emotions in the brain associated with depression and anxiety. The hippocampus is responsible for the stress components in the brain. The decrease activity in these regions symbolize a relaxation state reached by the female. She has to be in a relaxed state of mind to have an orgasm. There cannot be distractions for the achievement of orgasm. Once there, women can experience many different types of orgasms: Nipple Orgasm, Deep Spot Orgasm, G-Spot Orgasm, Clitoral Orgasm, Vaginal Orgasm, Blended Orgasm, Anal Orgasm, Continuous Orgasm, Multiple Orgasms and the Squirting Orgasm. The attempt to experience any one of these orgasms, as often as men experiencing orgasm, could be compared to trying to find the fountain of youth or the chalice of Jesus Christ, for most women. According to Kinsey Institute, “75% of men and 29% of women always have orgasms with their partner”(7). When women are able to experience orgasms, they experience a number of health benefits from having them. Orgasms can relieve pain by releasing oxytocin into the system. Orgasms get better with age and experience. There is not a specific evidence proving why this is the case. However, many researchers suggest it is because of the relationships formed by these women. These relationships have evolved to include a sense of security and trust that allows these women to enjoy orgasms in their relationships. A woman's self-esteem will also determine her experience of orgasms. Being adventurous and confident in bed will increase the opportunity of experiencing orgasms. Lastly, for some and most women, it just takes a long time to reach orgasmic levels. Women require longer stimulation.
Religion and Sex

Religion supplies so much of its communal understanding about sex to its followers. The behaviors expected by religion dictates the social constraints that bound its followers by. This influence shapes people's understandings or misunderstandings about sex. The unfortunate outcome, of these religious expectations, is the hindering for female sexual expression. Most religions dictate to women that any pleasure or pain associated with sex, is a topic that is not to be discussed. To reiterate, the main role of a wife is to supply her husband sexually, rear her children, and take care of the household. Her role affects her sexual identity, her sexual desires, and her sexual responsibility. Women find themselves overwhelmed in the matters of the home and their relationships, they do not understand they too should enjoy and embrace their sexuality. When they have to fulfill their sexual obligations, they find themselves not enjoying sex or finding it a painful experience. They lack the education of how sex works for them. This leads to them experiencing hypoactive sexual disorders, sexual arousal disorder, sexual aversion disorder, and many more.

Religious beliefs have an immense effect on individuals, couples, and their intimate lives. Their religions dictate the behaviors that should be exemplified by a man and a woman. Religions vary on the expectations of couples in regards to sex. Most religions are androcentric. Fundamentalist Islam believe male martyrs will receive 72 virgins when they enter heaven and their virgins will revert back to their virgin states again after sex. These men will also experience never ending erections. As noted by author Ibn Warraq, “Koranic commentator Al-Suyuti, wrote, 'Each time we sleep with a houri we find her virgin. Besides, the penis of the Elected never softens. The erection is eternal; the sensation that you feel each time you make love is utterly delicious and out of this world and were you to experience it in this world you would faint. Each chosen one [ie Muslim] will marry seventy [sic] houris, besides the women he married on earth, and all will have appetising vaginas.'“(1). Married female martyrs will receive eternal beauty beyond what they experienced on Earth, and they will be reunited with their husband and children. These married women, whom may have had multiple husbands in their pass
lives, may choose the earthly husband of their choice to be with in heaven. Nothing is mentioned about sexual promises for the female population. Fundamentalist Islamic women, whom have lead virtuous lives, will unfortunately not receive 72 male virgins upon entering heaven. On the opposing side Islam, Sigeh's is a permit that allows sex outside of marriage and premarital sex for both partners. Couples are allowed to have temporary marriages to engage in coitus, while still being committed to their significant other. This is a significant contrast to the Fundamentalist Islamic belief.

In Judaism, couples are not allowed to have sex while a woman is on her period, because it is seen as her monthly phase of purity. According to author Tracey Rich, “women who have sexual intercourse during their menstrual period are more vulnerable to a variety of vaginal infections, as well as increased risk of cervical cancer.” (4). There are many stigmas associated with sex, especially amongst women. Most religions require women to be virgins until they enter marriage. Religious beliefs have a strong influence on how people approach sex in their daily lives. Many male centric religions dictate to women that their roles in marriage is to sexually satisfy their husbands, take care of the family, and bear children.

In 1848 America, there was a society aimed to reach utopia called the Oneida community. They were also very well known for their silverware produced in this society. They believed in the belief of communal marriage, children, property, equality in gender roles, clothing, and child rearing. They believe it was the responsible of the community as an entirety to take care of the well-being of the society. This was a very neoteric ideology. They did not focus on one sex holding more importance than the other.

**Female Sex Taboos**

In modern society, there are a number of taboos that define how women should act and behave in sexual relationships. Women are expected to not have more than 3 sexual partners in their lifetime. If they do, they are called sluts, whores, or are viewed and stereotyped as promiscuous. The way a
woman dresses imposes she is actively searching for attention that leads to sex. She is assumed to be a prostitute or thought to be easy to get into bed. Women are not expected to enjoy sex. In a medical study conducted by Prof. Elisabeth Lloyd, professor of history, philosophical science and biology at Indiana University and Kim Wallen, a professor of behavioral neuroendocrinology at Emory University, 11 percent of women ranging from ages 18 to 60 never experienced an orgasm during intercourse. Modern day society does not allow women to participate in casual sex. Women who participate in casual sex are stereotyped as loose and wanting to have sex with anyone. They are assumed to not value sex. Women are told to keep their sexual lives private. Sex is not a proper topic that women should be talk about in public. It is viewed as disgusting, improper, and scandalous. Most of society believes that women do not want or enjoy sex. Popular belief is women believe sex is a chore and are too tired to participate in coitus. All forms of media poke fun at a heterosexual relationship when the wife is not in the mood. Women take a passive role in their sex lives. They feel there is no authority in their relationship to request or demand sex when they want it. There are many preconceived notions that dictate a woman's sexual behavior in society. The belief systems in the lives of women lends itself to these preconceived notions, silencing women from taking that active role they deserve. Many of these notions suppress the voice of women to determine how, when, and what they want from their sex lives.

*Causes for and Types of Female Sexual Dysfunction*

The causes for FSD vary for each individual female. Researchers have been able to come up with causes for FSD. According to Harvard Health Publications conditions of FSD can include but are not limited to [Estrogen insufficiency- reduced vaginal lubrication; testosterone insufficiency- reduced libido; diabetes- reduced vaginal lubrication, vaginal infections; thyroid, adrenal, pituitary disorders-reduced vaginal lubrication; sickle cell anemia- decreased arousal and orgasm; spinal cord damage, stroke, Parkinson's disease, multiple sclerosis- decreased vaginal lubrication, arousal, orgasm; vaginitis,
pelvic inflammatory disease, endometriosis- vaginismus, dyspareunia; prolapsed uterus or uterine fibroids- decreased arousal; arthritis- chronic pain that limits motion). Psychological causes are associated to stress, emotional and/or sexual abuse, depression, relationship issues, self-esteem issues, societal taboos, and any psychological condition that can affect women. All medical conditions that affect women end up causing hypoactive sexual disorders in women and are categorized as causes for FSD. The current causes for FSD are so broad that the medical community has determined to include everything as a trigger for FSD.

FSD can be categorized under four different categories. According to the Mayo Clinic, you may experience more than one type of female sexual dysfunction. Types include: Low Sexual Desire- diminished libido, or lack of sex drive; Sexual arousal disorder- desire for sex is there, but difficulty or unable to become arousal or maintain arousal during sexual activity; Orgasmic disorder- persistent or recurrent difficulty in achieving orgasm after sufficient sexual; Sexual pain disorder- pain associated with sexual stimulation or vaginal contact. The onset of FSD can occur at any time, at any situation, and at any age.

**How to Diagnose and Test for Female Sexual Dysfunction**

Diagnosing FSD can be a very challenging ordeal. The woman must identify that there is a problem. She needs to determine her symptoms, how long she has been experiencing them, what her sex life is like past and present. She needs to keep a record of what medications she has taken or is taking. She will need to review her own personal medical history, so she will be prepared for questions when she visits her doctor. This is also a time that she can prepare questions she may have for the doctor. This alone is a monumental and daunting step. The next step for the woman is to see her ob-gyn. The conversation between patient and doctor will become very intimate. The physician will perform an analysis of medical history and symptoms. According to the Mayo Clinic questions will range from, “When did you become sexually active?; How much are these problems bothering you?;
How satisfied are you with your current relationship?; Do you become aroused by your partner?; If you've had orgasms in the past, what were the circumstances; Do you experience orgasms?; Have you ever been a victim of sexual violence?” (4). Many individuals have find a lot of discomfort discussing such confidential topics with a complete stranger. After the conversation, the physician have will run tests such as a pap smears, pelvic exams, order more tests to rule out other medical problems, determine if the patient has hormonal or psychological issues, and determine if the patient can utilize the assistance of specialists that specialize in sex therapy.

Cures and Treatment Options for Female Sexual Dysfunction

All women diagnosed with FSD wonder if FSD is a curable disease. The answer is, it depends. According to WebMD, “The outlook is good for dysfunction that is related to a treatable or reversible physical condition.”(3). If the medical specialists determine that the FSD is not curable, there are other options available to aid in relieving their symptoms. Females affected by hormonal issues can be treated with estrogen and androgen therapy. There is only one specific occasion when specialists make a strong determination to implement estrogen therapy. It is to treat women who are peri and post-menopausal. For other patients not experiencing peri and post-menopause, doctors decide to implement estrogen therapy to see if those may work for them or not, due to underlying psychological issues the patients may have. Androgen or testosterone therapy is used because of the natural fact that testosterone fuels sex drive. Testosterone therapy is still in its early stages, as it is used on women.

Hypoactive sexual drugs for women are also in their infancy stages. In Raleigh, NC 2014, a pharmaceutical company named Sprout has resubmitted, to the FDA, for women a hyopactive sexual desire drug called flibanserin. Flibranserin is a non-hormonal drug that is a first of its kind to potentially enter the market. It has been sent to the FDA 15 times and is still waiting to be approved by the FDA. There are not any other drugs of this kind on the market. This is unfortunate, because men have been successful with hormone therapy, and they have drugs such as Cialis, Viagra, Stendra,
Staxyn and Levitra.

Treatment for women does not ensure that the woman's symptoms are alleviated, however, it is a step to help relieve them. According to NIH Public Access by Kyan Allahdadi, Rita Tostes, R. Clinton Webb concluded, “our limited knowledge is reflective of the inadequate treatment options available.”(8). There are other drugs that are being considered for treatment options. Tibolone—a synthetic steroid drug, Phosphodiesterase inhibitors—drugs currently used for erectile dysfunction for males. Currently in the medical community, there is not a successful treatment option for women. There is not a strong presence for the need and demand of FSD drugs in the marketplace to steam the drive of production. There is much debate in the medical community to why there isn't a strong presence. The speculation is the woman's body is more complex than a man's this is why there aren't drugs on the market; groups such as the National Women's Health Network, have sent petitions to push for progress in this market, believing it is because of gender bias is the reason behind the lax advances; and a conspiracy theory that the FDA has drugs that can help women, but are keeping them locked away. The common agreement, amongst all, is there is a lack of cures for FSD.

**Natural Remedies for Female Sexual Dysfunction**

Natural remedies are another alternative option for women to help resolve FSD without medications or hormone therapy. Sex therapy is an extremely common form of relief for women experiencing FSD. Addressing personal issues with a psychologist or a psychiatrist specializing in sexual disorders can aid learning how to deal with those issues that hinder sex. Diet, exercise, and healthy lifestyle can also allow for women to feel better about themselves or boost natural hormones and blood flow to facilitate sex drive. Acupuncture could possible trigger sex drive for women and also to alleviate pain associated with painful intercourse. The use of lubrication and stimulation devices, like vibrators or dildos, allow women to explore their other orgasmic areas. Despite all of these natural remedies treatment options, the most important is the woman's partner. Communication, overall
support, physical assistance in alleviating symptoms from a trusted partner can help discover new techniques, and/or provide needed comfort for their family member to heal.

There are a number of herbal remedies researchers have found that can also aid in combating FSD. DHEA is a hormone found in the adrenal glands. This hormone creates the estrogen and testosterone in the body. It can be cultivated from wild yam or soy. Gingko is commonly found in the marketplace. In addition to being used for memory, it can be used as a natural anti-depressant for those patients suffering from psychological FSD. L-Arginine is called an amino acid that aids in production of protein. It is currently used for men experiencing erectile dysfunction, and may aid in increasing blood flow in the body, including the sexual reproductive organs. Yohimbe is an ancient herbal remedy. The yohimbe is an evergreen tree found in specific parts in Africa. It has had a popular usage for male erectile dysfunction and may aid women. It works similar to gingko and increases blood flow and heightens nerve sensitivity in the vagina. Damiana is a wild shrub used by the Mayans for increase sexual desire. Many of these natural remedies have been used by different societies to aid in increasing sexual desire, however, there is no compelling evidence directly linking them to the cure of FSD or alleviation of FSD symptoms.

*Organizations for Patients experiencing FSD*

Women facing FSD are not alone. There are a countless number of women who are currently experiencing or have experienced FSD. Reaching out for help or to have questions answered is the first important step to create change. A stronger demand for research and FSD drugs needs to be placed upon the medical community. There is currently too little research targeting the understanding of FSD and too broad of treatments given to patients. Women have the power to drive this market and the ongoing research to aid women in enjoying their sexual lives.

There are organizations that women can become involved in to bring awareness to this quiet epidemic. The American Association for Marriage and Family Therapy, Sexuality Information and
Education Council of the US (SIECUS), Medline Plus: Sexual Health are all national organizations to become an advocate. For women locally looking for help, Awakenings is a specialty center in Raleigh, NC. They help individuals and couples attain help in intimacy and sexuality. Their clinicians are specially trained in the arena of sexual disorders. Duke has women's health centers which have departments that specialize in the treatment of FSD. One specialized clinic is found in Brier Creek, Raleigh, NC. The first step is to talk to an ob-gyn who can evaluate the issues and find referrals that will fit the needs of the patient. Staying persistent in finding a solution will make the difference in the life of the woman experiencing FSD.

Conclusion

One in ten women are burdened by female sexual dysfunction. A number of causes can attribute to the onset of FSD. Although society has evolved since the archaic understanding of female sexuality and the woman's sexual drive, additional education and public awareness is still needed. Women need to have a better understanding of the function of sex and sexual reproductive organs, knowing how to identify FSD, and how to combat this ever growing epidemic. There are many cultural, societal, and personal beliefs that hinder women from the understanding if she is experiencing a problem in that intimate space of her life. Contrary to their female counterparts, men have experienced success in the understanding and alleviation of male sexual dysfunction. Specialists, of FSD, find themselves in taboo ridden arenas. They often face disparity and no support for the help they offer and medical breakthroughs they want to make. Women need to be at the forefront of this epidemic and demand in all aspects a better quality of life.
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