SEEKING HELP FOR FEMALE SEXUAL DYSFUNCTION IN ALBERTA: A MANUAL

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Dedication

This project is dedicated to the many women who were not believed when they sought help for their sexual dysfunctions and the many women were told that their sexual dysfunctions were all in their heads, that they would resolve with time or marriage, that they just needed to relax, that sexual problems are normal for women/mothers, or that women do not need orgasms. This project is also dedicated to those who experience, and especially those who have died by suicide due to, the devastating consequences of post-SSRI sexual dysfunction, post-retinoid sexual dysfunction, post-finasteride syndrome, and persistent genital arousal disorder/genito-pelvic dysesthesia. May you rest in peace, may your deaths fuel a passion for future research, and may we find the cures.

Abstract

The proposed final project addresses the need for a bridge between women with sexual dysfunction and the healthcare available for these conditions. Many women experience sexual function problems but there are significant barriers to help-seeking for these conditions. As systemic change takes time, I aim instead to arm women with information that will help work within the current system. I conducted a literature review on female sexual dysfunction and women's help-seeking prior to developing a web-based guide for Albertan women seeking help for sexual dysfunctions. This web-based guide, available at www.femalesexualproblems.ca,was designed to help empower women with increased knowledge about why, when, where, and how to seek help in order to improve their help-seeking experiences, sexual dysfunction, and overall physical and mental health.

Keywords. Female sexual dysfunction, help-seeking, women, sexuality, experiences, barriers, sex therapy, sexism

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List of Abbreviations

AASECT	American Association of Sex Educators, Counselors, and Therapists
ACSHR	Action Canada for Sexual Health & Rights
AHS	Alberta Health Services
DCM	Dual Control Model
DSM-5	*Diagnostic and Statistical Manual of Mental Disorders*, 5th edition
FGAD	Female genital arousal disorder
FCAD	Female cognitive arousal disorder
FOD	Female orgasm disorder
FOIS	Female orgasmic illness syndrome
FSAD	Female sexual arousal disorder
FSD	Female sexual dysfunction
GPPPD	Genito-pelvic pain/penetration disorder
ICD-11	*International Statistical Classification of Diseases and Related Health Problems*, 11th edition
ICSM	International Consultation on Sexual Medicine
IPPS	International Pelvic Pain Society
ISSM	International Society for Sexual Medicine
ISSVD	International Society for the Study of Vulvovaginal Disease
ISSWSH	International Society for the Study of Women's Sexual Health
LDS	Latter-day Saint
PAS	Post-Accutane syndrome
PFS	Post-finasteride syndrome
PGAD/GPD	Persistent genital arousal disorder/genito-pelvic dysesthesia
PRSD	Post-retinoid sexual dysfunction
PSSD	Post-SSRI/SNRI sexual dysfunction
PVD	Provoked vestibulodynia
SHE	Sexual health education
SIECCAN	Sex Information & Education Council of Canada
STP	Sexual Tipping Point
UNESCO	United Nations Educational, Scientific and Cultural Organization
UNFPA	United Nations Population Fund (formerly the United Nations Fund for Population Activities)
WHO	World Health Organization
WSW	Women who have sex with women

Chapter I: Introduction

The purpose of this final project was to develop a web-based guide for women seeking help for female sexual dysfunction (FSD), bridging the gap between women's knowledge of FSDs and the healthcare available for these conditions. This chapter outlines an overview of this project, a brief description of female sexual subordinacy, an introduction to FSD risk factors and impacts, the rationale for developing this web-based guide, and the significance of this project.

Final Project Overview

To adequately support women with FSD in navigating the healthcare system and other resources available, women need accurate information about female sexual function and dysfunction, but they also need direction about why, when, where, and how to seek help effectively and efficiently. The end product of this project is a web-based guide where women can find all of this information. This will also help women to prepare for potentially negative help-seeking experiences or to identify sexual problems as soon as they arise. Due to the wide range of sexual health needs that exist among women, the project is specifically targeted to support women with FSD only. However, some of the information may still be helpful for women with other related conditions, such as overactive bladder (Jackowich et al., 2018), endometriosis, and sexually transmitted infections (Parish, Hahn, et al., 2019), given the potential overlap between symptoms of these conditions and FSD and also that healthcare providers who are knowledgeable and sympathetic about FSD are more likely to be familiar with these conditions.

An extensive review of literature and research relevant to FSD and help-seeking is shared, demonstrating the importance of female sexual function, the many influences on

female sexuality, the negative impacts of FSD, and the need for support when seeking help for FSD. Following this literature review, I explain the methodology that was used to acquire and review relevant literature and develop the web-based guide. The contents of the web-based guide, *What to Do When Sex Doesn't Feel Right*, are included in the appendices of this final project.

The Second Sex

Sexuality is slowly becoming less taboo in Western society (societies with predominantly European origins), as demonstrated by the increase in sexuality shown or discussed in media and also the increase in sex research since the new discipline of sexology was founded 1886 by Richard von Krafft-Ebing (Djajic-Horváth, 2015). Krafft-Ebing was not the first person to investigate causes of sexual behaviours, nor was he the last (Hawkes, 2004), but sex researchers' names did not become more well-known until the mid-20th century. Kinsey et al. published *Sexual Behavior in the Human Male* in 1948 and Masters and Johnson published their first book, *Human Sexual Response,* in 1966. While an interest in and acceptance of sexuality is increasing, the majority of historical literature has only referred to women's sexuality and bodies in relation to men's sexuality and bodies, which were seen as the default, similar to how "White" and "heterosexual" are seen as default or normal in Western society. Even in current medicine, there has been significantly more progress on male sexual dysfunction than on FSD, which have often been blamed on psychological problems and female "frigidity." Further, for a variety of sociocultural reasons, many women (and their male partners) do not prioritize or even pursue their own pleasure (Orenstein, 2016a), contributing to the pleasure gap and orgasm gap—the phenomenon where women experience less pleasure and fewer orgasms than men do during partnered

sexual encounters (Andrejek & Fetner, 2019; Armstrong et al., 2012; Blair et al., 2017; Frederick, John, et al., 2017; Garcia et al., 2014; Mintz, 2017; Richters et al., 2006; Wade et al., 2005).

As I have been studying sex therapy and women's sexuality before and during graduate school, it has become apparent to me that there is a lack of support for women experiencing sexual dysfunctions. Sexuality is an important part of most women's lives, through both partnered sex and masturbation. Unfortunately, many women experience sexual function problems. To make matters worse, there are many barriers inhibiting these women from seeking help from medical and mental healthcare providers for their sexual function problems, and when women do seek help, negative experiences are not uncommon (Berman et al., 2003; Jackowich, Boyer, et al., 2021; Mitchell et al., 2017; Sadownik et al., 2012).

Theoretical Foundations

There are a few concepts that are foundational to understanding women's help-seeking for sexual dysfunction. The first is intersectional feminism, which examines gender inequality and considers the impact of women's intersecting identities (e.g., sex, race, class) on their experiences (Crenshaw, 2017; hooks, 1981, 2000). The second concept is the biopsychosocial model of sexual response, which takes a holistic approach to women's sexuality and considers the influences of biological, psychological, sociocultural, and interpersonal factors on a woman's sexuality and sexual function (Faubion & Rullo, 2015; Goldstein et al., 2018; Thomas & Thurston, 2016) and also provides a basis for exploring biopsychosocial impacts of FSD. These foundational concepts provide a framework for understanding the broader contexts involved in women's sexuality, sexual function, their sexual experiences, and their help-seeking experiences.

Female Sexual Dysfunctions

Sexual dysfunctions are defined by the American Psychiatric Association (APA, 2013) as "disorders that are typically characterized by a clinically significant disturbance in a person's ability to respond sexually or experience sexual pleasure" (para. 1) and by the World Health Organization (WHO, 2018) as "syndromes that comprise the various ways in which adult people may have difficulty experiencing personally satisfying, non-coercive sexual activities" (para. 1). These problems may manifest in women's desire, arousal, orgasm, sexual pain, and sexual pleasure. About half of non-European Western women (from Australia, Canada, New Zealand, South Africa, and the United States) experience one or more sexual function problems (Moreira et al., 2005).

As demonstrated by the biopsychosocial model of sexual response (Thomas & Thurston, 2016), there are many risk factors for sexual dysfunction. Physiologic factors, such as medications (Albaugh, 2014; Feldhaus-Dahir, 2009; Healy, 2019; Healy et al., 2018; Healy et al., 2019; Hensley & Nurnberg, 2002) or muscular factors (Albaugh, 2014), can impact female sexual function, as can psychological factors, such as depression (Albaugh, 2014; Elbay, 2017; Faubion & Rullo, 2015; Wright & O'Connor, 2015) and anxiety (Albaugh, 2014). Sociocultural factors, such as religious or cultural beliefs (American Psychiatric Association, 2013; Brotto, Bitzer, et al., 2010; Wright & O'Connor, 2015) and upbringing (Basson, 2006; Faubion & Rullo, 2015; Ohl, 2007) also influence sexual function, as do relationship factors (American Psychiatric Association, 2013; Fugl-Meyer & Fugl-Meyer, 2005), including the sexual function of partners (American Psychiatric Association, 2013; Faubion & Rullo, 2015).

The biopsychosocial model (Thomas & Thurston, 2016) also provides a framework

for understanding the impact of FSD on women. Besides the fact that sexual satisfaction is a sexual right (WHO & UNFPA, 2010) and should thus be considered important on those grounds alone, women's sexual dysfunction can impact their mental health (Ayling & Ussher, 2008; Donaldson & Meana, 2011; Katz, 1995; Nappi et al., 2013; Segnini & Kukkonen, 2005; Sutherland, 2012), quality of life (e.g., Atallah et al., 2016; Blair et al., 2013; Buster, 2013; Faubion & Rullo, 2015; Laumann et al., 1999), and social life (Xie et al., 2012).

FSD can also have further impacts on other aspects of a woman's sexual function (Ayling & Ussher, 2008; Dunn et al., 2000; Gates & Galask, 2001; Jantos & White, 1997; MacNeil & Byers, 1997; Masheb et al., 2002; Meana et al., 1997; Quinn-Nilas et al., 2018; Sackett et al., 2001; Sadownik, 2000; White & Jantos, 1998; Wojnarowska, 1997). It is no surprise then that the impact of FSD reaches beyond the women in question, negatively affecting women's romantic relationships (e.g., Ayling & Ussher, 2008; Kingsberg, 2014) and their partners (Balon, 2017; Connor et al., 2008; Nylanderlundqvist & Bergdahl, 2003; Sadownik et al., 2017; Smith & Pukall, 2014; Sutherland, 2012).

There can be significant financial costs associated with management of FSD (Goldmeier et al., 2004; Jackowich, Boyer, et al., 2021; The SexMed Advocate, 2021; Xie et al., 2012) and FSD also has implications for physical health (Aslan & Fynes, 2008; Thomas & Thurston, 2016). Without knowledge of FSD and help-seeking options, women run the risk of not receiving the help they need and thus experiencing some or even all of these negative impacts.

Rationale

Many women with sexual dysfunction are not receiving the help they need (Gunter,

2019; Reed et al., 2014; ter Kuile et al., 2013), either because they have not sought help, they face barriers to seeking help (Berman et al., 2003; Brock et al., 2006; Feldhaus-Dahir, 2009; Ibine et al., 2020; Shifren et al., 2009), or they have negative experiences when seeking help (Berman et al., 2003; Mitchell et al., 2017; Sadownik et al., 2012).

Given that women's sexual pleasure in Western society has historically been and continues to be valued less than men's sexual pleasure (Rehman et al., 2013), it is no surprise that women's negative experiences with seeking help for FSD appear to be both under-acknowledged and under-addressed, if not blamed on their own help-seeking behaviours. Further, sexual health education (SHE) in elementary and secondary school rarely, if ever, mentions desire or sexual pleasure (Fine, 1988; Fine & McClelland, 2006; Rasmussen, 2012), especially not female sexual function and dysfunction. Generally, this SHE focuses on avoidance of negative consequences (sexually transmitted infections and unwanted pregnancies). Disappointingly, the same is often true for SHE in medical school (Abdolrasulnia et al., 2010; McCool et al., 2016; Pauls et al., 2005; Roos et al., 2009) and psychology programs (Burnes et al., 2017; Campos et al., 1989; Hanzlik & Gaubatz, 2012; Nagoski, 2015; Nathan, 1986; Wiederman & Sansone, 1999) and even the sexual health services available to Albertans (Alberta Health Services [AHS], 2019).

Given the many barriers women face when seeking help for FSD (Berman et al., 2003; Brock et al., 2006; Feldhaus-Dahir, 2009; Ibine et al., 2020; Shifren et al., 2009) and the negative experiences they often have when they do seek help (Berman et al., 2003; Jackowich, Boyer, et al., 2021; Mitchell et al., 2017; Sadownik et al., 2012), it is clear that something needs to be done to ameliorate women's help-seeking experiences. Indeed, while working on this final project, I have occasionally posed questions on social media to ask

women for suggestions regarding this web-based guide. The responses were overwhelming, and the following anonymous quotes, which have been included with permission, clearly demonstrate the need women have for guidance in seeking help for sexual dysfunction:

> "I'm intrigued by your project. I wish something like that was made available to me. I'm super emotional thinking of how helpful your manual will be. Thanks for taking on such a huge task."

Another woman replied to a pelvic floor physiotherapist's reply to my post:

> "I would never even bring it up with my general practitioner/healthcare provider in the first place. Ever. Unless there was a direct question asked in relation to a separate pelvic health issue, and even then it would be minimal discussion. I can also very much second [pelvic floor physiotherapist]'s comments of issues being pushed aside or ignored by family physicians. After childbirth, the standard reply to any type of pelvic dysfunction in my experience has been 'well, you've had a baby, so welcome to your new normal.' After the experiences I've had just with postpartum issues there is no way I'd trust a GP with questions about sexual dysfunction. So your manual is probably extra important for the gals like me who would quietly try to deal with whatever they're going through on their own."

These were the unsolicited private messages of female acquaintances, and they support my argument that many women with FSD are falling through the cracks and not receiving the help they need.

There are many ways to ameliorate the situation, including improving sexual health training for all healthcare practitioners and revamping provincial and national healthcare to allow for longer appointments and more affordable treatment options; however, these

solutions are not within the scope of this project, so improving this situation from another perspective is required. If I cannot change healthcare provider training and healthcare, then I will attempt instead to arm women with the information they need. Recent research suggests that women who advocated for referrals or read about the condition on their own—help-seeking strategies this web-based guide is designed to support—found these strategies to be helpful in accessing care (Jackowich, Boyer, et al., 2021; R. Jackowich, personal communication, May 4, 2021). A website is the ideal medium for this guide, as it can be updated, has no costs associated with dissemination, and facilitates access to other online resources. Providing this information to women with FSD and connecting them with relevant helping professionals and treatments is necessary. In creating this guide, I hope to empower women with FSD to pursue and receive the healthcare they need.

Significance of This Project

Given the detrimental effects of FSD, the barriers to help-seeking that women experience, and the negative help-seeking experiences that are so common, I anticipate that the development and dissemination of this web-based guide may facilitate better help-seeking experiences for women who use it. Educating women about female sexual function and dysfunction is expected to provide women with an accurate understanding of healthy sexual function against which they can compare their own experiences. This will help women know whether and when to seek professional help. Providing women with information about where and how to seek help will guide women in doing so effectively and efficiently, and will hopefully prevent them from pursuing treatments that waste their time and/or money.

While the literature I will review in the next chapter demonstrates that there is indeed research on causes and treatments for FSDs (albeit significantly more limited treatments for

FSD than male sexual dysfunctions; Kingsberg, 2020), many women are not getting the help they need. Some women do not seek help, some women delay seeking help, and many women have had negative experiences seeking help (Berman et al., 2003; Jackowich, Boyer, et al., 2021; Mitchell et al., 2017; Sadownik et al., 2012). This demonstrates that there are many gaps between women with sexual dysfunction and the healthcare available for these conditions. This project and web-based guide aims to bridge those gaps, empowering women to seek and receive the help they need, leading to improved mental health, quality of life, sexual function, relationships, and physical health.

Chapter II: Literature Review

The focus of this chapter is on outlining the current research relevant to FSD and help-seeking in order to support the development of a web-based guide to empower women with the knowledge they need to seek help for FSD. I will begin by defining the important terms relevant to FSD and help-seeking, explaining the importance of seeking help for FSD, including the impact of FSD on women's mental health, other aspects of sexual function, relationships, and physical health. Next, I will explain important aspects of female sexual function, including the relevant anatomy, followed by a discussion of the use of intersectional feminism and the biopsychosocial model in this project. This will lead into a description of several models of female sexual response, healthy sexual functioning, and FSDs. I will then address various sociocultural barriers to women's sexual pleasure and provide a synthesis of the literature on the behaviours, barriers, and experiences of women when they have sought help for FSD. The chapter will conclude by discussing the sociocultural and political contexts that impact Albertan women's sexual function, help-seeking behaviours, and help-seeking experiences.

Definition of Important Terms

A clear understanding of the definitions associated with FSD and help-seeking is needed in order to provide the context. Some of the terms associated with FSD are female(s) and woman/women; dysfunctions, disorders, problems, and concerns; vaginal intercourse; cunnilingus and fellatio; sex and masturbation; and healthcare professionals, medical professionals, and mental healthcare professionals. I will explain how I use these terms in this section.

Female(s) and Woman/Women

This project is aimed at helping cisgender women seek help for sexual dysfunction. As a result, whenever I use the terms "female" or "women," I am referring to cisgender women. However, some of the information in this project, such as the information on sociocultural barriers to help-seeking, will have relevance to the experiences of trans women and femme-presenting people; as such, uses of the words "woman" and "women" often include trans women and femme-presenting people. Further, some of the information in this project, such as the section on female sexual anatomy or the sexual response models, is relevant to those who were assigned female at birth, including trans men. As such, uses of the word "female" refer to people who were assigned female at birth, including trans men.

Dysfunctions, Disorders, Problems, and Concerns

While the International Consultation on Sexual Medicine (ICSM) and *International Statistical Classification of Diseases and Related Health Problems* (11th ed.; ICD-11; WHO, 2018) refer to sexual "dysfunction," the International Society for the Study of Women's Sexual Health (ISSWSH) and the *Diagnostic and Statistical Manual of Mental Disorders* (5th ed.; *DSM-5*; American Psychiatric Association, 2013) refers to sexual "disorders" (Parish et al., 2020). "Dysfunction" and "disorder" refer to sexual problems that meet diagnostic criteria in the *ICD-11* and the *DSM-5*. I have attempted to use the terminology of whomever I am citing, but the distinction between dysfunction and disorder in this project is otherwise inconsequential.

When sexual problems do not meet the diagnostic criteria of the *ICD-11* (WHO, 2018) or the *DSM-5* (American Psychiatric Association, 2013), or the literature is not clear on whether they meet the criteria, I refer to sexual "problems" and "concerns." Because of the need to discuss problems that meet diagnostic criteria, problems that do not meet

diagnostic criteria, and problems for which it is unknown whether or not they meet diagnostic criteria, I also use "problem" and "concern" to refer to the broader group of all sexual dysfunctions, disorders, problems, and concerns.

Vaginal Intercourse

In this project, I use the term "vaginal intercourse" to clearly refer to sexual activities in which a penis penetrates a vagina, while I use the term "intercourse" to include other penetrative activities, such as anal intercourse. When the research cited is ambiguous about whether the authors are referring to vaginal intercourse or all penetrative activities, I used the term "intercourse."

Cunnilingus

While the term "oral sex" may be more familiar to readers, it often leaves ambiguity about who is performing the act and who is receiving. Cunnilingus refers specifically to oral sex on a vulva while fellatio refers specifically to oral sex on a penis.

Sex and Masturbation

When using the term "sex," I am referring to all partnered sexual activities and behaviours, including vaginal intercourse, anal intercourse, cunnilingus, fellatio, mutual masturbation, and anything else that fits the definition of "partnered sexual activities and behaviours." I often refer to "partnered sex" and other variations on this term in order to avoid ambiguity. The term "masturbation" refers only to solo masturbation or solo sex, as the term "mutual masturbation" would sufficiently explain that partnered sexual behaviour.

Healthcare Providers, Medical Professionals, and Mental Healthcare Professionals

Since 2001 or earlier, some doctors and physicians have been fighting against being called "providers," arguing that it is insulting and devaluing to their extensive education and

comparing the use of the term to racial, ethnic, and gender insults (Taylor, 2001). These arguments have not disappeared (e.g., Dhand, 2015; Yee, 2019) and continue today on Twitter (e.g., #NotAProvider, #DontSayProvider). Not wishing to offend those from whom women must seek help or who have spent so many years becoming trained, I am reluctant to use this term. However, throughout this project, I am frequently required to refer to large groups of medical professionals and mental healthcare professionals and it is simply unrealistic not to use a catchall term for all the possible professionals to whom I may be referring. Thus, whenever I use the term "medical professionals," I am referring to doctors, gynecologists, urologists, urogynecologists, nurses, nurse practitioners, pelvic floor physiotherapists, and other professionals who work with women's bodies (and touch them) during diagnosis and treatment. Whenever I use the term "mental healthcare professional," I am referring to psychologists, counsellors, therapists, sex therapists, social workers, psychiatrists, and other professionals who work with the psychological aspects of women's problems (and do not touch women) as part of diagnosis and treatment. Whenever I use the term "healthcare professionals," I am referring to both medical professionals and mental healthcare professionals.

Importance of Seeking Answers for Women with FSD

Sexual health, sexual pleasure, and sexual satisfaction are human rights (Sex Information & Education Council of Canada [SIECCAN], 2020; WHO & UNFPA, 2010) and women's sexual satisfaction is important to their sexual wellness, sexual health, relationship (e.g., Ayling & Ussher, 2008), and general well-being (e.g., Atallah et al., 2016), as well as their social life (Xie et al., 2012), and their partner's mental health and sexual function (e.g., Sadownik et al., 2017). Sexual satisfaction within a relationship can also

predict future relationship satisfaction and stability (Christopher & Sprecher, 2000; Karney & Bradbury, 1995). Management and treatment FSDs can also have a negative financial impact on women and healthcare systems, depending on who is paying for treatment (e.g., Xie et al., 2012).

Although problems with desire, lubrication, and orgasm are more common than sexual pain (Laumann et al., 2009), sexual pain is the sexual function problem that is most often reported as distressing (Mitchell et al., 2016). It is likely for this reason that much of the research on the impact of FSD focuses on sexual pain disorders, such as provoked vestibulodynia (PVD), vulvodynia (vulvar pain), dyspareunia (painful intercourse), and vaginismus (inability to be vaginally penetrated). Limited research exists on the impact of non-pain FSDs (Nappi et al., 2016). Further, most of the research on the impact of FSD focuses on women in heterosexual relationships (e.g., Sadownik et al., 2017; Smith & Pukall, 2014); as a result, most of the research on impact of FSD is on sexual pain in women in relationships with men and not on the impact of FSD with masturbation, lesbians, or single women. While most of the research below pertains specifically to the impacts of sexual pain, I believe all FSDs will have these same impacts to varying degrees.

Impact on Women's Mental Health

Sexual dysfunction can have a negative impact on women's mental health, including self-esteem and body image. Looking at the issue broadly, women with sexual pain experience a negative impact on their quality of life (Atallah et al., 2016; Blair et al., 2013; Buster, 2013; Faubion & Rullo, 2015; Laumann et al., 1999). Many women with sexual pain feel guilt (Ayling & Ussher, 2008; Sutherland, 2012) and internalized pressure to be sexual with their partners—they feel obligated to engage sexually, as though they do not have a

choice (Sutherland, 2012). A woman like this cares about and wants to please her partner, views her partner's needs as more important than her own, and assumes responsibility for her partners' reactions (e.g., frustration, disappointment, anger) to her refusal of his advances (Sutherland, 2012). She also fears negative consequences if she refuses sex, feels social pressure to engage in sexual interactions, and views sexual interactions as part of her role as a wife or woman (Sutherland, 2012).

Women may experience negative thoughts, feelings, and behaviours as a result of sexual pain. Psychological distress and a range of negative feelings are common (Sadownik et al., 2012), including shame, embarrassment (Ayling & Ussher, 2008; Sutherland, 2012), frustration, diminished mood (Gates & Galask, 2001; Sadownik, 2000), anger, fear, grief, and confusion (Ayling & Ussher, 2008). Many women with sexual pain feel inadequate (Carter et al., 2019; Sutherland, 2012). Specifically, many feel inadequate as women (Ayling & Ussher, 2008; Sutherland, 2012) and sexual partners (Ayling & Ussher, 2008; Katz, 1995; Sadownik et al., 2012) due to the coital imperative, a commonly-held Western belief that positions vaginal intercourse as the only "real sex" and all other sexual behaviours as foreplay (Gavey et al., 1999; McPhillips et al., 2001; Jackson, 1984). Women often experience depression (Jantos & White, 1997; Masheb et al., 2002; Meana et al., 1997; Sackett et al., 2001; Sutherland, 2012; Wojnarowska, 1997) and anxiety (Gates & Galask, 2001; Jantos & White, 1997; Masheb et al., 2002; Meana et al., 1997; Sackett et al., 2001; Sadownik, 2000; Sutherland, 2012; Wojnarowska, 1997) due to their sexual pain.

Women with sexual pain are likely to experience negative thoughts about themselves. They may begin to view themselves as broken, damaged (Ayling & Ussher, 2008; Sutherland, 2012), abnormal, and incomplete (Ayling & Ussher, 2008; Donaldson & Meana,

2011; Sutherland, 2012). Their self-esteem may suffer (Katz, 1995; Nappi et al., 2013; Segnini & Kukkonen, 2005) and they may feel a loss of femininity, loss of self (Katz, 1995), and diminished confidence (Katz, 1995; Sutherland, 2012). Body image is often impacted by the experience of sexual pain as well. Women with vulvodynia reported viewing their bodies as "not normal," "worthless," "useless," "broken," and "dysfunctional" for not being able to satisfy their partners' sexual needs (Ayling & Ussher, 2008, p. 298). During sexual activity, women with sexual pain have reported associating their bodies with the words "garbage," "trash," "useless," "mutant," and "gimp" (Sutherland, 2012, p. 235). Some women with sexual pain view their genitalia as a useless and dead part of their body (Sutherland, 2012) and may begin to resent their body for being "faulty" (Ayling & Ussher, 2008, p. 302). These studies suggest that women with sexual pain are not only suffering from physical pain but intense emotional pain as well.

People with persisting sexual dysfunctions, especially those involving persistent abnormal genital sensations (persistent genital arousal disorder/genito-pelvic dysesthesia [PGAD/GPD]) or lasting loss of erotic sensation (post-SSRI sexual dysfunction [PSSD], post-retinoid sexual dysfunction [PRSD], post-Accutane syndrome [PAS], and post-finasteride syndrome [PFS]), appear to experience mental health impacts of a different magnitude. People with PSSD/PRSD/PFS (Grey, 2020; Healy, 2020; Hengartner et al., 2020; PSSD Canada, n.d.; Reisman, 2017; Rxisk, 2019) and PGAD/GPD (Aswath et al., 2016; Jackowich & Pukall, 2020a; Jackowich, Pukall, et al., 2021) experience severe depression and loss of quality of life, sometimes leading to suicide, due not only to the devastating effects of these sexual dysfunctions, but also likely to the experiences of not being believed by healthcare providers and the absence of a cure.

Impact on Other Areas of Women's Sexual Function

It is no surprise that women with sexual pain experience a negative impact on their sexual outcomes, including diminished sexual interest (Gates & Galask, 2001; Sackett et al., 2001; Sadownik, 2000; White & Jantos, 1998), diminished arousal potential (White & Jantos, 1998), decreased sexual satisfaction (Ayling & Ussher, 2008; Jantos & White, 1997; Masheb et al., 2002; Meana et al., 1997; Sackett et al., 2001; Wojnarowska, 1997), and diminished sexual self-esteem (Gates & Galask, 2001; Sackett et al., 2001; Sadownik, 2000; White & Jantos, 1998). Sexual satisfaction is an important component of sexual health. Unfortunately, many women are not sexually satisfied (Hartman, 1983; Higgins et al., 2011; Sánchez-Fuentes et al., 2014) and many women experience sexual function problems.

If treatment for FSD has not been pursued or has not yet been successful, women with sexual pain have the option to suffer through sexual interactions or avoid them completely. Some women avoid sexual interactions (Brotto et al., 2015; Reed et al., 2003; Sutherland, 2012) and refuse their partners' advances (White & Jantos, 1998) to avoid or reduce pain (Sadownik, 2000). These women may imagine circumstances in which they could avoid vaginal penetration, such as being single or being a lesbian (Ayling & Ussher, 2008).

Many women engage in painful and unwanted intercourse for their partners' benefits (Ayling & Ussher, 2008; Sutherland, 2012), to prevent their partners from straying (Barbach, 2000; Sutherland, 2012), and in hopes of experiencing pleasure themselves (Sutherland, 2012). Some women feel detached from the experience and their partner (Sutherland, 2012). They focus on their partners' sexual arousal (Brotto et al., 2015) and use encouraging or negative self-talk to get through the experience (e.g., "Grin and bear it;" Sutherland, 2012, p. 235). They may experience physical pain, ranging from "annoying" to "very excruciating"

during sexual interactions (Sutherland, 2012). They may be entirely motionless during the sexual act or mentally detach from the experience and think about other things (Sutherland, 2012). When the sexual interaction is over, these women are relieved, but the experience may also leave them feeling frustrated, guilty, sad, depressed, lonely, insecure, uncertain, anxious, and fearful (Sutherland, 2012). Meeting others' needs while not having their own needs met may lead them to feel exhausted, hurt, and angry (Sutherland, 2012).

Impact on Women's Relationships and Partners

While some quantitative research has suggested that relationship satisfaction in a couple where one partner has PVD did not suffer due to PVD (Reissing et al., 2003; van Lankveld et al., 1996), qualitative research has suggested that sexual pain does cause significant relationship problems (Connor et al., 2008; Sackett et al., 2001; Sheppard et al., 2008; Sutherland, 2012). Negative impacts on relationships are reported by both women with PVD (Sadownik et al., 2012) and their male partners (Sadownik et al., 2017; Smith & Pukall, 2014). People with PSSD symptoms, including loss of erotic sensation, may experience the termination of relationships (Grey, 2020).

Women's views of partnered sex and their partner deteriorate due to sexual pain. Women with sexual pain have negative views toward sexual activity (White & Jantos, 1998), viewing sex as a chore or a duty or even as "disgusting" and "dirty" (Sutherland, 2012, p. 236). A woman with sexual pain may have negative thoughts about her male partner, such as thinking he is abnormal and needy, believing that he resents her, or questioning her choice of partner (Sutherland, 2012). She may also wonder why her partner is with her while believing that other men would be less understanding than he is (Ayling & Ussher, 2008).

A woman may self-silence about the pain she experiences from intercourse (Ayling &

Ussher, 2008) because she fears her partner's rejection or infidelity (Sutherland, 2012) or views herself as an inadequate woman (Sadownik et al., 2012). Some women cope through the use of compensatory and addictive behaviours, such as alcohol, compulsive eating, and overwork (Sutherland, 2012). One woman even used non-monogamy as a way to satisfy her partner's sexual needs while allowing her to avoid the pain of intercourse (Ayling & Ussher, 2008).

The partners of women with FSDs are impacted as well, though little research exists on the impact of FSD on a woman's partner (Sadownik et al., 2017) and little to none exists on the impacts on same-sex partners. Lubrication difficulties may not have much impact on a woman's partner because supplemental lubricant is an easy solution, though some men feel the need for extra lubrication makes their sex lives unnatural (Connor et al., 2008). A woman's orgasm difficulties may not prevent intercourse or other sexual activities, but men do view women's orgasms as "masculinity achievements" (Chadwick & van Anders, 2017) and men are more sexually satisfied with women who orgasm more intensely and more frequently (Ellsworth & Bailey, 2013). However, low desire and sexual pain are factors that could interfere with the frequency or occurrence of intercourse or other sexual activity at all. Given that the coital imperative positions vaginal intercourse as "normal sex" (Gavey et al., 1999; Jackson, 1984; McPhillips et al., 2001), women's sexual pain and low desire will likely impact male partners of women who desire little to no intercourse by preventing or decreasing the occurrence of this activity.

Male partners of women with sexual pain (e.g., vulvar vestibulitis, dyspareunia, vulvar pain) may experience negative emotional consequences (Connor et al., 2008), such as anger, disappointment (Sutherland, 2012), frustration (Sadownik et al., 2017; Sutherland,

2012), guilt (Sadownik et al., 2017), and greater symptoms of depression (Nylanderlundqvist & Bergdahl, 2003). They are likely to experience sexual distress, either through diminished sexual experiences (e.g., decreased quality and quantity of intercourse) or constrained intimacy (e.g., diminished physical intimacy, disconnection; Sadownik et al., 2017). A man may experience relationship strain (e.g., fighting, questioning the relationship) and communication challenges, such as difficulty discussing his partner's PVD with her or anyone else (Sadownik et al., 2017). Erectile function, sexual satisfaction, and sexual communication may all suffer as a result of his partner's provoked vulvar pain (Chew et al., 2021; Smith & Pukall, 2014).

Physiological Implications of FSD

Not only can FSD impact women psychologically and socially, it can have a physiological implications for women too, as FSDs are often associated with other health problems. For example, some women's sexual desire is impacted by testosterone levels (Kingsberg & Rezaee, 2013), which can also impact bone density, body fat, lean muscle mass, risk of coronary heart disease, insulin sensitivity, and mood (Tyagi et al., 2017). Low testosterone can also be a result of other conditions, including hypopituitarism, premature ovarian failure, or adrenal insufficiency (Davis & Braunstein, 2012). Thus, low desire could be a sign of another health problem. Similarly, a variety of health conditions are associated with vaginal dryness, sexual pain, and other FSDs. Further, a studies on PGAD/GPD and vulvodynia found that many participants reported impediments to their ability to engage in household chores or employment (Jackowich, Boyer, et al., 2021) or participate in social activities (Xie et al., 2012). Thus, addressing women's sexual health and sexual satisfaction is concomitant with their physical health.

In looking at the impacts on women's mental health, sexual satisfaction, relationships, partners, and physical health, it is not surprising that women with sexual pain experience a negative impact on their quality of life (Atallah et al., 2016; Blair et al., 2013; Buster, 2013; Faubion & Rullo, 2015; Laumann et al., 1999). While women experience many barriers to seeking help for FSD, which I will address, there can be mild to severe consequences of failing to address the issue or having healthcare providers who fail to help. Having made an argument for why women with FSD should seek help and receive treatment, I will move on to describing women's sexuality, beginning with their sexual anatomy.

Anatomy of Female Sexual Pleasure: An Owner's Manual

As we are discussing female sexual functioning and issues arising from this, let us first explore the female anatomy involved in sexual function. An understanding of female bodies is important for female sexual function, and accurate terminology is imperative for effective communication between women and healthcare providers. This section addresses female genital anatomy and contains diagrams of female genitalia.

Female genitals contain the same type and almost as much erectile tissue as male genitals, but it is laid out differently as most female erectile tissue is inside the body (Dodson, 2002; Winston, 2010). Separate but interconnected structures (including the clitoris, vestibular bulbs, urethral sponge, and perineal sponge) form the network of female erectile tissue (Winston, 2010). The female genital area is richly innervated, and erectile tissue especially has many nerves. Nerves allow for movement and the perception of sensation. The external genital nerve (also known as the pudendal nerve) has branches that innervate the more external genitals, including the genital skin and the clitoris (glans, body, and legs) while the pelvic nerve innervates the deep genital structures, including the uterus,

bladder, and anus (Winston, 2010).

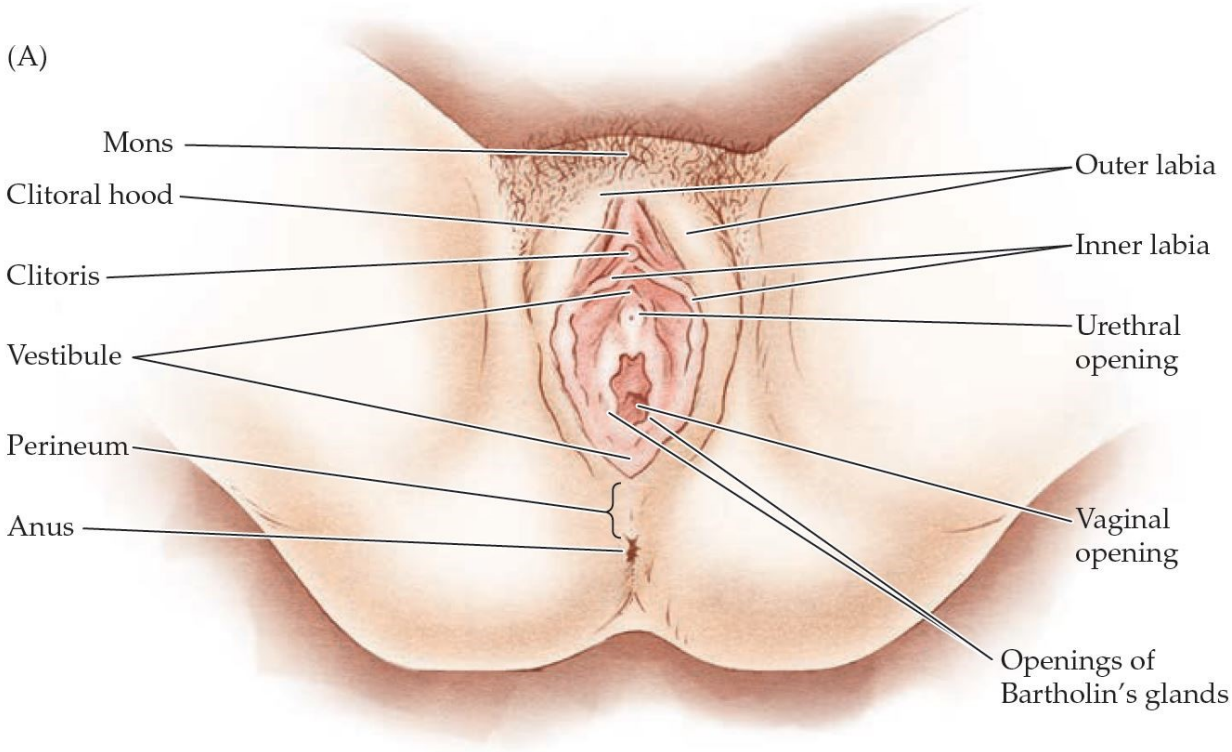
This section will be divided into external anatomy and internal anatomy. While external anatomy in medicine refers to the structures outside the true pelvis (i.e., mons, labia, clitoris, urethra, vestibule, vestibular bulbs, glands, vaginal opening; Hoare & Khan, 2020; Nguyen & Duong, 2020) and internal anatomy refers to the structures within the true pelvis (i.e., vagina, cervix, uterus, fallopian tubes, ovaries; Hoare & Khan, 2020), I will be referring to external anatomy and internal anatomy in the way many genital diagrams do—with external anatomy referring to the parts that are visible or palpable from the outside and internal anatomy referring to the parts that are not. This is similar to the way female sexuality authors (e.g., Gunter, 2019; LeVay et al., 2019; Kerner, 2010; Winston, 2010) discuss female anatomy.

External Genital Anatomy

The term vulva (see Figure 1) refers to all female external genitalia (Nguyen & Duong, 2020) or all the visible parts of female genitalia (Kerner, 2010). The term "vagina" is often used colloquially as a catch-all term for women's genitals (Kerner, 2010; Winston, 2010), and this contributes to an inaccurate understanding of female anatomy (Kerner, 2010). The vulva includes the mons, outer labia, outer labia, clitoris, urethra, vestibule, vestibular bulbs, paraurethral gland openings, vestibular gland openings, and vaginal opening (Hoare & Khan, 2020; Nguyen & Duong, 2020). The parts of the vulva vary in shape, size, and colour from female to female (Dodson, 2002; Nguyen & Duong, 2020; Winston, 2010). This discussion will begin with the most anterior part of the female genitals, the mons pubis.

Figure 1

The Vulva, or Female External Genitalia



Note. From LeVay et al. (2019, p. 25).

Mons Pubis. The mons pubis (or mons) is a mound of fatty tissue over the pubic bones and it is covered in pubic hair (Kerner, 2010; Nguyen & Duong, 2020; Winston, 2010). Its purpose is to provide cushioning during vaginal intercourse (Nguyen & Duong, 2020) and attract sexual partners by secreting pheromones (Winston, 2010; Nguyen & Duong, 2020).

Outer and Inner Labia. The mons connects directly to the outer labia or outer lips (Nguyen & Duong, 2020). The outer labia are also known as the labia majora ("big lips"), but outer labia is a more inclusive name because some inner lips protrude out from between the outer lips (Kerner, 2010; Winston, 2010). The outer labia are a fleshy pair of skin folds that cover (Nguyen & Duong, 2020) and protect (Winston, 2010) the inner parts of the vulva.

The outer sides of the outer labia are covered in pubic hair while the inner sides are smooth and contain oil glands and sweat glands (Kerner, 2010). These lips can be a source of sexual stimulation (Kerner, 2010; Winston, 2010), though they are not as sensitive as the inner labia or clitoris (Kerner, 2010). During sexual arousal, the outer labia engorge with blood and appear swollen (Kerner, 2010; Nguyen & Duong, 2020).

The outer labia surround the hairless inner labia (Kerner, 2010), which are a pair of thinner skin folds (Nguyen & Duong, 2020) with oil glands that present as tiny bumps (Kerner, 2010). The inner labia surround the glans (head) of the clitoris to form the clitoral hood and the frenulum. The inner labia also extend around the vagina and encircle and terminate at the vestibule (Nguyen & Duong, 2020). Diversity in the appearance (e.g., colour, size, shape, symmetry) of the inner labia is normal—both between females and within one vulva (Kerner, 2010; LeVay et al., 2019; Winston, 2010). Because they are dense with nerves, the inner labia are extremely sensitive (Kerner, 2010) and best touched with lubrication, either natural or synthetic (Winston, 2010). During sexual arousal, the inner labia will become engorged with blood (Kerner, 2010; Nguyen & Duong, 2020), causing their colour to darken (Kerner, 2010; Winston, 2010).

External Clitoris. The clitoris is a sensory organ (Nguyen & Duong, 2020), and its only purpose is to produce pleasure for its owner (Dodson, 2002; Gunter, 2019; Kerner, 2010; Winston, 2010). The external clitoris consists of the glans, hood, and the frenulum (Jannini et al., 2018). The clitoris also has a body and crura. Although it is easy to palpate the glans and body of the clitoris (Winston, 2010), the crura are not externally visible and will thus be discussed with internal genital anatomy.

The clitoral hood, also known as the prepuce (Jannini et al., 2018; Kerner, 2010), is

formed by the joining of two inner labia over the glans (Kerner, 2010; Winston, 2010). The hood protects the sensitive glans from overstimulation (Kerner, 2010; Winston, 2010), though the degree that the hood covers the glans varies between women (Winston, 2010). Pleasure can be created through the friction of rubbing the hood against the glans (Kerner, 2010; Mintz, 2017).

The glans (head) is the visible part of the clitoris (Kerner, 2010; Winston, 2010; Nguyen & Duong, 2020), at least if the hood is retracted (Winston, 2010). It is at the end of the unseen clitoral body and crura (Kerner, 2010). Glans size varies between women (Kerner, 2010) and is unrelated to clitoral sensitivity (Mintz, 2017)—the glans has many nerve endings and is thus highly sensitive (Kerner, 2010; Nguyen & Duong, 2020). On the underside of the glans, the inner labia connect to form a small area of sensitive skin called the frenulum, which is also rich in nerve endings (Kerner, 2010). During sexual stimulation and sexual arousal, the glans will become erect as it becomes engorged with blood (Nguyen & Duong, 2020). Arousal and impending orgasm, with the help of the suspensory ligament, will cause the glans to retract under the hood in order to protect itself from overstimulation (Kerner, 2010; Winston, 2010).

There are many claims that the glans has between 6000 and 8000 nerve endings (e.g., Angier, 2000; Carroll, 2018; Di Marino & Lepidi, 2014; Kerner, 2010; Nguyen & Duong, 2020; Winston, 2010) and that this is double the number of nerve endings in the penis, but my search for the original research supporting this claim came up empty. In fact, sex therapist Dr. Laurie Mintz (2021b) stated that, when writing her book *Becoming Cliterate,* she was also unable to find the source for this claim. As the clitoris and penis both developed from the same material in utero, Mintz (2017) stated that she and other scientists noted that

there are actually the same number of nerve endings on both the glans clitoris and the glans penis—the nerve endings are simply more densely packed in the clitoris. This would likely not be an important parallel to make, were it not for the fact that the clitoris has been so neglected in medicine and heterosexual women's lived experiences.

The glans of the clitoris connects to the clitoris body (or shaft), a soft, tubular pipe of erectile tissue which runs just beneath the hood (Kerner, 2010). It is about the width of a chopstick or a pencil, about half an inch to one inch long, and easily palpable with the fingers (Winston, 2010), especially when it is engorged (Kerner, 2010). The body is extremely receptive to sensation (Kerner, 2010), and the hood allows for the shaft to be rubbed without friction (Winston, 2010). The clitoris body is approximately two to four centimetres long (O'Connell et al., 1998) and extends toward the mons pubis for about three quarters of an inch before splitting into two thin crura (discussed in internal anatomy) that follow under the inner lips (Kerner, 2010).

Vestibule. Just below the clitoris is the anterior of the vestibule, a smooth surface just inside the inner lips that surrounds the vaginal opening and the urethral opening, which are also parts of the vestibule (Nguyen & Duong, 2020). The urethral opening is a small and sensitive hole or slit between the clitoris and the vaginal opening which opens into the urethra, a tube that extends from the bladder to the outside of the body in order to allow for the excretion of urine (Nguyen & Duong, 2020).

Beside the urethral opening are the duct openings of the paraurethral glands, which will be discussed with internal anatomy, as they are part of the urethral sponge. At the distal end of either side of the vaginal opening and within the vestibule are the duct openings of the greater vestibular glands (Gunter, 2019; Moore & Agur, 2018; Nguyen & Duong, 2020), also

known as the vulvovaginal glands or Bartholin's glands (Winston, 2010). The glands themselves are pea-sized (Nguyen & Duong, 2020) and lay under the outer labia (LeVay et al., 2019). During arousal (Winston, 2010), the greater vestibular glands produce a small amount of lubrication (Gunter, 2019; LeVay et al., 2019; Moore & Agur, 2018; Nguyen & Duong, 2020; Winston, 2010) and this mucus-like substance is secreted into the vagina and labia minora via the duct openings of the greater vestibular glands (Nguyen & Duong, 2020). The purpose of this lubrication may be to decrease the friction of vaginal intercourse (Nguyen & Duong, 2020) or maintain a healthy vaginal ecology (Winston, 2010).

The vaginal opening is partially covered by a membrane called the hymen (LeVay et al., 2019; Nguyen & Duong, 2020; Winston, 2010). The hymen (not depicted in the preceding figures) can vary in shape, thickness, and how much it covers the vaginal opening (Gunter, 2019). Historically, many cultures have believed that an intact hymen is proof that a female has never had vaginal intercourse (Gunter, 2019; LeVay et al., 2019; Winston, 2010); however, the state of the hymen is not a reliable indicator of prior vaginal penetration (Gunter, 2019; LeVay et al., 2019; Winston, 2010) and its purpose is probably simply to protect from infection (Gunter, 2019; Winston, 2010). The hymen may be torn or stretched by accident (Winston, 2010), tampons (Gunter, 2019; LeVay et al., 2019), intentional stretching (LeVay et al., 2019), physical activity, or first coitus (Gunter, 2019; LeVay et al., 2019; Winston, 2010). Painful tearing and bleeding during first vaginal intercourse can occur, but it is the exception and is usually due to inadequate arousal, feeling unsafe, or non-consensual experiences, not the hymen itself (Winston, 2010). If bleeding does occur, it will likely be a few spots (Winston, 2010) and should only occur with first coitus (Gunter, 2019). Hormonal changes during puberty may thin the hymen and cause it to disappear on its own

(LeVay et al., 2019; Winston, 2010). The hymen may also remain intact after sexual activity and it can, in rare cases, be very thick and obstruct the vaginal opening, at which point medical intervention is necessary (Gunter, 2019).

Because the vestibule houses the external openings of two canals (the vagina and the urethra) as well as the external openings of the two ducts that allow fluid emission (from the paraurethral glands and vulvovaginal glands), it is reasonable that Gunter (2019) refers to the vestibule as a transition zone between the vulva (external anatomy) and the vagina (internal anatomy). However, there is still one more area of female sexual pleasure to investigate.

Perineum and Anus. The external anatomy relevant to female sexual pleasure does not end at the vulva. Between vaginal opening and the anus is a smooth area of skin called the perineum (Kerner, 2010; Winston, 2010). Limited nerve endings on the surface of the skin allow this area to withstand the friction and thrusting of vaginal intercourse and the stretching of childbirth (Winston, 2010). Just under the perineum, between the vaginal canal and the anal canal, is the perineal sponge (Kerner, 2010; Winston, 2010), an area of sensitive erectile tissue (Kerner, 2010). The perineal sponge responds well to firm, rhythmic stimulation, and with high arousal, it will become firm and spongy and pleasurable to touch (Winston, 2010).

The anus is the opening to the gastrointestinal tract just before the rectum (Winston, 2010) and its stimulation can also be very pleasurable (Mintz, 2017; Winston, 2010). The inner anus is lined with nerve endings, and thus has potential for stimulation and pleasure (Winston, 2010). Some argue that the anus is part of the clitoral network, as the bulbocavernosus muscle located between the inner labia and the clitoris's vestibular bulbs is interwoven with the anus muscles (Kerner, 2010).

Internal Genital Anatomy

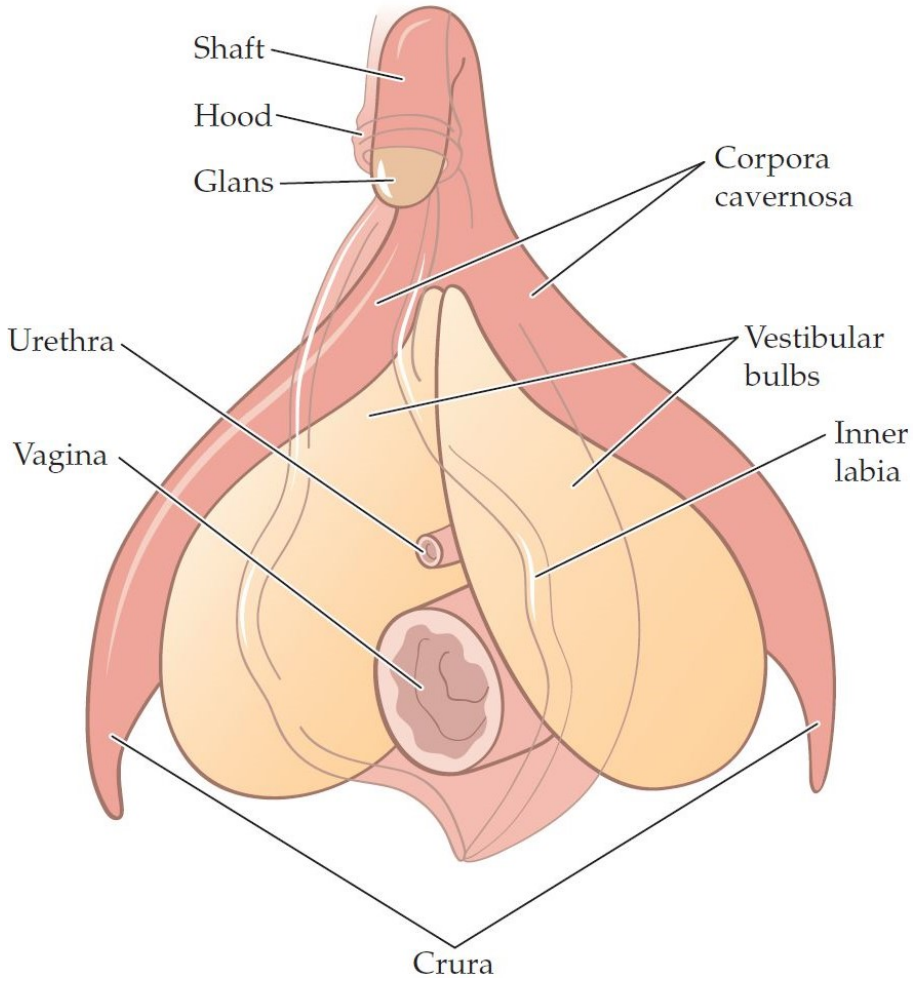
While the discussion of external anatomy ended posteriorly with the perineum and the anus, I will address internal anatomy in a similar order as external anatomy was addressed, starting with the most anterior internal genital anatomy: the internal parts of the clitoris.

Internal Clitoris. The clitoris (see Figure 2) has been described as part of a broader clitoral network with several names, such as the clitoral complex (O'Connell et al., 2008), clitoral urethral complex (Oakley et al., 2013), the clitourethrovaginal complex (Jannini et al., 2014), the clitoral network (e.g., Kerner, 2010) or, simply, the clitoris (LeVay et al., 2019), as shown in Figure 2. These broader definitions include several organs, including the clitoral glans, hood, body, crura, and some combination of the vestibular bulbs, vagina, inner labia, urethra, urethral sponge, perineal sponge, and possibly others. Adherence to or understanding of a particular model is not important for most women—only a simple understanding of the organs and their role in arousal and pleasure is needed. Thus, I will focus on the potential for tumescence and the quantity of nerve endings in the organs discussed.

The crura (or legs) of the clitoris are about five to nine centimetres long (Dodson, 2002; LeVay et al., 2019; O'Connell et al., 1998). They follow along the inner pubic bone and anchor the clitoris (Winston, 2010). In an unaroused state, the crura are generally obstructed by too much tissue to be palpable, but the top part of the crura may be palpable during high arousal (Winston, 2010).

Figure 2

Structure of the Clitoris



Note. From LeVay et al. (2019, p. 26).

Surrounded by the crura are the vestibular bulbs, also known as clitoral bulbs (Kerner, 2010). These paired organs are tear-drop shaped masses of erectile tissue that lie under the inner lips and vestibule, starting at the body of the clitoris and extending posteriorly to surround the urethra and vagina (LeVay et al., 2019; Nguyen & Duong, 2020; Winston, 2010). These structures are closely associated with the clitoris (O'Connell et al., 1998; Nguyen & Duong, 2020) and are considered internal parts of the clitoris (Kerner, 2010; LeVay et al., 2019). In fact, stimulating the clitoris stimulates the vestibular bulbs and vice

versa, which leads to arousal and engorgement (Winston, 2010). This stiffens and lengthens the vagina (LeVay et al., 2019) and creates a snug but flexible vaginal opening, allowing the vagina to accommodate a penis of almost any size (Winston, 2010). The vestibular bulbs can be stimulated through the outer lips and later through penetration (Winston, 2010). They are easily palpable when engorged, and a high level of engorgement increases the pleasure of vaginal intercourse (Winston, 2010), possibly due to the increased pressure that the bulbs exert on the body and crura of the clitoris (Nguyen & Duong, 2020).

The urethral sponge, also known as the anterior sponge, female prostate (Jannini et al., 2018; Winston, 2010) or G-spot, is a tube of spongy erectile tissue that surrounds the urethra anterior to the vagina (Winston, 2010). It is considered by some (e.g., Federation of Feminist Women's Health Centers, 1991; Kerner, 2010) to be part of the clitoral network, supporting the argument that all G-spot orgasms are, in fact, clitoral orgasms (Kerner, 2010; Mintz, 2021a). The urethral sponge is sensitive—though not as sensitive as the clitoral glans (Kerner, 2010)—and can provide pleasurable sensations with adequate arousal and engorgement (Winston, 2010). However, stimulation of the urethral sponge without arousal and engorgement will simply produce the urge to urinate (Kerner, 2010; Winston, 2010). Engorgement of the urethral sponge protects the urethra from the friction of vaginal intercourse (Kerner, 2010; Winston, 2010) and also from microbe invasion (Winston, 2010). Some (e.g., Gunter, 2019) argue that stimulating the urethral sponge is simply stimulating the clitoris through compression during penetration, but Gunter (2019) also argues that what matters is whether stimulation of the area produces pleasure.

The urethral sponge also houses the paraurethral glands (Winston, 2010), two glands at the distal end of the urethra (Di Marino & Lepidi, 2014), on either side of and opening into

the urethra (Jannini et al., 2018). The paraurethral glands (see Figure 3) are also known as Skene's glands or lesser vestibular glands (Nguyen & Duong, 2020) and are homologous to the male prostate (Nguyen & Duong, 2020). They are the source of female ejaculate, an antimicrobial liquid that may help prevent infections in the urethra (Nguyen & Duong, 2020; Winston, 2010). Female ejaculation, which usually happens during orgasm and sometimes with high arousal (Winston, 2010), is not common (Kerner, 2010) and most women who do ejaculate had to learn how to do it (Winston, 2010). Some women cannot control their ejaculation and report that it is inseparable from orgasm, while others can ejaculate voluntarily (Kerner, 2010)—some of these voluntary ejaculators do it for entertainment purposes (Dodson, 2002) and state that it does not enhance their arousal or pleasure (Dodson, 2002; Kerner, 2010). When ejaculating, women may expel small or large amounts of liquid. When small amounts of liquid are expelled, it usually comes from the paraurethral glands, but when women release a large amount of liquid, it is likely coming from the bladder (Dodson, 2002; Gunter, 2019; Kerner, 2010). However, advocates for women's sexual pleasure argue that what matters is whether it feels good, not whether or not the liquid expelled is urine (Dodson, 2002; Gunter, 2019). Further, women should not be made to feel inadequate if they cannot or do not want to ejaculate (Dodson, 2002; Gunter, 2019; Kerner, 2010).

Vagina. Posterior to the urethra and urethral sponge (Hoare & Khan, 2020; Nguyen & Duong, 2020) and anterior to the rectum (Hoare & Khan, 2020) is the vagina (see Figure 3). It is a flexible, muscular tube (Nguyen & Duong, 2020) that points down and forward and opens through the vestibule (Hoare & Khan, 2020). It is approximately six to eight centimetres in length (Hoare & Khan, 2020) and it can contract enough to be snug on a penis

or expand enough to birth a baby (Winston, 2010). Despite many diagrams showing otherwise (including the otherwise excellent figures I have chosen to depict the female genitals), the vagina is not, in fact, a gaping hole or a spacious canal—it is a collapsed tube (Winston, 2010) that expands to accommodate whatever pushes its way in or out.

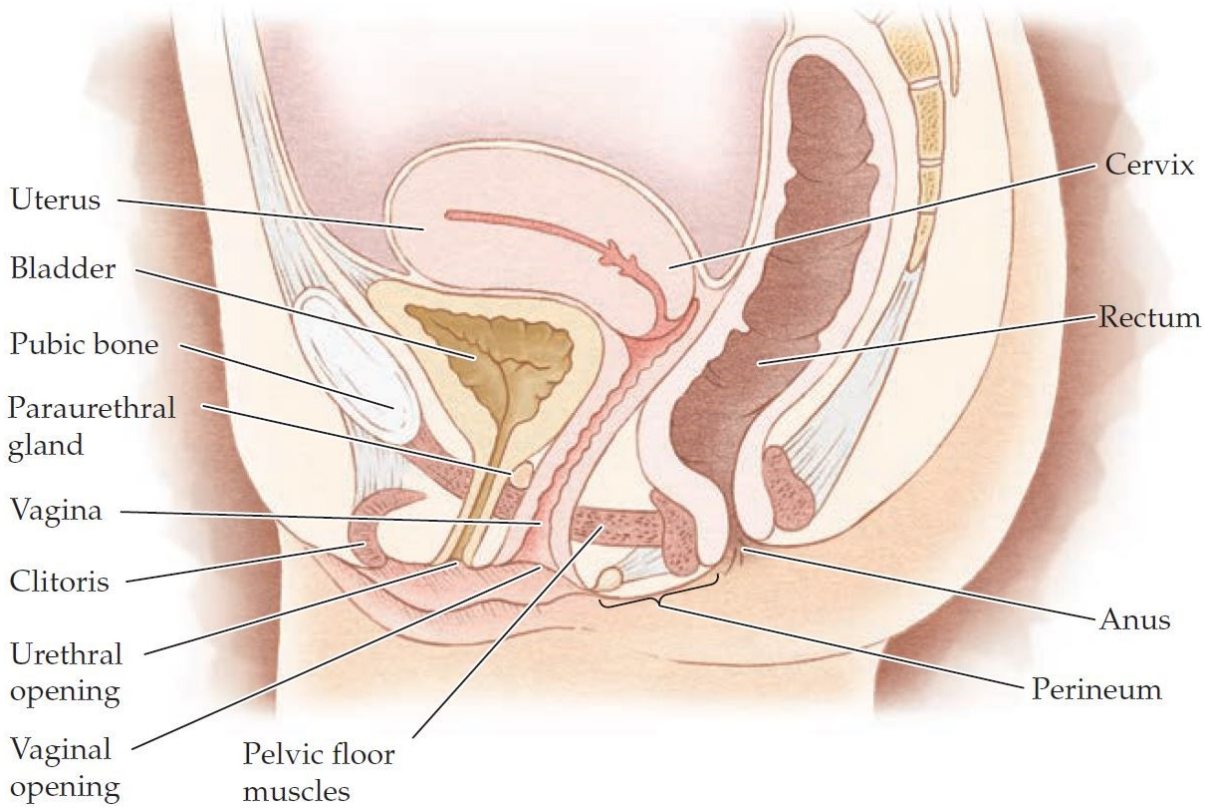
The word "vagina" comes from the Latin word for sheath, sword repository, or sword scabbard (Gunter, 2019; Kerner, 2010; O'Connell et al., 2008; Winston, 2010), thus defining the vagina in terms of its relationship to the penis and its dependency on vaginal intercourse for meaning (Kerner, 2010). As a result, some writers on women's sexuality (e.g., Winston, 2010) prefer to refer to the vagina as a "pussy" or "yoni" and many laypeople exclusively use these and many other terms to refer to the female genitals (Braun & Kitzinger, 2001). While I support women in using these terms, many of these words are anatomically ambiguous and may also refer to the vulva (Braun & Kitzinger, 2001), so I recommend using the word "vagina" when clarity is necessary, despite my aversion to its Latin meaning.

The vagina functions as a passageway for menstrual blood, semen, and babies (Nguyen & Duong, 2020; Winston, 2010), and it can also provide pleasure when properly stimulated (Winston, 2010). The pelvic nerves enter the vagina on either side of the proximal vagina, and arousal causes the uterus to lift out of the way and expose these spots, which can then be stimulated by thrusting activity, to which they respond well (Winston, 2010). That is to say, deep and repetitive thrusting may be pleasurable when highly aroused and the cervix is out of the way (Winston, 2010). If a female is not aroused enough, the uterus will not lift and deep thrusts will hit the cervix, which will likely be unpleasant or painful (Winston, 2010). The urethral sponge can also be stimulated through the anterior wall of the vagina (Kerner, 2010; Winston, 2010).

Vaginas always have some degree of natural lubrication which is increased by sexual arousal, though breastfeeding or being postpartum or postmenopausal will decrease natural lubrication and make the vagina more fragile (Winston, 2010). However, increased vaginal lubrication does not necessarily mean a female is ready for penetration, as this is an early sign of arousal (Winston, 2010). One important consideration about vaginas is that they never need washed—they are self-cleaning (Gunter, 2019; Winston, 2010). The external vulva can be washed with water only or with a gentle cleanser—not soap—but neither water nor cleanser should be used in the vagina (Gunter, 2019).

Figure 3

Sagittal View of the Internal Female Sexual Organs



Note. From LeVay et al. (2019, p. 31).

Uterus and Cervix. At the closed end of the vagina is the cervix (see Figure 3),

which separates the vagina and the uterus (Hoare & Khan, 2020; Nguyen & Duong, 2020; Winston, 2010). The uterus is a muscular (Hoare & Khan, 2020), pear-shaped (Winston, 2010) organ, with the approximate dimensions of three inches by two inches by one inch in a female who has not given birth (Hoare & Khan, 2020). One of the major supports of the uterus is the round ligament (Hoare & Khan, 2020), which connects the uterus and the inner lips (Kerner, 2010) and connects to muscles that encircle the vaginal opening (Winston, 2010). This allows the uterus to lift when a female is fertile (Winston, 2010) and also during arousal and orgasm (Gunter, 2019; Kerner, 2010; Winston, 2010), making room at the back of the vagina for sperm and protecting the cervix from a battering during penetration (Winston, 2010). Because the uterus is involved in orgasm, women who have had a hysterectomy may report that their orgasms feel different (Winston, 2010).

Muscles. In female genital anatomy, there are a number of important muscles that either form or support the perineum and the pelvic floor (Nguyen & Duong, 2020). When these muscles are too tight and/or too weak (note that the muscles be both tight and weak), a number of negative outcomes may occur, including genital pain and urinary urgency (Prendergast & Rummer, 2016). It is important to remember that tight muscles are not necessarily strong; tight muscles are simply unable to relax, while a strong muscle must be able to contract *and* relax (Jadan, 2016). Kegel exercises (contracting and relaxing the pelvic floor muscles) can create or exacerbate pain if they are performed when contraindicated, such as when the pelvic floor muscles are too tight (Prendergast & Rummer, 2016). Kegels should only be done after a qualified pelvic floor physiotherapist recommends them (Prendergast & Rummer, 2016). While these muscles are relevant to female sexual function and dysfunction, a thorough overview is not necessary for this project. For a brief review, see Stein (2009,

chapter 1) or Winston (2010, pp. 129–133), and for a more thorough review, see Prendergast and Rummer (2016). Now that I have described the anatomy involved in female sexual function and pleasure, I can describe two theories that provide a framework to understand the various ways female sexual response is influenced. Intersectional feminism considers the impacts of women's multiple identities on women and their experiences while the biopsychosocial model considers the impacts of biological, psychological, sociocultural, and interpersonal factors on female sexual response.

Theoretical Lens

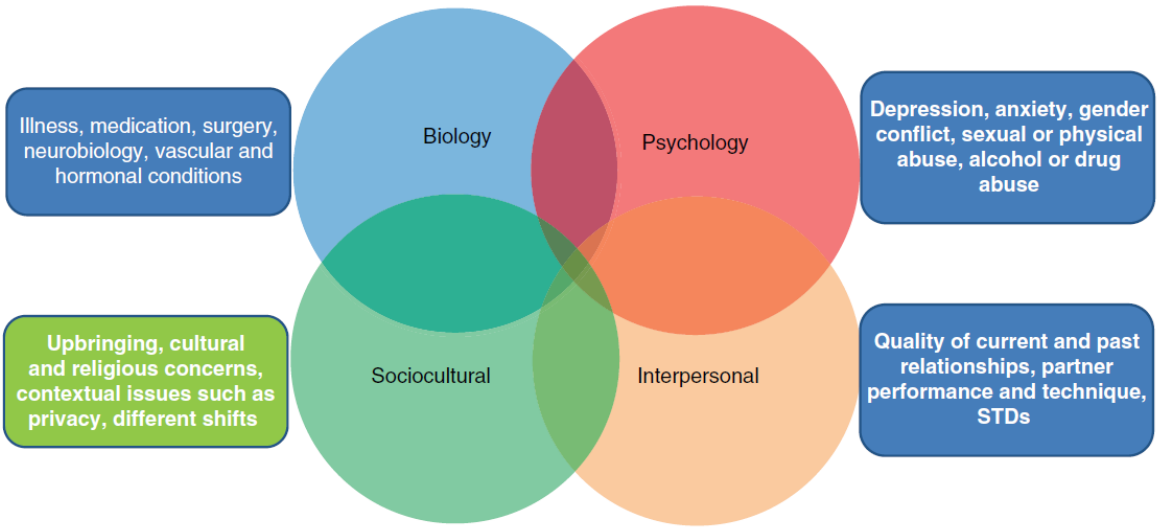
What is a theoretical lens? A theoretical lens provides direction about what topics are important, who to study, and what questions to ask, and it can provide a broad explanation for behaviours and attitudes (Creswell & Creswell, 2018). In this project, I use intersectional feminism and a biopsychosocial lens. Intersectional feminism provides a framework to understand women's sociocultural contexts and a biopsychosocial model provides a framework to understand both the factors that influence female sexual function and the various impact of FSDs.

Biopsychosocial. While Thomas and Thurston (2016) were not the first to propose a biopsychosocial model of sexual function (e.g., Althof et al., 2005; Rosen & Barsky, 2006), they applied the biopsychosocial model to female sexual function and dysfunction. This model also takes a holistic approach to women's sexuality and considers the influences of biological, psychological, sociocultural, and interpersonal factors on female sexual function (see Figure 4). Women's sexual functioning complaints have historically been blamed on psychological factors (Parish et al., 2016), but biological factors (e.g., hormone imbalances), sociocultural factors (e.g., cultural norms) and interpersonal factors (e.g., current and past

relationships) can also exert a strong influence on sexual functioning (Kingsberg & Althof, 2018; Thomas & Thurston, 2016).

Figure 4

Biopsychosocial Model of Sexual Response



Note. From Kingsberg and Althof (2018, p. 54).

The biopsychosocial model is compatible with Basson's (2000, 2001, 2005) and Bancroft's (2009) model; however, the relevance of the biopsychosocial model should also be considered in the reverse direction: women's sexual functioning also has an impact *on* biopsychosocial factors (Kingsberg & Rezaee, 2013). That is to say, a FSD has many causes, but it can also cause problems for a woman's psychological well-being, physical health, romantic/sexual relationships (Aslan & Fynes, 2008; Thomas & Thurston, 2016), overall quality of life (Aslan & Fynes, 2008), and even her partner's sexual functioning (Aslan & Fynes, 2008; Balon, 2017). FSD can also have an economic impact through the healthcare costs of managing FSD (Goldmeier et al., 2004; Jackowich, Boyer, et al., 2021; The SexMed Advocate, 2021; Xie et al., 2012) and a social impact through domestic violence, increased divorce rates, and single parent families (Aslan & Fynes, 2008). A biopsychosocial lens is

useful for conceptualizing both the risk factors and impacts of FSD.

Intersectional Feminism feminism considers the impact of women's overlapping identities, including (but not limited to) sex, gender, race, ethnicity, religion, sexual orientation, and socioecomonic status. These identities are considered to varying degrees in the DCM/STP model (Bancroft et al., 2009; Perelman, 2009), Basson's circular model (Basson, 2000, 2001, 2005), and the biopsychosocial model of sexual response (Thomas & Thurston, 2016), and these identities may impact a woman's sexual functioning (e.g., religion), help-seeking behaviours (e.g., cultural or socioeconomic status), and help-seeking experiences (e.g., institutional racism). Some may erroneously interpret this as blaming women and women's intersecting identities for their problems, arguing that women's bodies are inherently dysfunctional, that White people are inherently healthier, or that middle- and upper-class people are smarter and better at taking care of their health. However, these identities are only salient because of the structures that privilege them (Williams, 2020). The patriarchy privileges male bodies and men's views, racism privileges White people, and classism privileges the middle and upper class. Make no mistake: I am blaming women's problems on these structures.

Women's sexuality has long been regarded as more "complicated" or "mysterious" than men's sexuality, as evidenced by recent journalism or TEDx Talk titles arguing for and against the phenomenon, such as *The enduring enigma of female sexual desire* (Nuwer, 2016), *The enduring myth of 'complicated' female sexuality* (Volpe, 2019), or *Women's sexuality isn't 'complicated'* (TEDx Talks, 2016b). I believe that women's sexuality is no more complicated than men's sexuality but that it is simply not be the *same* as men's sexuality. That is to say, intercourse is an excellent source of stimulation for penises, but it is

inherently inadequate in stimulating the clitoris, which is the homologous organ of the penis in women. And yet, Western society has called women "frigid" and "complicated" for not having orgasms from vaginal intercourse. Further, Western society is still working at gender equality when it comes to both documentation of women's lives and research on women's bodies. "While many thousands of men's lives have been recognized and recorded for centuries and across cultures, women's life stories have been documented far less often, even forgotten" (Brooks, 2007, p. 55). Historically, women have been inappropriately excluded from some research, delaying the advancement of knowledge, denying potential benefits to women, and even harming women (Matlin, 2012; Tri-Council, 2014). Attempts to rectify the inappropriate exclusion of women have resulted in women instead being harmed by male bias in medical research (Jackson, 2019). The phenomenon of gender inequality impacting women's sexuality will be addressed at length in the upcoming sections.

Women's sexuality does not exist in a vacuum—biological, psychological, sociocultural, and interpersonal factors influence female sexual function. Looking at women's lived experiences through the lens of intersectional feminism allows us to understand the impacts of women's intersecting identities on their lived experiences of sexual dysfunction and help-seeking. The biopsychosocial model provides a framework to understand the impacts of various factors on female sexual function and the impacts of FSD on women, their relationships, and their partners. As I explain a brief history of sexual response models in the next section, the relevance of the biopsychosocial model to FSD will become even more apparent.

Models of Female Sexual Response

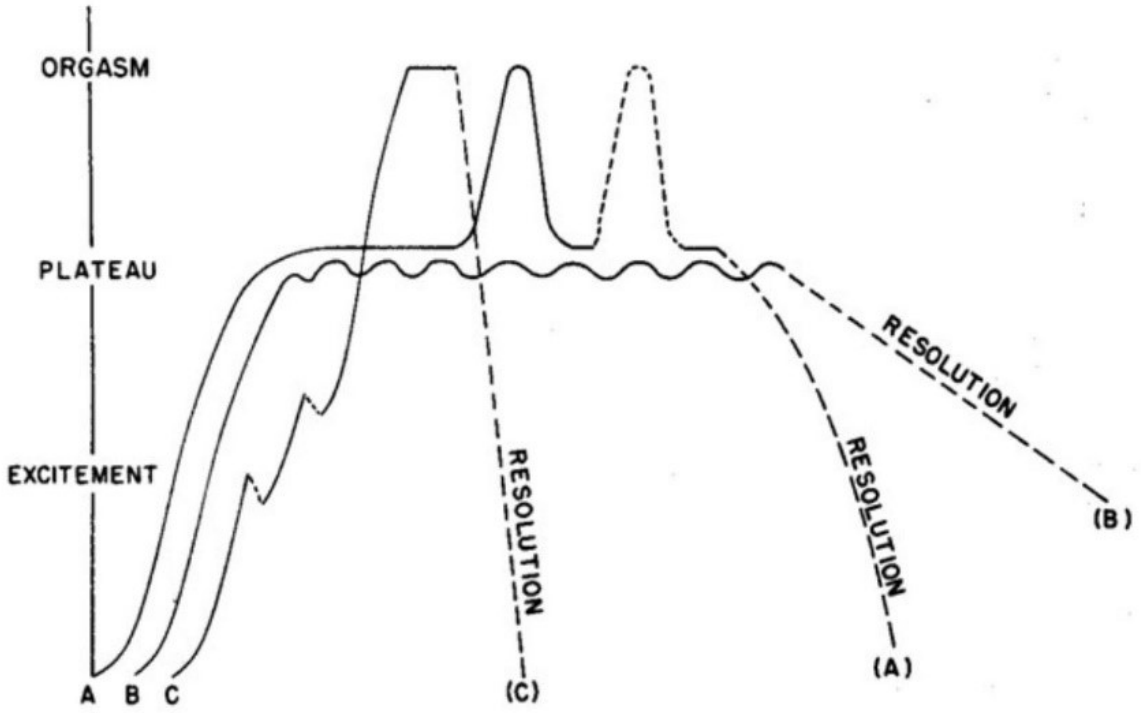
Sexual response models have been proposed by several sex researchers and have

evolved significantly over time. The first sexual response models were linear while recent models of sexual response involve a holistic approach to sexuality, similar to the biopsychosocial model of sexual response I will discuss later (Thomas & Thurston, 2016). All of these sexual response models have influenced the current FSD nomenclature and classifications (Parish et al., 2020).

Linear Models of Female Sexual Response. The traditional, linear sexual response model was created by William Masters and Virginia Johnson (1966, 1970), who conducted a study in which they observed the physiological responses of women and men during sexual activity in a laboratory. From these observations, they created the first model for human sexual response. The four-phase sexual response model described in their research includes excitement, plateau, orgasm, and resolution (see Figure 5). They described how physical or psychological stimulation leads to excitement, and the adequacy of stimulation directly impacts the intensity of sexual response and the length of the excitement stage. During the plateau phase, sexual tension is increased; however, if stimulation or sexual drive are inadequate or if stimulation ceases, a person will not achieve orgasm and will instead experience a lengthy resolution phase. They found that, with adequate stimulation, orgasm occurs as a brief (a few seconds), involuntary climax, though female orgasms vary in intensity and duration more than male orgasms. Figure 5 depicts the three most common variations on the female sexual response model, including the potential for one orgasm (line C), no orgasm (line B), or multiple orgasms (line A; Masters & Johnson, 1966, 1970).

Figure 5

The Female Sexual Response Model as Described by Masters and Johnson



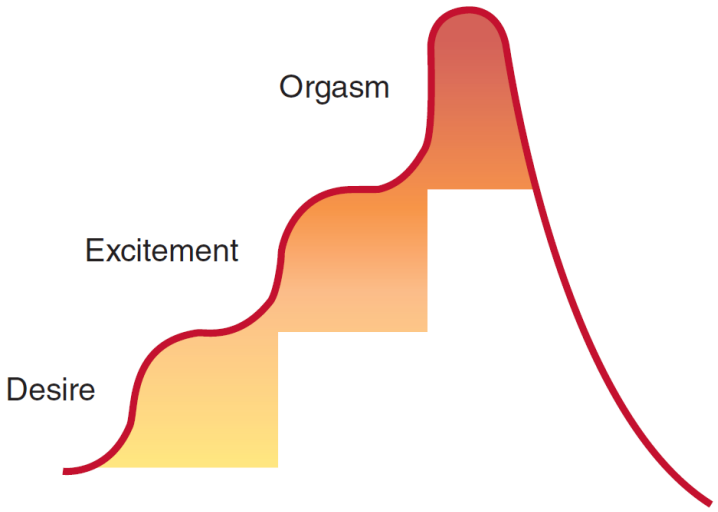
Note. From Masters and Johnson (1966, p. 5).

Kaplan (1979) refined the sexual response model of Masters and Johnson by adding desire, omitting plateau and resolution, keeping excitement and orgasm (see Figure 6). The desire stage of Kaplan's model does not have a corresponding stage in the Masters and Johnson model, though Nagoski (2015) suggested that this may be because the experiments of Masters and Johnson only sought to study arousal and orgasm—not desire—and that desire is not necessary for arousal. Kaplan described sexual desire as an appetite or drive initiated in the brain. The arousal stage, defined in females by swelling and lubrication of the genitals, corresponds with the excitement and plateau stages of the Masters and Johnson model. Stimulation of the clitoris produces orgasm, involuntary contractions of "certain genital muscles" (Kaplan, 1979, p. 19). The resolution stage was omitted because it may be

considered merely the absence of sexual arousal.

Figure 6

Kaplan's (1979) Three-Stage Model of Sexual Response



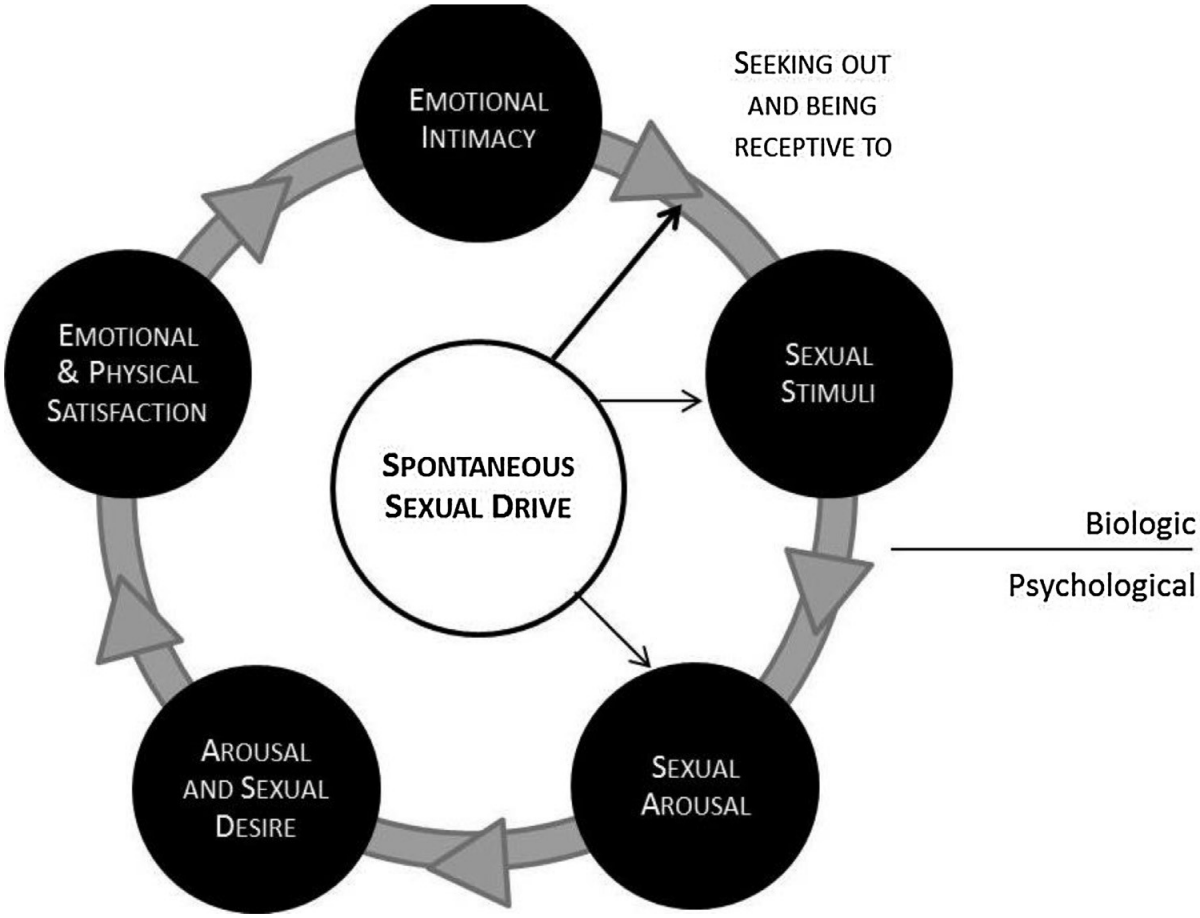
Note. From Crooks and Baur (2011b, p. 164).

The sexual response models proposed by Masters and Johnson (1966, 1970) and Kaplan (1979) are referred to as "linear" models because they assume that sexual response is initiated by spontaneous sexual desire and progresses from one phase to the next (Parish et al., 2020). The Masters and Johnson model has been criticized for being too linear and using men's sexuality as a basis (Basson, 2008) and also for basing their model on a small subset of women (Basson, 2000), as Masters and Johnson only studied women who were willing to be observed in a laboratory setting and who could achieve orgasm from vaginal intercourse. Kaplan's model has been criticized for inadequately reflecting women's real sexual experiences (Basson, 2000). That is to say, women in new relationships often endorse these linear models more than women in long-term relationships do, as women in new relationships tend to experience sexual response in this linear way, beginning with spontaneous desire.

Circular Incentive-Based Model of Female Sexual Response. Basson (2000) proposed and refined (2001, 2005) a new model of female sexual functioning which is more circular. This model considers factors of women's sexual satisfaction that have been previously ignored, including "trust, intimacy, the ability to be vulnerable, respect, communication, affection, and pleasure from sensual touching" (Basson, 2000, p. 52). Unlike the traditional sexual response models which only allow for spontaneous sexual desire, Basson's model argues that desire can also occur *in response* to sexual stimuli; thus, sexual response actually begins with seeking out or being willing to become receptive to sexual activity (Basson, 2000, 2001, 2005). Her motivations for engaging in sexual activity may include expressing love to her partner, sharing physical pleasure, experiencing emotional closeness, making her partner happy, or increasing her own well-being. The woman is then willing to find and attend to sexual stimuli. Her mind processes these stimuli, which are influenced by biological and psychological factors, leading her to a state of subjective sexual arousal (i.e., she perceives that she is sexually aroused). If sexual stimulation continues, sexual excitement and arousal will increase, leading to *responsive sexual desire*. If stimulation is adequate and the woman continues to enjoy it, she will experience sexual satisfaction, regardless of the occurrence of orgasm. Basson's (2000, 2001, 2005) circular model is depicted in Figure 7 and depicts how desire can first occur at various points in the sexual response cycle: while seeking out or being receptive to sexual stimuli, while experiencing sexual stimuli, or while experiencing sexual arousal.

Figure 7

An Adaptation of Basson's Model of Female Sexual Response



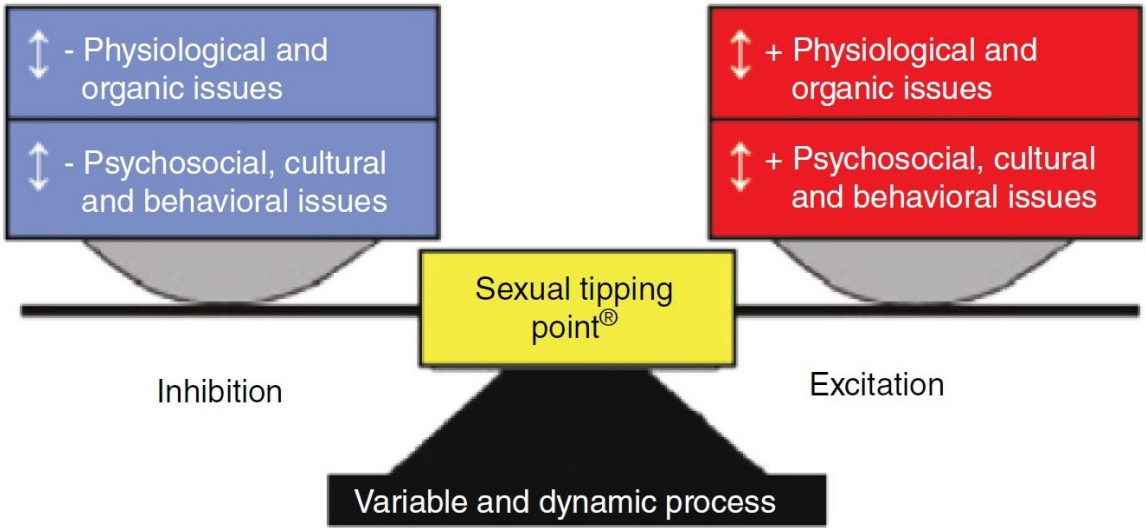
Note. Thomas and Thurston (2016, p. 51).

Sexual response models help people to understand whether they are normal and whether they need help. A model that represents both functional and dysfunctional women has not yet been identified (Giles & McCabe, 2009; Sand & Fisher, 2007); however, women with sexual dysfunctions identify more strongly with Basson's model than with the Masters and Johnson or Kaplan models (DeRogatis et al., 2016; Giles & McCabe, 2009; Sand & Fisher, 2007). It is for this reason that this project incorporates Basson's model of sexual response. However, there is another relevant sexual response model that will also be used.

Dual Control Model and Sexual Tipping Point. Another important sexual response models is Bancroft's (1999) Dual Control Model (DCM) of male sexual response, adapted for female sexual response by Carpenter et al. (2008), and Perelman's (2009) Sexual Tipping Point (STP) model, shown in Figure 8. According to the DCM/STP model, a person's sexual response is controlled by a balance between excitatory and inhibitory influences unique to that person (Bancroft et al., 2009; Perelman, 2009). These influences can be physiological, organic, psychosocial, cultural, and behavioural (Perelman, 2009; Pfaus, 2009). Low excitation and high inhibition are salient to FSD and can be understood using a driving analogy: high inhibition is like sticky or sensitive brakes while low excitation is like having no fuel (Lorenz & Finley, 2020) or an insensitive gas pedal. For example, if a woman has high excitation factors (e.g., a trusting relationship, erotic cues) but higher inhibition factors (e.g., a long list of chores, side effects from medications), then the net sum is sexual inhibition—inhibition of her desire, her arousal, and/or her orgasm. In this instance, there is nothing wrong with her excitation—the problem is that she has too many inhibiting factors. People with unsatisfactory desire, arousal, and orgasm often try to fix these problems by increasing excitation factors (e.g., bringing in sex toys, taking pharmaceuticals, trying out swinging) but these efforts may be fruitless if the inhibition factors (e.g., fatigue, relationship distrust, body image issues) are too influential (Nagoski, 2015). Alternatively, low excitation (e.g., a woman who requires significant stimulation) combined with lower inhibition (e.g., minimal inhibitors) still results in a net sum of sexual excitation.

Figure 8

Sexual Tipping Point Model of Sexual Excitation and Inhibition



Note. From Pfaus and Jones (2018, p. 27).

This balancing model of sexual response focuses on factors that promote and inhibit sexual response, and not on stages of sexual response (Hayes, 2011); as such, it is not incompatible with the linear or circular models—it merely looks at sexual response from a different angle and can function in tandem with the other models. The DCM/STP model (Bancroft et al., 2009; Perelman, 2009) is useful for conceptualizing the various factors that influence desire, arousal, and orgasm and finding corresponding therapeutic interventions (Parish et al., 2020). Examining inhibitory factors through a feminist lens may be particularly useful, as many inhibitory factors are foundational to feminism, such as unequal division of labour, gendered labour, emotional labour (Hamilton, 2021; Mind Body Training Institute & Buehler, 2021), the wage gap, and the orgasm gap.

Because much of the literature on sexual function and dysfunction is based on the models of Masters and Johnson (1966, 1970) and Kaplan (1979), the linear models cannot be

ignored. However, given that high inhibition and low excitation are the very etiologies (e.g., low testosterone) and target interventions (e.g., relationship therapy) of FSD, and that women with FSD identify more strongly with Basson's circular model than with the linear sexual response models (DeRogatis et al., 2016; Giles & McCabe, 2009; Sand & Fisher, 2007), it is also important to understand both the DCM/STP model (Bancroft et al., 2009; Perelman, 2009) and Basson's (2000, 2001, 2005) circular model of sexual response. These models of female sexual response provide the foundation to discuss the next topics, healthy sexual functioning and FSDs.

Healthy Sexual Functioning in Women

The WHO (2006) defines *sexual health* holistically as "a state of physical, emotional, mental and social well-being in relation to sexuality; it is not merely the absence of disease, dysfunction or infirmity" (p. 5). What does that look like specifically? While Masters and Johnson (1966, 1970) and Kaplan (1979) proposed the first models of sexual response, which were linear, Basson's (2000, 2001, 2005) circular model considers factors of female sexual satisfaction that have been previously ignored, normalizes desire that only occurs in response to sexual stimuli and/or arousal, and empowers women to declare their sexual satisfaction irrespective of orgasm. This may be why women with sexual dysfunctions identify more strongly with Basson's (2000, 2005) model than with the linear models (DeRogatis et al., 2016; Giles & McCabe, 2009; Sand & Fisher, 2007). Thus, I will examine sexual health in terms of the stages of Basson's (Basson, 2000, 2001, 2005) circular model of sexual response: willingness, desire, arousal, orgasm, pleasure, and sexual satisfaction.

Willingness and Consent

Willingness to be sexual is the first stage of Basson's (2000, 2001, 2005) sexual

response model and refers to "a willingness to find and consciously focus on sexual stimuli" (2005, p. 1328). This willingness is related to sexual consent, which is the freely given agreement to sexual activity (Planned Parenthood, n.d.; Rape Abuse and Incest National Network, n.d.; Sex and U, n.d.). Willingness is openness to sexual activity, while consent is the agreement to sexual activity. Even without experiencing spontaneous sexual desire, a woman can engage in a healthy sexual interaction if she is open to the sexual encounter and consents to it. She may be willing to engage in sexual behaviour because she expects to experience responsive sexual desire once the sexual encounter is underway, or she may have other motivations, such as expressing love, sharing in physical pleasure, increasing her well-being, or pleasing her partner (Basson, 2000, 2001, 2005).

While some women have experienced arousal and orgasm during rape and sexual assault, this is because the body was designed to respond this way to sexual stimulation and not because they secretly desired rape (Levin & van Berlo, 2004). There is no physical, emotional, mental, or social well-being in relation to sexuality within rape and sexual assault, and thus, consent is crucial to sexual health and healthy sexual functioning, even in consensual non-consent ("rape roleplay").

Desire and Arousal

While many women conflate desire and arousal (Brotto et al., 2009; Graham et al., 2004; Laan & Both, 2008) and even the *DSM-5* (American Psychiatric Association, 2013) combined desire and arousal disorders into one diagnosis (female sexual interest/arousal disorder), desire and arousal are in fact distinct experiences that do not always happen together. Desire is an "anticipatory motivational state" (Parish et al., 2016, p. 1890), which means that sexual desire can be a desire for the rewards of sexual activity (e.g., physical

pleasure, emotional intimacy, or other rewards); however, if these rewards diminish, then sexual desire may also diminish (Perelman, 2009; Pfaus et al., 2012). It is often challenging to discern normal sexual desire from abnormal sexual desire because sexual desire can be described in many ways (Parish et al., 2016).

When desire occurs spontaneously, it is referred to as spontaneous sexual desire (Basson, 2000). Nagoski (2015) estimates that about 15% of women experience spontaneous sexual desire. While desire may precede sexual activity in newer relationships (Dennerstein et al., 2001), Basson (2008) argued that it is also normal for desire to occur *after* sexual activity begins, particularly in long-term relationships (Basson, 2000). This is known as responsive sexual desire. The implication is that spontaneous sexual desire is not a prerequisite for healthy sexuality (Nagoski, 2015), but that it is also normal for sexual desire to develop only after seeking out stimuli or becoming sexually aroused.

Sexual arousal occurs after desire in Kaplan's (1979) model of sexual response, but arousal can occur before or after desire in Basson's (2000, 2001, 2005) model. Many researchers (e.g., Levin & van Berlo, 2004; Meston & Stanton, 2019) distinguish between subjective sexual arousal and genital arousal. Subjective sexual arousal refers to mental engagement and focus on sexual stimuli while genital arousal refers to the body's physical changes in response to sexual stimulation (Meston & Stanton, 2019). These two types of arousal do not necessarily occur synchronously (Meston & Stanton, 2019). Genital arousal in women can be gauged by genital swelling, vaginal lubrication, and clitoral engorgement (Meston & Stanton, 2019), though women are not necessarily always subjectively aware of their body's physiological arousal (Basson, 2000; Chivers et al., 2010).

A woman's genital lubrication and engorgement may not be noticeable to her for

several reasons: her genitals are caudally located and thus somewhat hidden from her own view, she may not notice the sensation of genital lubrication, clitoral and labial engorgement are generally not visible when wearing clothing, and most of the female sexual anatomy structures that engorge (e.g., vestibular bulbs; see earlier Figure 2) are internal structures and therefore engorge *inside* a woman's body (Puppo, 2013; Winston, 2010).

Orgasm

Orgasm is the sensation of intense pleasure induced by erotic stimulation (Meston et al., 2004). In Basson's (2000, 2001, 2005) circular model of sexual response, orgasm is an optional aspect of the sexual satisfaction stage. Neither of the linear models account for sexual satisfaction, though orgasm is also optional in the sexual response model of Masters and Johnson (1966, 1970) while it appears to be mandatory in Kaplan's (1979) model.

Different women require and prefer different kinds of stimulation for orgasm to occur (Herbenick et al., 2018; Masters & Johnson, 1966; Meston et al., 2004). Some women experience multiple orgasms while others cannot, prefer not to, or have not been properly stimulated to experience them (Crooks & Baur, 2011b). However, while orgasm is often considered the pinnacle of sexual activity in Western society, orgasm is not a requirement for sexual satisfaction (Tiefer, 2002) or healthy sexual functioning. Healthy sexual functioning involves the ability to participate in sexual activity in the ways in which one desires (WHO, 1992), so if a woman does not desire orgasm, then not achieving orgasm is not a problem. Additionally, personal distress is a required symptom for diagnosis of any sexual dysfunction by the *DSM-5* (American Psychiatric Association, 2013), so a woman who is not bothered by being anorgasmic could not be diagnosed with a sexual dysfunction. However, few women say that their orgasms are unimportant or that they would enjoy sex just as much without

them, and many women feel cheated, angry, resentful, and frustrated if they do not have an orgasm while their male partner does (Hite, 2004). Women who orgasm more easily during partnered sex are more likely to view orgasm as important (Laan & Rellini, 2011), suggesting that women may diminish the importance of their orgasm if they do not achieve it easily. Women's supposedly "complicated" sexuality and the ostensible elusiveness of female orgasm has likely led both women and men to assume that women value their orgasms less than they really do.

Pleasure and Sexual Satisfaction

Healthy sexual functioning involves pleasurable and safe sexual experiences (WHO, 2006). Touching and stimulating the genitals (externally or internally) should produce pleasure and should not be painful. Sexual stimulation does not ever need to involve vaginal penetration; however, inserting a finger, penis, or tampon into the vagina should not cause a woman pain (Albaugh, 2014). Comfortable sexual penetration is facilitated by increases in vaginal moisture and elasticity (Albaugh, 2014); however, artificial lubricants are often incorporated when a woman's body does not produce lubrication as quickly or abundantly as she would like.

Sexual pleasure comes from participation in sexual activities that women actually desire and that lead to arousal and/or orgasm. The coital imperative promotes the idea that women should be having and enjoying vaginal intercourse (Gavey et al., 1999; Jackson, 1984; McPhillips et al., 2001)—and many women do have and enjoy vaginal intercourse. However, vaginal intercourse alone is not what leads most women to orgasm (Hite, 2004; Lloyd, 2005; Marcus, 2011; Mintz, 2017; Nagoski, 2015), and research by Hurlbert, Apt, et al. (1993) suggests that so-called "foreplay," not vaginal intercourse, is what gives most

women the most sexual satisfaction. Of course, a partner's sexual knowledge and sexual skills are relevant to a woman's ability to experience pleasure with her partner, as a woman may be completely sexually functional and yet be sexually unresponsive during partnered sex due to her partner touching her in ways that differ from how she experiences pleasure. It should go without saying that communicating her sexual preferences to a partner who integrates this information into their sexual practices will likely alleviate this issue.

Sexual satisfaction is the last stage of Basson's (2000, 2001, 2005) sexual response cycle and refers to a woman's subjective evaluation of her sexual experience (Lawrance & Byers, 1995; Rehman et al., 2013). Sexual satisfaction is considered a sexual right (WHO & UNFPA, 2010), though the importance of orgasm to sexual satisfaction varies between women (APA, 2013). While some studies have demonstrated that orgasm is not required for sexual satisfaction (e.g., Hite, 2004; Wallin, 1960; Waterman & Chiauzzi, 1982), other studies have found that orgasm is in fact important for women's sexual satisfaction (e.g., Fugl-Meyer et al., 2006; Kelly et al., 2004; Sigusch & Schmidt, 1971) and that greater sexual satisfaction is correlated with more frequent orgasm (Haavio-Mannila & Kontula, 1997; Hurlbert, Apt, et al., 1993; Hurlbert, White, et al., 1993). While women can experience sexual satisfaction with or without orgasm, it is up to each individual woman to decide for herself whether she is sexually satisfied.

Healthy sexual functioning in women involves consent, desire (including responsive desire), arousal after adequate and desired stimulation, the ability to orgasm if desired, pleasure, sexual satisfaction, and the absence of pain. It should be noted that fluctuations in the intensity and frequency of desire, arousal, and orgasm are normal, but sex (including masturbation and oral sex) should never hurt. What does it look like when something goes

wrong with a women's sexual function?

Female Sexual Dysfunctions and Disorders

Women can experience functional issues or pain with any stage of sexual response. Discussion around female sexual function problems are usually centred around issues with desire, arousal, orgasm, and pain, but it should be noted that these aspects of sexual experience are not distinct and can be influenced by a woman's personal biology, sociology, or culture (Parish et al., 2020), hence my endorsement of Basson's (2000, 2001, 2005) and the balancing scale (Bancroft et al., 2009; Perelman, 2009) models of sexual response, as well as the biopsychosocial model.

The American Psychiatric Association (2013) defined sexual dysfunctions as "disorders that are typically characterized by a clinically significant disturbance in a person's ability to respond sexually or experience sexual pleasure" (para. 1) and the WHO (2018) defined sexual dysfunctions similarly. However, the definitions of specific sexual dysfunctions vary depending on the organization doing the defining. The *DSM*, which mainly defines psychiatric conditions, and the *ICD*, which mainly defines medical conditions, are the two internationally accepted health classification systems (McCabe et al., 2016). The focus of each system (psychiatric versus medical) inherently biases its definitions (McCabe et al., 2016). However, teams of sexual medicine experts from various professional organizations, such as the ISSWSH and the ICSM, have recently formed consensus panels to use current scientific evidence revise and redefine FSDs (Parish et al., 2020). After a brief discussion of FSDs in the *DSM* and the *ICD*, I will discuss the FSDs defined by these sexual medicine experts.

Several decades ago, experts believed that sexual dysfunctions were caused by

psychological factors, so mental health providers interested in sexual dysfunctions took it upon themselves to create such definitions (Parish et al., 2016). The *DSM* was created to classify mental disorders (Parish et al., 2020), so organically-caused FSDs are inherently inappropriate for inclusion. FSDs, specifically female sexual desire and arousal disorders, first appeared in the *DSM-III* (American Psychiatric Association, 1980). These FSD definitions were revised as new editions of the *DSM* were published (*DSM-III-R* in 1987, *DSM-IV* in 1994, and *DSM-IV-TR* in 2000). FSDs in the *DSM-5* diverge conceptually from the previous editions of the *DSM*; specifically, desire and arousal disorders were merged into one disorder and dyspareunia and vaginismus were merged into one disorder. These decisions were made without evidence and have been heavily criticized (Balon & Clayton, 2014; Brotto, 2010; Parish et al., 2020).

Although healthcare professionals and sexual medicine experts have recognized the *DSM* (*DSM-III* through *DSM-5*) as the accepted system for classification and diagnosis of FSD (DeRogatis et al., 2016), concerns have been raised over whether the *DSM-5* adequately reflects the diversity of women's actual experiences of sexual dysfunction (Clayton et al., 2010; DeRogatis et al., 2010; DeRogatis et al., 2011). That the *DSM-5* is a diagnostic system for psychiatric disorders suggests that the manual is inherently incapable of encompassing the full breadth of FSDs. However, the *DSM-5* has also failed to include several "distressing sexual conditions experienced by women," including persistent genital arousal disorder (PGAD), female orgasmic illness (FOIS), and pleasure dissociative orgasm disorder (PDOD; Parish et al., 2016).

The *International Statistical Classification of Diseases and Related Health Problems* (*ICD*), maintained by the World Health Organization (WHO), is the international standard

system for defining, classifying, and diagnosing health conditions (WHO, n.d.-a). Unlike the *DSM*, the *ICD* focuses on medical conditions (McCabe et al., 2016) and was originally created to classify causes of death (Moriyama et al., 2011). While sexual medicine societies have contributed expertise to the new *ICD-11* (Parish et al., 2020), a thorough discussion of *ICD-11* FSD definitions will be foregone in favour of those created by sexual medicine expert consensus panels.

FSD Classifications and Definitions by Sexual Medicine Expert Consensus Panels

The ISSWSH challenged the appropriateness of the *DSM-5*'s FSD definitions (DeRogatis et al., 2016) and developed a unified set of definitions of various FSDs (Parish et al., 2016). This list includes a desire disorder, arousal disorders, orgasm disorders, and pain disorders (Parish et al., 2016; Parish, Meston, et al., 2019).

Desire Disorders. The ISSWSH only defines one desire disorder, hyposexual desire disorder (HSDD). Although desire and arousal disorders have been combined in the *DSM-5* (e.g., female sexual interest/arousal disorder [FSIAD]), desire and arousal disorders are distinct and should not be merged (Clayton et al., 2010; DeRogatis et al., 2010; DeRogatis et al., 2011). The ISSWSH's proposed definition of HSDD involves

> any of the following symptoms for a minimum of six months: Lack of motivation for sexual activity as manifested by decreased or absent spontaneous desire (sexual thoughts or fantasies); or decreased or absent responsive desire to erotic cues and stimulation or inability to maintain desire or interest through sexual activity; Loss of desire to initiate or participate in sexual activity, including behavioral responses such as avoidance of situations that could lead to sexual activity, that is not secondary to sexual pain disorders; And is combined with clinically significant personal distress

that includes frustration, grief, guilt, incompetence, loss, sadness, sorrow, or worry. (Parish et al., 2016, p. 1892)

The symptoms should be rated as *mild*, *moderate,* or *severe*, and can be classified as *acquired* (e.g., first occurring after an event, such as surgery) versus *lifelong* (i.e., the woman has always had the condition) and *generalized* (i.e., occurring in all sexual situations) versus *situational* (e.g., only with a partner, a specific partner, or a certain activity).

Arousal Disorders. The ISSWSH identified two types of female sexual arousal disorders (FSADs): female genital arousal disorder (FGAD) and female cognitive arousal disorder (FCAD). I have included persistent genital arousal disorder/genito-pelvic dysesthesia (PGAD/GPD) in this section, though it could also fit under pain disorders or orgasm disorders, depending on the individual's specific symptoms.

Female Genital Arousal Disorder (FGAD). FGAD is the difficulty or inability to achieve or sustain sufficient genital response (e.g., lubrication and engorgement) and sensitivity of the genitalia while engaged in sexual activity (Parish, Meston, et al., 2019). These symptoms must cause distress and last for at least six months (Parish, Meston, et al., 2019). FGAD is usually acquired and generalized (Parish et al., 2016; Parish, Meston, et al., 2019). Diagnosis of FGAD is performed mainly by history and physical examination and should not be diagnosed in women whose insufficient genital arousal is due to insufficient stimulation (Parish et al., 2016). Other conditions (e.g., vulvovaginal atrophy, vulovaginal infection or inflammation, inflammatory disorders of the vulva or vagina, vestibulodynia, and clitorodynia) should be ruled out before an FGAD diagnosis can be made (Parish et al., 2016).

Female Cognitive Arousal Disorder (FCAD). FCAD is the cognitive counterpart of

FGAD, characterized by difficulty or inability to achieve or sustain sufficient mental arousal or engagement with sexual activity (Parish, Meston, et al., 2019). These symptoms must cause distress and last for at least six months (Parish, Meston, et al., 2019). The symptoms should be rated as *mild*, *moderate*, or *severe*, and can be classified as *acquired* versus *lifelong* and *generalized* versus *situational* (Parish et al., 2016). Women may experience FGAD and FCAD independently or concurrently (Parish, Meston, et al., 2019).

Persistent Genital Arousal Disorder/Genito-Pelvic Dysesthesia (PGAD/GPD). PGAD/GPD is completely different from the two FSADs and was not included in the *DSM-IV-TR* or the *DSM-5*. PGAD/GPD is characterized by unwanted or intrusive, distressing, and recurrent or persistent sensations of genital arousal or genital dysesthesia, unaccompanied by sexual interest or thoughts, for a minimum of three months (Parish et al., 2016; Parish, Hahn, et al., 2019). It can be classified as *lifelong* versus *acquired* and *generalized* versus *situational*. Sexual activity and/or orgasm produce limited resolution, no resolution, or even aggravation of symptoms. Orgasm may be aversive or compromised, and orgasm frequency, intensity, timing, and/or pleasure may be impaired (Parish et al., 2016). Women with PGAD/GPD may experience psychological distress, including despair and suicidality (Parish et al., 2016). Certain circumstances (e.g., sitting, stress, nervousness) may increase genital symptoms, though physical examination during symptoms demonstrates that physical lubrication and engorgement of the genitals is inconsistently noted (Parish et al., 2016). More research is needed on this condition (Parish et al., 2016).

Orgasm Disorders. The ISSWSH identified two orgasm disorders: female orgasm disorder (FOD) and female orgasmic illness syndrome (FOIS). PGAD/GPD could also be considered an orgasm disorder, given that some people with this condition experience

unwanted orgasms.

Female Orgasm Disorder (FOD). FOD describes a variety of female orgasm issues. With FOD, orgasms occur less frequently or not at all (anorgasmia), less intensely, too late or too early than the woman desires, or with absent or decreased pleasure (pleasure dissociative orgasm disorder [PDOD]; Parish et al., 2016). FOD is classified as *lifelong* versus *acquired* and *generalized* versus *situational* (Parish et al., 2016). A woman who can achieve orgasm with clitoral stimulation but not through vaginal penetration alone should not be diagnosed with FOD (Parish et al., 2016).

Female Orgasmic Illness Syndrome (FOIS). FOIS is characterized by aversive symptoms that occur before, during, or after orgasm. These symptoms are not necessarily related to altered quality of orgasm (Rasmussen & Olesen, 1992). A few examples of these aversive symptoms are disorientation, seizures (orgasmic epilepsy), chills, and genital pain. Women with FOIS experience very different sets of symptoms, which may last for minutes, hours, or days after orgasm (Parish et al., 2016). It should be noted that, due to a lack of research, the definitions of PGAD, PDOD, and FOIS were based on the opinions of a consensus panel with expertise on female sexual function and dysfunction, including psychiatrists, psychologists, healthcare providers in various specialties including gynecology and sexual medicine, basic scientists, and one sexuality educator (Parish et al., 2016). Additionally, further research is needed on all disorders in many areas, such as validation of diagnostic criteria and effects of psychotherapeutic and medical interventions (Parish et al., 2016).

Pain Disorders. The 2016 ISSWSH expert consensus panel that addressed the previous FSDs did not address sexual pain disorders. However, ISSWSH did address sexual

pain disorders in consultation with other sexual medicine organizations, specifically the International Society for the Study of Sexual Medicine (ISSM) at the Third (Pukall et al., 2016) and Fourth ICSM meetings (McCabe et al., 2016) and the International Society for the Study of Vulvovaginal Disease (ISSVD) and the International Pelvic Pain Society (IPPS) at the 2015 ISSVD, ISSWSH and IPPS Consensus Panel of Persistent Vulvar Pain and Vulvodynia (Bornstein et al., 2015; Bornstein et al., 2016).

Vulvar Pain Caused by a Specific Disorder. The ISSVD, ISSWSH, and IPPS focused its definition of vulvar pain on etiology. This terminology consensus conference compiled the following factors as causes of vulvar pain: infectious (e.g., herpes), inflammatory (e.g., lichen sclerosis), neoplastic (e.g., Paget disease), neurologic (e.g., nerve compression), trauma (e.g., female genital cutting), iatrogenic (e.g., chemotherapy), and hormonal deficiencies (e.g., genitourinary syndrome of menopause). It should be noted that it is possible for a woman to have one of these factors and vulvodynia (i.e., the factor is not causing her vulvar pain; Bornstein et al., 2016).

Additional descriptors were included for both vulvar pain caused by a specific disorder and vulvodynia. The pain may be localized to a specific area (e.g., clitoris or vestibule) or generalized or mixed (i.e., both localized and generalized). It may be provoked (i.e., with contact) or spontaneous (i.e., unprovoked) or mixed. The onset of symptoms may be primary (i.e., lifelong) or secondary (i.e., acquired). Timing of symptoms may be described as intermittent, persistent, constant, immediate, or delayed (Bornstein et al., 2016).

Vulvodynia. The ISSVD, ISSWSH, and IPPS terminology consensus conference defined vulvodynia as vulvar pain that lasts at least three months, has no discernable cause, and may have associated factors (Bornstein et al., 2016). Vulvodynia can be described further

using the same descriptors as those listed for vulvar pain caused by a specific disorder (Bornstein et al., 2016).

Independent from the ISSWSH, at the Fourth International Consultation of Sexual Medicine (ICSM-4) in 2015, sexual medicine experts reached a consensus on the terminology and classification of several FSDs (McCabe et al., 2016). These experts adopted some *DSM-5* definitions, some *DSM-IV-TR* definitions, some *ICD-10* definitions, and developed some new definitions (McCabe et al., 2016). Most of the disorders that arose out of the ICSM-4 are similar in terminology and definition to those of the ISSWSH, with the exception of painful orgasm and female genital-pelvic pain dysfunction (FGPPD), which I will discuss next.

Painful Orgasm. Painful orgasm is simply defined as "the occurrence of genital and/or pelvic pain during or shortly after orgasm" (McCabe et al., 2016, p. 141). It is not clear why the ISSWSH did not recognize painful orgasm in its classification system. The sexual medicine experts at the ICSM-4 had separate definitions for painful orgasm, PGAD/GPD, and postcoital syndrome (similar to FOIS), but it is possible that ISSWSH intended for painful orgasm to fall under either GPAD/GPD and FOIS, as both disorders involve aversive orgasm symptoms.

Female Genital-Pelvic Pain Dysfunction (FGPPD). The sexual medicine experts at the ICSM-4 defined FGPPD as

> persistent or recurrent difficulties with at least one of the following: (i) vaginal penetration during intercourse; (ii) marked vulvovaginal or pelvic pain during genital contact; (iii) marked fear or anxiety about vulvovaginal or pelvic pain in anticipation of, during, or as a result of genital contact; or (iv) marked hypertonicity or

> overactivity of pelvic floor muscles with or without genital contact (McCabe et al., 2016, p. 141).

While there is some overlap between FGPPD and ISSWSH's two vulvar pain definitions, only the ICSM-4's definition of FGPPD includes fear of pain.

Diagnosis of painful orgasm or FGPPD should note whether the dysfunction is *lifelong* or *acquired*, has been occurring for at least three months (necessary for FSD diagnosis), leads to individual distress, and occurs in 75% to 100% of sexual experiences (McCabe et al., 2016). Table 1 shows the relationships between FSDs of the American Psychiatric Association's *DSM-5*, the ISSM's ICSM-4, the ISSWSH, and the WHO's *ICD-11*. It is important to remember, however, that disorders in the same row are placed there as they represent similar disorders—they are not necessarily the same and do not necessarily have the same diagnostic criteria. Empty table cells suggest that there is no corresponding disorder under that classification system.

Table 1

FSD Nomenclature from Classification Systems and Sexual Medicine Experts

APA [*DSM-5*](2013)	ICSM-4 (2015/2016)	ISSWSH (2016, 2019, & 2021)	WHO [*ICD-11*] (2017)
Female sexual interest/arousal disorder	Hypoactive sexual desire dysfunction	Hypoactive sexual desire disorder	Lack or loss of sexual drive
	Female sexual arousal dysfunction	Female cognitive arousal disorder	
		Female genital arousal disorder	Failure of genital response
Genito-pelvic pain/penetration disorder (GPPPD)	Female genital-pelvic pain dysfunction (FGPPD)	Vulvar pain related to a specific disorder or vulvodynia	Non-organic dyspareunia
			Non-organic vaginismus
	Persistent genital arousal disorder/genito-pelvic dysesthesia (PGAD/GPD)	Persistent genital arousal disorder/genito-pelvic dysesthesia (PGAD/GPD)	Excessive sexual drive (Note: Most people with PGAD/GPD do not appreciate this diagnosis)
	Painful orgasm		
	Postcoital syndrome (post-orgasmic illness syndrome)	Female orgasmic illness syndrome	
Female orgasmic disorder	Female orgasmic dysfunction	Female orgasm disorder	Orgasmic dysfunction
			Sexual aversion
	Hypohedonic orgasm	Pleasure dissociative orgasm disorder (can be a symptom of PSSD)	and lack of sexual enjoyment
Substance/ medication-induced sexual dysfunction		Post-SSRI sexual dysfunction (PSSD)	
Other specified sexual dysfunction			Other sexual dysfunction, not caused by organic disorder or disease
Unspecified sexual dysfunction			Unspecified sexual dysfunction, not caused by organic disorder or disease

Note. Adapted from the APA (2013); Bornstein et al. (2016); DeRogatis et al. (2016); McCabe et al. (2016); Parish et al. (2016); Parish, Meston, et al. (2019); Pukall et al. (2016); Pukall (2021).

Post-SSRI/SNRI Sexual Dysfunction and Other Medication-Induced Sexual Dysfunctions

As research on post-SSRI sexual dysfunction (PSSD) is new, the most up-to-date

ISSWSH definition is a working definition from the ISSWSH annual meeting: “distressing issues with sexual function/pleasure that emerge with SSRI initiation/termination and persist after termination (not due to depression or other contributors)” (Pukall, 2021, 18:45). These symptoms may include low desire, decreased vaginal lubrication, decreased orgasm frequency and intensity, loss of pleasure with orgasm, and genital/nipple numbness. Other drugs may also cause lasting sexual dysfunctions, including finasteride (“Propecia”), and isotretinoin (“Accutane”), and SNRIs. These conditions have similar symptoms and are known as post-finasteride syndrome (PFS), post-retinoid sexual dysfunction (PRSD), or post-Accutane syndrome (PAS).

Note that other causes must be ruled out in order to be diagnosed with PSSD (Pukall, 2021). This is because other conditions, such as depression, can cause some sexual dysfunctions, such as low desire or orgasm difficulties. However, not experiencing any sexual dysfunction until starting or finishing a drug and having symptoms that persist after cessation strongly suggest that the drug is the cause of the sexual dysfunction (Giatti et al., 2018; Things I Learned Researching Sex, 2021). Further, some symptoms (e.g., lack of sexual pleasure) are not a symptom of depression (or acne or hair loss) and can thus not be blamed on the original condition (Pukall, 2021).

Given that the causes of sexual dysfunctions can include any number of biopsychosocial factors, trying to diagnose women using only the *DSM*, with its focus on psychiatric illnesses, will inevitably leave many women without a proper diagnosis. Unlike the *DSM*, the *ICD* focuses more on physical maladies. The ISSM, being a sexual medicine organization, is well-posed to provide expert knowledge on FSDs but is not focused specifically on women. However, the ISSWSH, an organization whose only focus is

women's sexual health, used a consensus panel of sexual medicine experts to name and define FSDs (Bornstein et al., 2015; Bornstein et al., 2016; Parish et al., 2016; Parish, Hahn, et al., 2019; Parish, Meston, et al., 2019); as such, the ISSWSH should be viewed as the authority on FSD nomenclature and definitions.

Unfortunately, the current ISSWSH FSD terms and definitions are too new to have been used in much research. Throughout the years, both within and without these aforementioned organizations (American Psychiatric Association, ICSM, ISSWSH, ISSVD, IPPS, and WHO), the names and definitions of FSDs have undergone numerous changes. This has muddied the waters of research. Research on prevalence of these specific conditions is rare, compounded by the fact that research on women's sexual functioning complaints is already limited. However, there is still research on the prevalence of traditionally accepted sexual dysfunctions, including low desire, lubrication difficulties, orgasm difficulties, and sexual pain.

Prevalence

Research on women aged 40 to 80 in 29 countries suggested that 48.5% experience at least one sexual function problem, and 54.5% of non-European Western women (including Canada and the USA) experience at least one sexual function problem (Moreira et al., 2005). If we look strictly at diagnosable sexual dysfunctions (excluding sexual problems that occur only occasionally), these statistics are somewhat lower, with 37% of Anglophone women (from the USA, Canada, UK, Australia, and New Zealand), 28% of Canadian women, and 32% of American women experiencing at least one sexual dysfunction (Nicolosi et al., 2006). Looking at the prevalence of specific sexual dysfunctions in Canadian women, they experience the following sexual function problems periodically or frequently: low sexual

desire (10.7%), lubrication difficulties (12.0%), inability to reach orgasm (10.4%), pain during sex (7.4%), or unpleasurable sex (8.0%; Brock et al., 2006). It is likely that Albertan women experience similar prevalence. Unfortunately, it is unclear how many complaints of low desire are actually complaints of absent or low spontaneous desire (Basson, 2000). These rates are similar to rates of these FSDs in American women (Laumann et al., 2009) but lower than the rates of specific FSDs of Anglophone women (Nicolosi et al., 2006). There is no research on arousal disorders in Albertan or Canadian women, but 26.1% of American women (Shifren et al., 2008) and 62% of women who filled out a web-based survey (Berman et al., 2003) reported experiencing low sexual arousal. The prevalence of PGAD/GPD is difficult to discern because the condition has been relatively unrecognized and underreported due to women feeling ashamed and embarrassed by their symptoms (Brotto, Bitzer, et al., 2010), though recent research suggests about one to four percent of people in North America experience PGAD/GPD (Jackowich & Pukall, 2020b). There does not appear to be any research on the prevalence of PSSD, PRSD, PAS, and PFS.

Risk Factors for Female Sexual Dysfunctions

Sexual dysfunctions are often multifactorial and can be classified into the four categories of the biopsychosocial model: biological, psychological, sociocultural, and interpersonal. While individual FSDs have their own set of etiologies, there is much overlap between different FSDs, and an in-depth exploration of specific cause-and-effect of each dysfunction is unnecessary for the purposes of this project. Please see Parish et al. (2016), McCabe et al. (2016); Parish, Meston, et al. (2019), Bornstein et al. (2016), and Pukall et al. (2016), for an in-depth overview of the various FSD etiologies.

Physiological Factors. Many physiological factors can impact women's sexual

functioning, including pregnancy (Byrd et al., 1998; Wright & O'Connor, 2015), childbirth (Aslan & Fynes, 2008; Wright & O'Connor, 2015), menopause (Khajehei et al., 2015; McCool et al., 2016; Nappi et al., 2016), and age (Aslan & Fynes, 2008; Laumann et al., 1999). Medications, including birth control pills (Feldhaus-Dahir, 2009), Accutane (Healy et al., 2018), and antidepressants (Albaugh, 2014; Healy, 2019; Healy et al., 2019; Hensley & Nurnberg, 2002), can affect a woman's sex drive, ability to orgasm, or even her ability to feel pleasure or genital sensation. Genital sensations may also be disrupted by nerve damage, neuropathy (Albaugh, 2014; Goldstein et al., 2017; Komisaruk & Lee, 2012), or surgery in the genital area (Albaugh, 2014). Hormone imbalances can cause vaginal atrophy or sexual pain (Albaugh, 2014). Diabetes, thyroid problems, hypertension, hyperlipidemia, heart disease (Aslan & Fynes, 2008), atherosclerosis, and cancer (Feldhaus-Dahir, 2009) may negatively affect sexual functioning. Sexual pain could be caused by dermatological conditions, infections, muscular factors (Albaugh, 2014), and clitoral adhesions (Aerts et al., 2018; Rubin et al., 2017). Women with poor overall health also have elevated risk for sexual pain (Laumann et al., 1999).

Psychological Factors. Poor mental health (American Psychiatric Association, 2013; Basson, 2006), including emotional distress, stress (American Psychiatric Association, 2013; Faubion & Rullo, 2015; Laumann et al., 1999; Wright & O'Connor, 2015), depression (Albaugh, 2014; Elbay, 2017; Faubion & Rullo, 2015; Wright & O'Connor, 2015), and anxiety (Albaugh, 2014), is related to sexual dysfunction in women. Sexual abuse is associated with FSD (American Psychiatric Association, 2013; Faubion & Rullo, 2015; Sharma & Kalra, 2016; Wright & O'Connor, 2015). Self-image (Faubion & Rullo, 2015) and body image can impact women's sexual functioning (American Psychiatric Association,

2013; Khajehei et al., 2015; Kingsberg & Rezaee, 2013), as can unrealistic expectations or a lack of sexual knowledge and skills (Albaugh, 2014; Feldhaus-Dahir, 2009).

Sociocultural Factors. Libido and orgasm achievement can be influenced by religious or cultural beliefs (American Psychiatric Association, 2013; Brotto, Bitzer, et al., 2010; Wright & O'Connor, 2015), particularly in strict or patriarchal cultures and religions (Kingsberg & Rezaee, 2013). Low educational attainment is positively associated with sexual function problems (Abdo et al., 2004; Laumann et al., 1999; Lou et al., 2017; Safarinejad, 2006; Shifren et al., 2008)—that is to say, higher levels of education provide some protection from some sexual function problems. Because it is often a reflection of the culture in which one is raised, ethnicity may also be a factor in prevalence and type of dysfunction experienced (Laumann et al., 1999). Other risk factors for sexual dysfunctions include upbringing (Basson, 2006; Faubion & Rullo, 2015; Ohl, 2007), societal pressures, cultural norms and expectations (Basson, 2006; Faubion & Rullo, 2015; Ohl, 2007), and deterioration of socioeconomic status (Laumann et al., 1999).

Interpersonal Factors. Relationship factors may be a large contributor to women's sexual function problems (American Psychiatric Association, 2013; Fugl-Meyer & Fugl-Meyer, 2005). Unmarried (premarital, divorced, widowed, or separated) women may be more likely to experience sexual anxiety and difficulties with orgasm than are married women (Laumann et al., 1999), though married women may experience significantly higher rates of distressing sexual function problems (Shifren et al., 2009; Shifren et al., 2008). This may seem paradoxical, but one possible explanation is that long-term partners facilitate more comfortable sexual experiences, that their spouses know how to meet their sexual needs, and that partnered women experience both personal and relational distress when they experience

sexual dysfunctions, while single women only experience personal distress. Sexual function problems in a woman's partner may also contribute to her own sexual dysfunction (American Psychiatric Association, 2013; Faubion & Rullo, 2015).

In this section, I described a brief history of the classification and diagnosis of sexual dysfunction and explained why I use the nomenclature and definitions from sexual medicine experts such as the ISSWSH. I then explained desire disorder, arousal disorders, orgasm disorders, pain disorders, and medication-induced sexual dysfunction that has recently been recognized. Finally, I addressed prevalence and the many risk factors for FSDs. Having described FSDs in detail, I now move on to explain the various ways social and cultural factors can influence women's sexual satisfaction and development of FSDs.

Western Sociocultural Barriers to Women's Sexual Satisfaction

In Western society, there are several barriers to women's sexual satisfaction and pleasure. Some women do not enjoy sex—either sometimes or all the time. A quick google search for "I don't enjoy sex" yields millions of results, such as *Don't enjoy sex? You're not alone* (Robinson, 2017) or *Health check: Is it normal not to want sex?* (Richters, 2016). Enjoying sex is considered normal in Western society and not enjoying sex falls outside of cultural norms. However, many Western sociocultural factors are significant barriers to women's sexual satisfaction and pleasure. I will examine several of these barriers below.

Religious and Cultural Beliefs and Practices

Sexual enjoyment is influenced by both culture and religion. Studies on the influence of religion on sexual satisfaction have produced mixed results (Sánchez-Fuentes et al., 2014). However, Heinemann et al. (2016) outlined the negative impact of culture on sexual satisfaction, such as the belief in some Asian cultures that absent desire is not abnormal (i.e.,

that women are not entitled to have sexual desire) or the preference in sub-Saharan Africa for a dry vagina during intercourse (Atallah et al., 2016). Additionally, some African and Middle Eastern cultures engage in female genital cutting, defined as "partial or total removal of the external female genitalia or other injury to the female genital organs for non-medical reasons" (OHCHR et al., 2008, p. 1), which can cause a long list of immediate and long-term health complications, including infertility, severe pain, and even death (OHCHR et al., 2008). Cultures or religions may also prescribe limits on enjoyment of sexual activity. For example, the Church of Jesus Christ of Latter-day Saints (CoJCoLDS, 1995, 2011) teaches that sexual behaviour should only occur within a heterosexual marriage, and the Catholic church teaches that the only moral way to enjoy sex is to experience it with one's spouse for the purpose of procreation (Pope Paul VI, 1968; The Vatican, n.d.).

A commonly held Western belief is that men have no sexual self-control and thus women must be responsible for controlling whether sexual interactions occur. Gender differences exist in the initiation and rejection of intercourse. For instance, Peplau et al. (1977) and Sprecher and Hatfield (1996) found that in heterosexual couples, women's sexual attitudes were stronger predictors of whether and when the couple had sex. In other words, women were the sexual gatekeepers, meaning that they were required to decide whether or not to engage sexually with a constantly interested male partner (Brian, 2009). More recently, it has been found that women and men may actually engage in a similar amount of gatekeeping, unless they have previously had sex with their partner, which is the context in which women gatekeep significantly more than men do (Brian, 2009). Evolutionary theorists argue that women are more selective about their sexual partners because of their unique risks in having sex (e.g., Gangestad & Simpson, 2000), while social learning and socialization

theorists argue that learned gender roles contribute to women's sexually restrictive behaviour (Peplau et al., 1977). Gatekeeping is interesting because it is gendered, but it may also be harmful to women's sexual response. That is, women who gatekeep may inadvertently learn to inhibit their sexual responses due to constantly being on guard (Lips, 2020). However, research on women's reasons for having sex and gatekeeping behaviour is often centred on vaginal intercourse and not on activities that more reliably lead to women's orgasms (e.g., cunnilingus sex, intercourse with clitoral stimulation).

Nobody Talks About Women's Pleasure

Barriers to female sexual pleasure begin at a young age, as few people discuss pleasure (or masturbation) with children of any gender (Orenstein, 2016b). Parents often fail to teach their daughters (or sons) the location, function, or existence of the clitoris (Kreinin, 2002; Ogletree & Ginsburg, 2000) or the potential pleasure of sex for women (Brock & Jennings, 1993; Tolman, 1994). This "psychological clitoridectomy" (Orenstein, 2016b, 7:17), or the linguistic mutilation of women's genitalia—i.e., referring to all female genitalia as the "vagina" and the absence of the clitoris in sexual education (Braun & Kitzinger, 2001) and common vernacular (Ogletree & Ginsburg, 2000)—makes it difficult for women to understand and connect with their genitalia and sexuality (Lerner, 1976). Girls and women end up feeling shame about their genitals (Dodson, 2002; Orenstein, 2016b; Winston, 2010) and female sexual gratification is shamed (TEDx Talks, 2016a), which persists into adulthood (Barmak, 2016).

Prioritizing Men's Sexual Pleasure Over Women's

Men's sexual satisfaction is valued in most cultures, but strong taboos around women's sexuality have existed and continue to exist in many cultures (Rehman et al., 2013).

Today's Western social norms appear to support and promote the sexual satisfaction of both women and men (Schwartz & Young, 2009), although women's sexual pleasure continues to remain subordinate to men's pleasure, and women's sexual concerns are frequently still minimized and dismissed by many healthcare providers.

In Western culture, men's sexual pleasure is prioritized (Orenstein, 2016b; Wetzel, 2018) and even celebrated, while women's sexual pleasure is shamed (TEDx Talks, 2016a). Women have been socialized to minimize the importance of their own sexual pleasure and comfort (Carter et al., 2019; Wetzel, 2018). Women learn that men's orgasms are vital to intercourse, which ends when a man ejaculates (Kerner, 2010; Muehlenhard & Shippee, 2010; Wetzel, 2018), but that women's orgasms are just a bonus (Chalker, 2018; Pin, 2019; Wetzel, 2018). In fact, college-aged women perform significantly more oral sex than they receive (Herbenick et al., 2010; Wetzel, 2018; Wood et al., 2016), though fortunately these numbers actually reverse beyond age 30 (Herbenick et al., 2010). Further, women learn that being sexy is more important than experiencing sexual pleasure (Barmak, 2016). As a result, women learn that their pleasure does not matter (Jawed-Wessel, 2016). Instead, women measure their satisfaction by their partner's pleasure (McClelland, 2009). Even Te Linde's *Operative Gynecology* textbook references women's "feminine role as givers of pleasure" (Jones & Rock, 2015, p. 38). Women—and men—need to prioritize women's pleasure.

The prioritization of men's sexual pleasure over women's is intertwined with several phenomena, including the Western emphasis on vaginal intercourse (the coital imperative), the fact that men have significantly more orgasms than women do during partnered sex (the orgasm gap; Andrejek & Fetner, 2019; Blair et al., 2017; Mintz, 2017), and the discrepancy between the behaviours that give women the most pleasure and the behaviours in which they

actually engage. Looking at the experiences of women who have sex with women provides us with important insights into female sexuality independent of men. I will explore these topics in this section.

The Coital Imperative. Western culture overvalues vaginal intercourse (Mintz, 2015). Despite a marked low frequency of coital orgasm in women, Western society continues to expect women to orgasm during vaginal intercourse (Blair et al., 2017; Hunter, 2014; Wetzel, 2018). This expectation comes from three sources. The first source is the evolutionary belief that sexual pleasure ensures reproduction, while in fact only male sexual pleasure ensures reproduction (Hite, 2004). The second is that patriarchal societies have positioned vaginal intercourse as the only natural, healthy, and moral form of sexuality (Hite, 2004) and all other sexual behaviours as foreplay or the sexual behaviours of adolescents; this is known as the coital imperative (Gavey et al., 1999; Jackson, 1984; McPhillips et al., 2001). The third source of this erroneous expectation is the Freudian model of female sexuality (Hite, 2004), which posits that clitoral orgasms are immature and that the mature orgasm must transfer to the vagina (Freud, 1905, 1961). This Western emphasis on vaginal intercourse, which is very effective at producing men's orgasms but not women's, inevitably leads to an incongruence between the behaviours practiced by heterosexual couples and those that lead to women's orgasms.

The Discrepancy Between Behaviours Practiced and Behaviours That Produce Female Orgasms. Because of the coital imperative and the fact that Western women and men prioritize men's sexual pleasure, there is a discrepancy between the behaviours practiced by heterosexual couples and the behaviours that reliably produce orgasms in women (Andrejek & Fetner, 2019; Blair et al., 2017). A pervasive Western belief is that the best or

healthiest way to engage in sexual pleasure is with a partner, and that the best way to be sexual with a partner is vaginal intercourse (Gavey et al., 1999; Jackson, 1984; McPhillips et al., 2001). This belief has many origins, including the early Christian prohibition on all nonprocreative sexual behaviours and the false historical belief that masturbation causes disease (Carroll, 2018).

Most Appealing, Satisfying, and Orgasmic Partnered Sexual Behaviours. Because women engage in different sexual behaviours at different times for different reasons (e.g., their partner's pleasure, location constraints, desire to get pregnant), a woman's engagement in a behaviour does not necessarily reflect whether that behaviour is enjoyable. I did not find any research on partnered sexual behaviours that women find "most enjoyable," but I will discuss behaviours that women find appealing or satisfying and behaviours that reliably lead to women's orgasms.

Herbenick et al. (2017) found that 70% of women rated vaginal intercourse as "very appealing"—the highest rated of any partnered sexual behaviour. The next most appealing behaviours were much less popular in comparison (43% to 49%): kissing or saying romantic things during sex, gentle sex, receiving cunnilingus, and giving or receiving a massage before sex (Herbenick et al., 2017). It is interesting that vaginal intercourse is viewed so favourably by women, as vaginal intercourse alone does not reliably lead to women's orgasms (Hite, 2004; Lloyd, 2005; Marcus, 2011; Mintz, 2017; Nagoski, 2015), especially in casual sex (Richters et al., 2006). However, many women do report sexual satisfaction from vaginal intercourse. This may be due to a number of factors, such as women not necessarily correlating orgasm with sexual satisfaction (Hite, 2004; Wallin, 1960; Waterman & Chiauzzi, 1982), women's low expectations of pleasure, or women's limited knowledge about their

capacity for pleasure (Hunter, 2014; McClelland, 2009; Orenstein, 2016b). Women may also favour vaginal intercourse because they prioritize men's sexual pleasure (Orenstein, 2016b; Wetzel, 2018) and base their own satisfaction on how satisfied their partner is (McClelland, 2009). While clitoral stimulation is not built into vaginal intercourse, it can easily be added, and it would increase the likelihood and/or quality of a woman's coital orgasm (Herbenick et al., 2018; Hite, 2004). Vibrators are also an effective path to female orgasm (Davis et al., 1996; Herbenick et al., 2009; Hite, 2004; Sherfey, 1973), and can be incorporated into most sexual activities.

While women rate vaginal intercourse as very appealing, sexual satisfaction is associated with receiving more cunnilingus (Blumstein & Schwartz, 1983; Frederick, Lever, et al., 2017; Hite, 2004; Richters et al., 2006), reaching orgasm more consistently (Frederick, Lever, et al., 2017; Haavio-Mannila & Kontula, 1997; Hurlbert, Apt, et al., 1993; Hurlbert, White, et al., 1993), and sexual variety (Frederick, Lever, et al., 2017; Haavio-Mannila & Kontula, 1997; Richters et al., 2006). The most reliable path to female orgasm is clitoral stimulation (Lloyd, 2005; Mintz, 2017), either through cunnilingus (Frederick, John, et al., 2017; Richters et al., 2006) or other "foreplay" (Hurlbert, Apt, et al., 1993). In fact, cunnilingus is the most reliable partnered path to orgasm (Frederick, John, et al., 2017; Richters et al., 2006). Paradoxically, the women in one study did not report a strong desire for cunnilingus, possibly due to a number of factors, including the belief that they should orgasm from vaginal intercourse, being self-conscious about their genitals, having an untalented sexual partner, or to avoid feeling obligated to perform fellatio (Blair et al., 2017).

Most Common Partnered Sexual Behaviours. Over three quarters of adult women have ever had vaginal intercourse or received cunnilingus (Herbenick et al., 2017), but the

frequency of these behaviours varies greatly with age. In research on Australians, most women (94%) reported that their last partnered sexual encounter involved vaginal intercourse while only 76% said it involved manual stimulation of the clitoris and 24% reported cunnilingus (Visser et al., 2003). This is consistent with a more recent study of Americans by Herbenick et al. (2017) in which the most common sexual behaviours reported by women in the previous month were vaginal intercourse (53%), performing oral sex (36%), and receiving cunnilingus (32%). This is disappointing for women, given that clitoral stimulation is necessary for most women's orgasms, but it does provide a very concrete explanation for the orgasm gap. The relatively small gap between lifetime prevalence and prevalence within the last month of vaginal intercourse, cunnilingus, masturbation, and vibrator use suggests that these are common Western sexual behaviours (Herbenick et al., 2017).

Herbenick et al. (2017) found that recent vaginal intercourse and receiving cunnilingus peaks with women in their 30s (77% and 51% respectively) and declines to 15% and 17%, respectively, in women aged 70 or higher. However, increased age does not necessarily equate to increased lifetime practice of sexual behaviours. With all partnered sexual behaviours, lifetime prevalence increases with older age groups to a certain point, and then decreases with each successive age group. For example, prevalence of lifetime receiving cunnilingus peaks with women in their 40s (90%) and then decreases to 77% in women aged 70 or higher. With the exception of vaginal intercourse, in which almost all women over age 70 have engaged, the lifetime prevalence of other sexual behaviours also tends to peak with middle-aged women (Herbenick et al., 2017). This suggests that middle-age is when many women begin to expand their sexual repertoires to include more activities (and more orgasmic activities), but that many older women belong to a generation that inhibited their

sexual exploration.

Enduring Unwanted Sex. Many women endure unwanted sex (Ayling & Ussher, 2008; Febos, 2021; Lawrance & Byers, 1995; Sutherland, 2012) in order to prevent their partners from straying (Barbach, 2000; Morgan, 2020) or to maintain their relationship, even when sex hurts (Sutherland, 2012), and over half of women who experience sexual pain do not tell their partners (Carter et al., 2019). Worse, women are even less likely to speak up about pain if they are experiencing little to no pleasure (Carter et al., 2019). Why do women remain silent about sexual pain? The main reasons are that painful sex has been normalized for women, some women view pain as insignificant, some women (or even their partners) prioritize their partner's enjoyment, and the pressures of gendered interactions (e.g., avoiding awkwardness or managing their partner's emotions; Carter et al., 2019) silence women. Some doctors may unintentionally reinforce the idea that painful vaginal intercourse is normal (Carter et al., 2019) or that women do not need to enjoy sex (Barbach, 2000). Women may be told to expect pain with vaginal intercourse (Barbach, 2000) and some men may even use the Bible to justify the expectation that women endure painful sex for their male partners' enjoyment (Biblical Gender Roles, 2018; Loofbourow, 2018). Women also endure unwanted sex with men to avoid seeming rude or to avoid men's negative reactions, including hurt, disappointment, anger, and violence (Febos, 2021). This normalization of women enduring unwanted or painful sex contributes to female sexual problems and could certainly impact women's willingness to seek help or healthcare providers' responses when women do seek help.

Women Who Have Sex with Women (WSW). WSW provide us with a unique look into female sexuality. Compared to heterosexual women, lesbians are at less of a risk of

sexual dysfunction (Breyer et al., 2010; Shindel et al., 2012), report better orgasmic function (Beaber & Werner, 2009; Coleman et al., 1983), and experience lower rates of orgasm difficulties and sexual pain (Peixoto & Nobre, 2015). Eighty-eight percent of lesbian women orgasm with a partner frequently or always (even more than the 72% of lesbian women who frequently or always orgasm during masturbation), while only 66% of heterosexual women orgasm with a partner frequently or always (Coleman et al., 1983). Additionally, few lesbians (2%) never experience orgasm, compared to 13.3% of heterosexual women (Coleman et al., 1983). Among lesbian, bisexual, and heterosexual women, lesbians report having the most orgasms (Breyer et al., 2010; Frederick, John, et al., 2017; Garcia et al., 2014; Mintz, 2015).

The discrepancy between sexual problems in WSW and heterosexual women may be due to WSW's inherent understanding of pleasuring a female partner and the nature of WSW sexual interactions, which do not prioritize vaginal penetration (a possible source of pain and a limited source of pleasure; Bailey et al., 2003). This discrepancy is also partially explained by lesbians' shorter relationships (i.e., relationship length impacts sexual satisfaction and lesbians have shorter relationships on average; Peixoto & Nobre, 2015). Regardless, lesbians experience higher rates of orgasm and lower rates of sexual pain than heterosexual women even when relationship length is accounted for (Peixoto & Nobre, 2015), and they are just as sexually satisfied (Blumstein & Schwartz, 1983) as heterosexual women, if not more satisfied (Blair et al., 2017).

These studies suggest that the introduction of men (or, more likely, penises) into women's sexuality inhibits women's orgasms (Mintz, 2015). As one sex educator explains, "When women are put in a situation where the penis is not involved—as in the situations I described before [masturbation or sex with other women]—then sex differences disappear"

(Wetzel, 2018, 7:36).

The Orgasm Gap. The discrepancy between the behaviours practiced by heterosexual couples and the behaviours that reliably produce orgasm in women (Andrejek & Fetner, 2019; Blair et al., 2017) inevitably leads to the orgasm gap. An abundance of research reports the existence of the orgasm gap, the fact that men have significantly more orgasms than women do during partnered sex (Andrejek & Fetner, 2019; Armstrong et al., 2012; Blair et al., 2017; Frederick, John, et al., 2017; Garcia et al., 2014; Mintz, 2017; Richters et al., 2006; Wade et al., 2005), especially during penile-vaginal intercourse (Wade et al., 2005). The orgasm gap should also be considered an arousal gap and a pleasure gap, given that orgasm is extremely unlikely without pleasure and arousal. This rule holds true whether the women and men in question are heterosexual, homosexual, or bisexual: in a study on 52,588 people (25,554 women), heterosexual men reported having the most orgasms (95% said they usually or always orgasm) and heterosexual women reported having the fewest orgasms (65% said they usually or always orgasm; Frederick, John, et al., 2017). Women are even less likely to have orgasms during casual sex (Richters et al., 2006). However, women's prioritization of men's orgasms does not mean that they happily accept it. When their male partners orgasm and women do not, women feel angry, resentful, frustrated, and cheated (Hite, 2004).

While the orgasm gap is often chalked up to women's supposedly "complicated" sexuality (Barmak, 2016; Nuwer, 2016; Volpe, 2019; Wetzel, 2018) or psychological issues (e.g., body image, anxiety; Stanford, 2007), the orgasm gap appears to be a social issue, not a biological one. That is to say, women's orgasmic capacity is the same as men's, but Western society expects women's sexuality to function like men's sexuality, which generally means

orgasming from vaginal intercourse. This is demonstrated by (and perpetuated by) the fact that Masters and Johnson (1966) performed their research on couples having vaginal intercourse—not couples having oral sex, and not people masturbating. Because they only studied vaginal intercourse, Masters and Johnson (1966) found that women take significantly longer to reach orgasm than men do. However, women and men have similarly high rates of orgasm during masturbation—94% for women (Hite, 2004) and 98% for men (Hite, 1981). Women and men also take about the same amount of time to orgasm during masturbation (Hite, 2004; Kinsey et al., 1953; TVO, 2007). What is notable is that heterosexual women orgasm at a much higher rate during masturbation than during vaginal intercourse and heterosexual sex (Laumann et al., 1994; Lloyd, 2005; Wade et al., 2005) and that about one third of women rarely or never orgasm during vaginal intercourse (Lloyd, 2005). Among those women who can orgasm during vaginal intercourse, additional clitoral stimulation is necessary for orgasm frequency and/or quality for most of them (Herbenick et al., 2018; Hite, 2004). In fact, in research on thousands of women, 95% said that clitoral stimulation is their most reliable route to orgasm (Mintz, 2017). This—requiring clitoral stimulation for orgasm—is normal sexual function for women (Winston, 2010). Vaginal intercourse stimulates the vagina but tends to neglect the external clitoris, so it inherently provides inadequate clitoral stimulation for most women. The clitoris and the penis are homologous organs, having both developed from the genital tubercle in utero (Nguyen & Duong, 2020), and as such, both organs require adequate stimulation for orgasm to occur. (Imagine if men were expected to orgasm without their penises being stimulated.)

Sexual scripts are another important contributor to the orgasm gap. For example, many people subscribe to sexual scripts that place the responsibility of women's orgasms on

men's penises (Chadwick & van Anders, 2017; Muehlenhard & Shippee, 2010). Many people also follow sexual scripts that position "foreplay" only as a preparatory activity, followed by vaginal intercourse (the main event) that leads to a woman's orgasm and ends when the man orgasms (Muehlenhard & Shippee, 2010). Following these scripts—which do not promote clitoral stimulation—inevitably diminishes a woman's ability to orgasm with her male partner, particularly if he orgasms before she does. Sex researchers and clinicians have perpetuated this destructive and sexist belief. For example, the inability to achieve orgasm from vaginal intercourse was given the name "situational orgasmic dysfunction" in the 1970s (Marcus, 2011), prominent sex researchers renamed it "coital anorgasmia" (Masters et al., 1986), and sex therapists and others devised various methods and programs to treat these so-called "disorders" (Marcus, 2011). Again, not orgasming from vaginal intercourse alone is normal sexual function for women because their clitorises are not adequately stimulated (Winston, 2010).

This discussion may lead readers to question the widespread Western belief that women have lower sexual desire than men and wonder if heterosexual women would have comparable sexual desire if their clitorises were getting as much attention as men's penises do—and if this would diminish or eliminate the orgasm gap. I believe it would. However, the orgasm gap is also important to the discussion of FSD in another way: without understanding the social and relational factors that contribute to the orgasm gap, its very existence perpetuates the notion that women's sexuality is complicated and finicky, which hinders women with FSDs from even realizing that they have a problem, let alone seeking help. Further, these societal misconceptions about women's sexuality may cause healthcare providers to minimize or even dismiss women's concerns about sexual function.

Many Women Do Not Engage in Sexual Self-Discovery

Masturbation refers to manual stimulation (with a hand or another object) of the genitals, by oneself or another person (Saral, 2015). Because definitions and colloquial use of the term usually refer to solo sexual activity, and because masturbation is a more common term for solo sexual behaviours than other terms (e.g., solitary sex, sexual self-stimulation, and self-pleasuring; Dodson, 2015), I will use the term masturbation to refer only to solo sex.

There is no correct method of masturbation—it is simply what works best for each individual (Martz, 2004). Women may touch themselves using their fingers, vibrators (Martz, 2004) or dildos (TENGA et al., 2019), though almost all women who masturbate with a dildo add clitoral stimulation (Kinsey et al., 1953), and few women masturbate in imitation of intercourse (vaginal insertion alone; Hite, 2004). Women may enhance their masturbation through fantasies (Martz, 2004; TENGA et al., 2019), pornography, erotica, music, or thinking about previous sexual experiences (TENGA et al., 2019). On average, it takes women about four minutes to orgasm from masturbation—the same amount of time it takes a man to orgasm from masturbation (Hite, 2004; Kinsey et al., 1953; TVO, 2007).

Shame. Masturbation was referred to as "self-love" in ancient Ireland, but through Christian misinterpretations, the act of masturbation erroneously became known as "self-abuse" (Dodson, 2015). Masturbation is considered a sin by some religions, including Orthodox Jews (though it is not a sin for women), Latter-day Saints, and Catholics (Dodson, 2015). The demonization of masturbation has led to personal shame, fear, and misinformation (Crooks & Baur, 2011b). Planned Parenthood Federation of America (2003) outlined several historical myths about the evils of masturbation, such as the belief that it caused physical deterioration and disfigurement. These myths were intended to prevent

masturbation, and this goal birthed a variety of unsubstantiated and/or torturous masturbation prevention techniques, including clitoridectomy (Ehrenreich & English, 2005), and suggestions given to parents included applying caustic chemicals to the clitoris, avoiding hot foods, immobilizing children's hands at night, chastity belts, stitching the labia together, and cauterizing the urethra (Stengers & Van Neck, 2001, as cited in Planned Parenthood Federation of America, 2003). This shame about masturbation has resulted in some women being unwilling to masturbate (Moore, 2018), many people being reluctant to discuss or admit to masturbation (Regnerus et al., 2017), and the belief that women simply do not masturbate (Bell, 2018; Spolia, 2016; Weiss, 2016).

Prevalence. Women masturbate less frequently than men do and fewer women masturbate than men do (Herbenick et al., 2017). In a study of 1046 American women, 41% had masturbated in the last month and 22% had never masturbated (Herbenick et al., 2017). Alternatively, Yule et al. (2017) found that over 70% of asexual women and over 90% of sexual women masturbate at least monthly. Women also tend to underreport masturbation (Alexander & Fisher, 2003), so it is safe to assume that the behaviour is prevalent among women.

It might seem reasonable that with each successive age group (e.g., teens, 20s, 30s) more women would have masturbated at least once, but this was not the case in a study by Herbenick et al. (2010). In fact, reports of lifetime masturbation peak with women aged 25 to 29 (with 85% having masturbated at least once), and this rate declined with each age group, with only 58% of women aged 70 or more having ever masturbated (Herbenick et al., 2010).

Adults who are most likely to masturbate—and masturbate more frequently than others—have liberal political views, have post-secondary education, and live with a sexual

partner (Laumann et al., 1994). Despite the prevalence of masturbation, sex education curricula have typically focused on the prevention of disease and pregnancy (e.g., Alberta Learning, 2002a; Alberta Learning, 2002d; SIECCAN, 2019), omitting the important topics of masturbation and pleasure. Masturbation in sexual health education is often missing until college and university.

Benefits. Masturbation has many benefits. It allows for sexual exploration, sexual expression, and sexual gratification without the risks (e.g., STIs, pregnancy) and stressors of partnered sex (e.g., partner judgment, worrying about partner enjoyment). Women are more likely to experience orgasms (Laumann et al., 1994; Lloyd, 2005; Wade et al., 2005) and multiple orgasms (Crooks & Baur, 2011b) during masturbation than during sexual intercourse or other partnered sexual activity—specifically, masturbation leads to orgasm for 94% of women (Hite, 2004). Masturbation's benefits extend to partnered sex too, as masturbation allows women to learn about their sexual responses and negotiate partnered sexual activities that provide her more pleasure (Kinsey et al., 1953; Richters et al., 2014). Masturbation also has significant benefits for women with sexual dysfunctions. Because some sexual dysfunctions, particularly orgasm dysfunctions, are often treated with "directed masturbation" (Heiman & Meston, 1997; Pascoal, 2017), it is likely that learning about their own sexual responses through masturbation would prevent some women from experiencing sexual dysfunctions.

Women masturbate for a variety of reasons, including for sexual pleasure, to relieve tension, for fun (Yule et al., 2017), self-care (TENGA et al., 2019), or to avoid engaging sexually with another person (Brotto, Knudson, et al., 2010). Eighty-one percent of women continue to engage in masturbation when they are in a relationship (TENGA et al., 2019).

Interestingly, masturbation appears to fulfill a more complementary role for women's partnered sexual activity and a more compensatory role for men's (Impett & Peplau, 2006; Regnerus et al., 2017). In other words, women's masturbation increases with partnered sexual activity, while men's decreases.

Women Who Do Not Masturbate. Some women do not masturbate at all, and there are a variety of reasons for this, including being asexual (Knudson et al., 2007; Yule et al., 2017), not knowing how, shame, fear of being caught, low sex drive, a partner's insecurity (Moore, 2018), lack of interest, being in a relationship (Cassano, 2018), and religious prohibition (Cassano, 2018; Levesque, 2011; Wells, 2006), though many religious people masturbate despite their prohibitive religious beliefs. If a woman is seeking help for FSD, however, aversion to masturbation may interfere with treatment, as masturbation, or "directed masturbation," is a standard recommendation for some sexual dysfunctions, particularly orgasm dysfunctions (Heiman & Meston, 1997; Pascoal, 2017).

Asexuality is a sexual orientation describing people who do not experience sexual attraction to other people (The Asexual Visibility & Education Network, n.d.-b). Approximately 1% of the population is asexual (Bogaert, 2004). It is different from celibacy, which is the choice not to act on sexual impulses (The Asexual Visibility & Education Network, n.d.-b). Over 70% of asexual women masturbate at least monthly (Yule et al., 2017). While significantly fewer asexual women masturbate than sexual women, many asexual women do masturbate and they masturbate for somewhat different reasons than sexual women (e.g., "I feel that I have to", Yule et al., 2017, p. 316).

While most (74–79%) asexual women are single, and most asexual people have not had intercourse (Brotto, Knudson, et al., 2010), some asexual people engage in sexual

activity for their partners' benefit (The Asexual Visibility & Education Network, n.d.-a). Many groups of girls and women are incorrectly assumed to be asexual, including older women (Etaugh, 2013), women who have cancer (Ussher et al., 2013), mammies (Crooks & Baur, 2011a; Thomas et al., 2013), children, mothers (Weisskopf, 1980), women with disabilities (Cordes et al., 2013), women with mental illness (Davison, 2013), women during the Victorian era (Crooks & Baur, 2011a), and even lesbians (Rose & Eaton, 2013). However, masturbation is a safe and healthy outlet for any woman who wishes to do so, including those who cannot consent to sex or do not have access to a consenting partner.

Women's Sexuality Is Deemed "Too Complicated"

One enormous barrier to women's sexual pleasure is the belief that women's sexuality is too complicated (Barmak, 2016; Nuwer, 2016; Volpe, 2019; Wetzel, 2018). Arguments are made that women's orgasms are unnecessary because sex is for reproduction, that it is more difficult for women to achieve orgasm, or that the clitoris is difficult to find and challenging to operate (Wetzel, 2018). Figure 9 is a representation of how Western society views male sexuality versus female sexuality: men are easily aroused and uncomplicated, while women are so complicated that it is difficult or impossible to successfully pleasure them. However, in reality, these challenges are simply a lack of understanding due to a history of women's sexuality being viewed through the lens of male sexuality—we are expecting women to function as men do. However, women's sexuality is really just misunderstood (Barmak, 2016). Intercourse easily and directly stimulates a man's primary pleasure organ—the penis—but it does not easily and directly stimulate a woman's primary pleasure organ—the clitoris. However, it is not difficult to add clitoral stimulation to intercourse, nor is it difficult to engage in other sexual behaviours, such as cunnilingus, that

do adequately stimulate the clitoris.

Figure 9

Man, Woman

Note. Sculpture by Miller Levy (2010), photographed by Barend Jan de Jong. Permission granted by photographer.

Why Don't Women Ask for Pleasure?

By now, the reader may have a burning question in their mind: If women are not receiving pleasure, why do they not just ask for it or demand it? Peggy Orenstein (2016b), author of *Girls and Sex*, argues that young women are actually quite motivated to have sex, but they do not feel entitled to experience pleasure. Asking for pleasure assumes that one deserves pleasure (Wetzel, 2018), and Western society has tended to shame female sexual pleasure (TEDx Talks, 2016a), so women's silence about their sexual needs should not be surprising. While the *DSM-5* states that the importance of orgasm (and thus, to some degree,

pleasure) varies between women, Hunter (2014) argues that culture mediates a woman's *ability* to ask for pleasure. Women avoid asking for pleasure for various reasons, including fears of losing a partner's love, fears of losing economic stability, and habit (Hite, 2004). Reluctant partners further inhibit women from advocating for their own pleasure, and many people assume that sex is over once a man has had an orgasm (Wetzel, 2018). Wetzel (2018) notes that a woman's silence does not mean that she does not desire pleasure—just as silence does not equal consent—and that women should not have to ask for pleasure equality. Instead, a woman's partner should prioritize her pleasure just as much as they prioritize their own.

Gendered power relations also inhibit women asking for pleasure. One example of this phenomenon is that men feel entitled to sexual pleasure and women's bodies while women feel obligated to provided sexual pleasure to men without claiming any for themselves (Cairns, 1993). Another example of gendered power relations is manifested in the fact that clitoral knowledge is related to orgasm in masturbation but not heterosexual partnered sex (Wade et al., 2005)—so women know how to orgasm, but something inhibits them from translating this knowledge to partnered sex. Indeed, in heterosexual sex, both women and men privilege men's orgasms over women's orgasms (Wade et al., 2005). Men's egos (i.e., men's self-esteem, not the Freudian concept) play a role in the orgasm gap, as some women fake orgasms (Muehlenhard & Shippee, 2010) and avoid asking for the clitoral stimulation they need (Hite, 2004; Salisbury & Fisher, 2013) in order to protect men's egos. In fact, in one study, when asked what they thought about the use of a vibrator during intercourse, most men expressed indifference or negative reactions, such as feeling incompetent (Muehlenhard & Shippee, 2010). This is unfortunate, given that vibrators are so

successful at producing women's orgasms (Davis et al., 1996; Herbenick et al., 2009; Hite, 2004; Sherfey, 1973) and the lack of evidence that women become dependent on vibrators (Marcus, 2011). Women may also avoid asking for cunnilingus to avoid feeling obligated to perform fellatio (Blair et al., 2017). Fellatio for cunnilingus may seem like a fair exchange if we consider vaginal intercourse alone to be as pleasurable for women as it is for men, but it simply is not (Haavio-Mannila & Kontula, 1997) and vaginal intercourse certainly does not lead to equal numbers of orgasms for women and men. In heterosexual sex, vaginal penetration and clitoral stimulation should be considered equal (Blair et al., 2017; Mintz, 2015), as vaginal penetration leads to orgasm for most men and clitoral stimulation leads to orgasm for most women.

Another reason that women may not ask for their sexual needs to be met is that they may not even realize sex is supposed to feel good. Hunter (2014) explained how her mother's generation experienced an abundance of orgasmless intercourse without "clinically significant distress" (required by the *DSM-5* for FSD diagnosis) simply because they did not expect to experience sexual satisfaction. Similarly, Orenstein (2016b) described how young women sometimes report higher sexual satisfaction than young men because they have such low expectations—if a young woman engages in a sexual encounter hoping that sex does not hurt, that she will feel close to her partner, and that her partner will have an orgasm, then she will be satisfied if the encounter meets those criteria. These low expectations extend to gender differences in definitions of bad sex and good sex. When asked to describe low and high ends of a satisfaction scale (see Figure 10), women described the low end as depressing, painful, or degrading sex, while men described it as sex with an unattractive partner or insufficient stimulation (McClelland, 2009). Similarly, women described the high end of the

sexual satisfaction scale based on safety, closeness, and their partner's sexual satisfaction, while men described the high end based on their own orgasm (McClelland, 2009). Women and men are measuring sexual satisfaction with drastically different scales.

Figure 10

Women's and Men's Descriptions of the High and Low Ends of a Sexual Satisfaction Scale, Based on Their Experiences

Note. Adapted from McClelland (2009).

Sexual Dysfunction in Women Versus Men

FSD is somewhat normalized. Inability to enjoy sex, difficulties with orgasm, experiencing pain, and lubrication challenges are often seen as "normal problems" or even just "normal function" for women. Women who seek help may be told that their sexual function problems are all in their heads (Boatman, 2020; Graziottin, 2008; Jackowich, Boyer, et al., 2021; Sadownik et al., 2012) or that they just heed to relax or have a glass of wine (Boatman, 2020). Treatment options are limited (Kingsberg, 2020), doctors are not familiar with what treatments exists, and the treatments available are usually not covered by insurance (e.g., Eros Clitoral Therapy Device—essentially a clitoral pump).

For men, erection and orgasm problems are not as normalized. His problems may be

blamed on pornography or masturbation (despite the lack of evidence for such claims). However, there are many treatment options for male sexual dysfunctions—last year in the US, there were 26 FDA-approved drugs for the treatment of male sexual dysfunction and zero for women (Kingsberg, 2020). Today, there are approximately 30 FDA-approved drugs for men and three or four for women (J. Pfaus, personal communication, March 7, 2021). Men's sexual dysfunction drugs, such as Viagra and Cialis, are household names, getting a prescription is easy, and men's treatments are more often covered by health insurance (The Alan Guttmacher Institute, 1994).

This problem is summed up succinctly in the image in Figure 11, in which a young girl, representing erectile dysfunction, is receiving all the attention of her father, who represents research funding. In the foreground, another child, representing chronic pelvic pain, appears to be struggling to stay afloat. In the bottom half of the image, at the bottom of the ocean, is a skeleton representing a number of other FSDs, completely neglected.

There are many sociocultural barriers to women's sexual function and pleasure, including religious and cultural beliefs, sexual shame (especially for women), the prioritization of men's sexual pleasure, many women's lack of sexual self-discovery, the faulty belief that female sexuality is "complicated," and the dearth of research and treatments for FSD. These barriers may exacerbate FSDs that women already have, such as a woman who experiences pain with vaginal intercourse but continues to prioritize her male partner's preference for intercourse, leading to more pain and other issues (such as resentment). These sociocultural barriers also relevant and prominent in other areas, including women's help-seeking behaviours, help-seeking barriers, and help-seeking experiences.

Figure 11

A Meme On Gendered Allocation of Research Funds for Sexual Dysfunction

Note. From Vulvar Healing (2021). Permission granted by creator.

Help-Seeking Behaviours, Barriers, and Experiences

These sociocultural barriers diminish the importance and understanding of women's sexual satisfaction. The diminished value of women's sexual satisfaction impacts the help-seeking behaviours of women with FSD and the behaviours of the healthcare providers from whom they seek help. It is no surprise that these behaviours then influence women's experiences when they do seek help. In this section, I will address how women have sought help for FSD, what they report as barriers to help-seeking, the barriers faced by healthcare providers, and women's actual experiences when they have sought help.

How Women Seek Help

The primary care physician is one of women's preferred professionals for discussing sexual function problems (Bergvall & Himelein, 2014; Jackowich, Boyer, et al., 2021; Rosen et al., 2012; Shifren et al., 2009; Thomtén, 2014). Women are also likely to talk to a gynecologist or urologist about sexual function problems (Bergvall & Himelein, 2014; Berman et al., 2003; Rosen et al., 2012; Shifren et al., 2009) and many women have sought help from physical therapists (Jackowich, Boyer, et al., 2021). Women are less likely to seek help from mental health professionals, but some women have sought or would seek help from psychiatrists, psychologists, counsellors, and therapists (Bergvall & Himelein, 2014; Berman et al., 2003; Jackowich, Boyer, et al., 2021; Rosen et al., 2012; Shifren et al., 2009). Few women have sought help from endocrinologists (Berman et al., 2003; Rosen et al., 2012), religious advisors (Brock et al., 2006; Crosby & Bossley, 2012) or pharmacists (Brock et al., 2006; Moreira et al., 2005; Nicolosi et al., 2006).

Many women look for help outside of formal healthcare settings, discussing their sexual function problems with their partners/spouses, friends, or family members. Some

women seek help from anonymous sources, such as books, magazines, telephone helplines, movies, or the internet (Brock et al., 2006; Moreira et al., 2005; Nicolosi et al., 2006; Rosen et al., 2012; Shifren et al., 2009).

Women's Barriers to Seeking Help

Several factors can deter or prevent women from seeking help for their sexual function problems. Some of these factors are personal factors, but some are external factors related to healthcare access or their healthcare provider.

Lack of Awareness. Women themselves may not recognize their own experiences as a problem (Ibine et al., 2020) for a variety of reasons, and as a result, these women do not necessarily seek help (Berman et al., 2003; Brock et al., 2006; Ibine et al., 2020; Shifren et al., 2009). Poor or inaccurate sex education (at home, at school, or through socialization) rarely, if ever, includes sexual pleasure—especially women's sexual pleasure (Fine, 1988; Fine & McClelland, 2006)—and may include false and damaging outdated beliefs about women, such as the idea that sexual desire is unfeminine, shameful, or "slutty" (Crooks & Baur, 2011a; Tolman, 1994, 2002); that women's enjoyment of sex is unfeminine and interferes with reproduction; or that the female body is inherently dysfunctional (Ehrenreich & English, 2005). Women may believe that having FSD is normal (Ibine et al., 2020), that this is just how women experience sex (e.g., "I don't care for sex but neither do most women" or "sex should hurt"), or that sexual problems are a normal part of aging (Brock et al., 2006), motherhood, first-time intercourse, or even all intercourse. Many Canadian women do not seek help because they are comfortable the way they are, they do not think the problem is very serious, or they are waiting to see if the problem goes away (Brock et al., 2006). Additionally, women may never even have considered seeking help (Berman et al.,

2003) and may be less likely to seek help if they are not distressed by their sexual function problem (Shifren et al., 2009). Many women also fail to seek help because they are not aware of what services are available (Fitter et al., 2009). Not seeking help should not be taken as an indication of contentment, however, as many women who have not sought help would like to do so (Berman et al., 2003). Women may also not wish to undergo any treatment (McCool et al., 2016).

Discomfort and Awkwardness. Mental discomfort is a commonly reported barrier to seeking help for FSD. Some people report that stigma against seeking treatment for sexual problems may be a barrier (Bergvall & Himelein, 2014). Some women believe that their healthcare provider cannot help them (Berman et al., 2003; Brock et al., 2006; Ibine et al., 2020; Jackowich, Boyer, et al., 2021; Kingsberg, 2014; Marwick, 1999; Moreira et al., 2005), or that the healthcare provider will be dismissive (Jackowich, Boyer, et al., 2021; Marwick, 1999). Women may be too embarrassed to bring up sexual function problems (Berman et al., 2003; Jackowich, Boyer, et al., 2021; Nicolosi et al., 2006; Shifren et al., 2009) or they may believe that their doctors will be embarrassed (Jackowich, Boyer, et al., 2021; Marwick, 1999; Nusbaum et al., 2004). Women may also expect (Berman et al., 2003; Brock et al., 2006; Moreira et al., 2005; Nicolosi et al., 2006) or prefer that doctors initiate these discussions (Nusbaum et al., 2004).

A healthcare provider's characteristics may contribute to women's discomfort with seeking help. The age (e.g., too young, too told) of a healthcare provider (Gott & Hinchliff, 2003; Nusbaum et al., 2004) or a significant age gap between the patient and physician may inhibit women from seeking help for sexual function problems (Nusbaum et al., 2004). Many women report that the gender of their healthcare provider is important (Moreira et al., 2005;

Nusbaum et al., 2004): specifically (and unsurprisingly), women prefer seeing female physicians (Gott & Hinchliff, 2003; Nusbaum et al., 2004). Interestingly, women in the study by Nusbaum et al. (2004) did not report that having a male physician was a barrier. Finally, a healthcare provider's professional approachability, including comfort discussing sex, may influence women's help-seeking behaviour (Brock et al., 2006; Fitter et al., 2009; Moreira et al., 2005).

Issues with Healthcare Access. The healthcare system in Canada is not necessarily easy to navigate or understand. Accessing healthcare generally requires seeing a family physician for one's problems and hoping that they make referrals to specialists if necessary. This is time-consuming and requires patients to share intimate details and be assessed (mentally and/or physically) by multiple healthcare providers, which can be exhausting, embarrassing, and invasive. These multiple appointments often force women to make accommodations for childcare or work. There may also be extensive wait times between referrals (Alberta Health, n.d.; Jackowich, Boyer, et al., 2021), forcing women to continue to suffer through symptoms while they wait. Further, women whose partners would not want them to seek help (e.g., because a male doctor might see her genitals) may struggle to seek help without being caught and may face consequences if caught.

Limited time with physicians is cited as an extremely common barrier for women who wish to discuss sexual function problems (Nusbaum et al., 2004; Shifren et al., 2009). People may also be deterred by their own overestimation of the cost of health services (Azar et al., 2013). A fifth of Canadian women reported that they had not consulted a doctor because they did not have a regular physician or that going to the doctor is expensive (Brock et al., 2006). Indeed, many people with PGAD/GPD report that the high costs of diagnosis

and treatment were a significant barrier, as was a lack of access to a regular physician for some (Jackowich, Boyer, et al., 2021).

Alberta Health Care provides full coverage for some healthcare, such as hospital visits and family doctors. Unfortunately, many services are not covered, such as prescription drugs, psychologists, and pelvic floor physiotherapy (Government of Alberta, n.d.). As a result, payment for many healthcare options falls on the individual, and many Albertans do not have health insurance or the funds to pay for some treatments. Further, insurance policies are another barrier, as they may not cover the FSD treatments recommended by doctors. In a 1994 study, 97% of insurance policies covered prescription drugs but only half covered contraceptives (The Alan Guttmacher Institute, 1994) and treatments exclusively for men's sexual function problems (e.g., drugs for prostate/urological issues, sometimes penile implants) are generally covered by employer insurance plans (White, 2002). Some Canadian health insurance plans fail to mention treatments for FSD at all and exclude drugs for erectile dysfunction (e.g., Canadian Automobile Association, n.d.; Great-West Llife, n.d.; Green Shield Canada, n.d.; Manulife, n.d.; Sun Life Assurance Company of Canada, n.d.-a), while others explicitly exclude drugs for the treatment of sexual dysfunction (e.g., GMS Health Insurance, 2019; Sun Life Financial, 2014). Finally, some Canadian health insurance plans make no mention of coverage for sexual dysfunction treatment at all (e.g., ScotiaLife Financial, n.d.; Sun Life Assurance Company of Canada, n.d.-b). Sexual dysfunction treatment—especially FSD treatment—is either excluded or ignored by health insurance providers.

Healthcare Provider Barriers to Helping Women with Sexual Function Problems

A number of barriers inhibit healthcare providers from helping women with FSD. The

barriers faced by healthcare providers share several similarities with the barriers women face when help-seeking, including poor education about female sexual response and FSD, discomfort with discussing sexual concerns, and systemic barriers within their own profession.

Not Initiating Discussion. Healthcare professionals may not bring up the topic of sexual functioning with patients (Brock et al., 2006; Feldhaus-Dahir, 2009; Moreira et al., 2005; Nusbaum et al., 2004) for several reasons, including their expectation that patients will voluntarily bring up complaints (McCool et al., 2016), their own embarrassment (Blair et al., 2013), or their desire not to be intrusive (Gott & Hinchliff, 2003; McCool et al., 2016). Physicians are inhibited from initiating discussions about sexual health when patients differ from them in gender (Burd et al., 2006; Dyer & das Nair, 2013; Gott, 2004; Hinchliff et al., 2004), age, marital status, education, race, or ethnicity (Burd et al., 2006; Gott, 2004; Hinchliff et al., 2004). For example, male OB/GYNs may be less likely to initiate discussions about sexual functioning than female OB/GYNs (McCool et al., 2016). Biases such as ageism may also prevent healthcare providers from discussing sexuality (Berman et al., 2003; Gott & Hinchliff, 2003; Lindau et al., 2007; McCool et al., 2016) and screening older women for sexual dysfunctions (Pauls et al., 2005). Doctors may also simply be dismissive of women's concerns (Cacchioni & Wolkowitz, 2011; Donaldson & Meana, 2011; Jackowich, Boyer, et al., 2021). Additional barriers to initiating discussions of sexual health with patients include a healthcare provider's communication skills (McCool et al., 2016) and the belief that sexual function problems are not serious (Feldhaus-Dahir, 2009).

Inadequate Training. Lack of knowledge about FSDs and their treatment is a major barrier to addressing women's sexual concerns by both medical professionals (Donaldson &

Meana, 2011; Feldhaus-Dahir, 2009; Gott & Hinchliff, 2003; Kingsberg & Rezaee, 2013; Roos et al., 2009; Verrastro et al., 2020) and mental healthcare professionals (Miller & Byers, 2009; Verrastro et al., 2020). For medical professionals, this is caused by poor training in residency and post-residency (Abdolrasulnia et al., 2010; McCool et al., 2016; Pauls et al., 2005; Roos et al., 2009). This lack of inclusion is partially caused by an already crowded curriculum and the fact that sexual medicine is multidisciplinary, spanning across fields such as medicine, surgery, and psychiatry (Weerakoon & Stiernborg, 1996). Primary care physicians receive little or no education in sexual medicine during medical school or residency training (Abdolrasulnia et al., 2010; Blair et al., 2013; Rosen et al., 2006; Solursh et al., 2003). More than half (61%) of medical schools provide 10 or fewer hours of training in human sexuality (Leiblum, 2001), and what little training is offered tends to have a heavy emphasis on contraception and STIs, though sexual violence and FSD are apparently the next most-covered topics (Barrett et al., 2012). Several researchers have suggested recommendations to accommodate better sexual education training in medical school, such as investments in training, training health professionals instead of delegating to specialists (Verrastro et al., 2020), and increased research on training programs (Weerakoon & Stiernborg, 1996). Indeed, this research is being done and has demonstrated that sexuality education training has improved the ability of medical providers to assist patients with their sexual concerns (e.g., Bauer et al., 2013; Fronek et al., 2005; Fronek et al., 2010; Higgins et al., 2012; Jonsdottir et al., 2015; Leiblum, 2001; Post et al., 2008; Sung & Lin, 2013).

Given that their sexuality education in medical school was lacking, it is likely that many medical professionals (at least general practitioners) are unaware of what FSD treatment options are available unless pharmaceutical representatives purposely contact them.

For example, Viagra (sildenafil) and Cialis (tadalafil), common prescription drugs for erectile dysfunction, are household names, and most people know what a penis pump is. The female equivalents, Addyi (flibanserin) or Vyleesi (bremelanotide), are newer and often unheard of, and clitoral pumps (e.g., the Eros; NuGyn Inc., n.d.-b) are less well-known and usually marketed as sex toys (e.g., PinkCherry, n.d.), not medical devices. (Penis pumps are also marketed as sex toys, but many more brands of medical penis pumps exist than the single Eros medical device.) This lack of knowledge about sexuality extends to doctor's referrals, as medical professionals lack knowledge about referral options, have limited options (McCool et al., 2016; Pauls et al., 2005), and infrequently refer women to sexuality professionals (McCool et al., 2016).

Education in human sexuality is not any better in the mental health field. Like medical school training in human sexuality, of those psychology programs that do include training in human sexuality, there is a heavy emphasis on infections and disease (Nagoski, 2015). Most psychology graduate programs offer little to no training in sexuality (Burnes et al., 2017; Campos et al., 1989; Hanzlik & Gaubatz, 2012; Nathan, 1986; Wiederman & Sansone, 1999) and most mental healthcare professionals report having received little to no training in sexuality during graduate school (Burnes et al., 2017; Campos et al., 1989; Hanzlik & Gaubatz, 2012; Miller & Byers, 2008, 2009, 2010; Wiederman & Sansone, 1999). However, as programs with limited training in human sexuality are unlikely to participate in studies on the inclusion of these courses (Sansone & Wiederman, 2000), these estimates may actually overrepresent levels of human sexuality training (Burnes et al., 2017). Unfortunately, while human sexuality training is desired by graduate students, many program administrators report that there is no room for human sexuality courses in their curricula

(Burnes et al., 2017) and mental healthcare professionals do not pursue much training in this area after graduate school either (Miller & Byers, 2009). Instead, mental healthcare professionals rely heavily on consultation and referral (Miller & Byers, 2009).

Additionally, sex positivity (being nonjudgmental of people's sexual choices, interests, and expressions; Donaghue, 2015) is lacking in graduate counselling psychology training (Burnes et al., 2017). This missing aspect can have negative impacts when counsellors begin seeing clients, including the counsellor's reluctance to bring up sexual topics with clients, which inadvertently inhibits clients' disclosures of sexual issues (Hanzlik & Gaubatz, 2012), and leads to a counsellor's decreased willingness to treat sexual function problems (Miller & Byers, 2008) and an increased avoidance of discussing sexual function problems (Reissing & Di Giulio, 2010). While sex positivity is absent from graduate education programs (Burnes et al., 2017), sexuality training in mental healthcare has demonstrated mental healthcare providers' increased ability to deal with patients' sexual health concerns (e.g., Higgins et al., 2012; Post et al., 2008; Quinn & Happell, 2012).

An already crowded curriculum is one of the barriers to inclusion of courses in human sexuality (Burnes et al., 2017; Verrastro et al., 2020), but psychological accreditation institutions do not require courses in human sexuality either. For example, the American Psychological Association (2019) merely mentions sexual orientation as one requirement in a long list of "cultural and individual differences and diversity" to which accredited institutions have a responsibility and commitment. Similarly, the Canadian Counselling and Psychotherapy Association (CCPA, 2019) only requires some training in gender issues, specifically sex role development and sexual orientation, and the College of Alberta Psychologists (CAP, 2017) only lists "sex differences" and "sexual orientation" as examples

of the required training in cognitive and social bases of behaviour. Sexual function and dysfunction are unlikely to be covered under these requirements. However, not requiring training in human sexuality sends a message that knowledge in this area is unimportant to the psychology profession (Burnes et al., 2017).

Systemic Barriers. Like patients, physicians and OB/GYNs commonly cite limited time during the appointment as a barrier to initiating discussions on sexual health (Blair et al., 2013; Dyer & das Nair, 2013; McCool et al., 2016; Roos et al., 2009; Sarkadi & Rosenqvist, 2001). A shortage of sex therapists and psychologists can cause long waiting times, and medical providers may be unsure of therapy options (McCool et al., 2016; Pauls et al., 2005). A lack of research on women's sexual dysfunctions and treatments means that healthcare providers cannot even recommend many evidence-based treatments (Basson et al., 2000; Feldhaus-Dahir, 2009; McCool et al., 2016). One consequence of this lack of research is the fact that, in the United States, significantly fewer drugs have been approved for premenopausal FSDs than for male sexual dysfunctions (Kingsberg, 2020). Postmenopausal women face a different issue: misinformation claiming that hormone therapy is dangerous (i.e., causes cancer) for menopausal women has prevented many doctors from prescribing treatments that would benefit these women (Simon, 2020). However, while research and medicine for women's sexuality still lags behind that on men, it is receiving more attention than it has historically. Unfortunately, history has set very low standards.

One enormous issue is the assumption that a medical professional who deals with female genitals (i.e., gynecologist, urologist) is also trained in FSD. In reality, physical examination of the clitoris is not regularly taught in urology or gynecology training programs (Aerts et al., 2018). Gynecologists generally deal with the reproductive system (e.g.,

pregnancy, childbirth, menstruation, fertility), while urologists generally deal with the genitourinary system (e.g., kidneys, bladder, urethra, male fertility). Also, many urology services focus on men's bodies and not women's (e.g., Alberta Urology Institute, n.d., mentions men or male organs 39 times but makes no mention of women or female organs). The clitoris is not often not considered part of the reproductive system (though it should be; Levin, 2019) or the genitourinary system, and its treatment—let alone training—is not in the repertoire of many gynecologists and urologists. At ISSWSH's 2017 conference, Dr. Rachel Rubin, a board-certified urologist, asked which healthcare professionals are responsible for the clitoris, then provided the answer: not OB/GYNs, not urologists, and not primary care physicians (Rubin, 2017; Winter, 2017). If not them, then who? Fortunately, ISSWSH members like Dr. Rachel Rubin are working to change this.

Other Helpers' Barriers to Helping Women with Sexual Function Problems

Women may also seek help from sources other than doctors and counsellors, such as pastoral counsellors, friends, or books. Unfortunately, pastoral counsellors frequently lack knowledge or rely on misinformation about sex therapy (Ciarrocchi, 1993) and pharmacists are only equipped to prescribe medication, mostly with prescriptions from doctors. Partners/spouses, friends, or family members may be comfortable places to seek help, but these laypersons are limited to their own experiences for their knowledge. Books, magazines, movies, and the internet all offer a broad range of self-help options (including education) with the benefit of anonymity and affordability, but women may be overwhelmed by the sheer volume of materials available, and they may also lack the knowledge to discern what is helpful and accurate and what is not. For example, American actress, singer, author, and businesswoman Gwyneth Paltrow recommends vaginal steaming (Goop, n.d.), purported to

improve pelvic health (Tikkun Holistic Spa, n.d.), but OB/GYNs strongly advise against it (Gunter, 2015). Telephone helplines for sexual concerns in Canada are a possible starting point for many women seeking help, but they are few and far between. For example, Sex Sense (n.d.) accepts phone calls and emails, but is only available for residents of British Columbia and the Yukon. HealthLink is a health line available in seven of Canada's provinces and territories, including Alberta (HealthLinkBC, 2019), though it is intended for all health concerns, not specifically for sexual function problems. There are a lot of resources available, but few of them are relevant to FSD and available to Albertan women. Unfortunately, many women may not have heard of these options or considered them as possible resources for sexual function problems. Compiling these self-help resources in a web-based guide (see Appendix B: What to Do When Sex Doesn't Feel Right) and describing their utility will help women discover and select appropriate self-help options.

Women's Experiences When They Have Sought Help

In a comedy sketch on Perimenopause (CBC Comedy, 2019), a woman wonders if her hot flashes, forgetfulness, sleeplessness, and emotional outbursts mean she is hitting perimenopause. She eventually goes to see her doctor, who also does not know. He says, "There's not really much research. I mean, who really cares, right?" The woman becomes exasperated and responds, "I don't know, how about like maybe you just tell me what's going on with my body? Like, anything? Is that, is that too unreasonable a request?" The doctor bluntly responds, "It is. Yes, definitely." Even if a woman seeks help, it is not uncommon for doctors to lack the knowledge or even the desire to help her.

The extremely limited literature on women's help-seeking experiences suggests that overall, women are not receiving quality care. Many women who have sought help for sexual

dysfunctions have experienced frustration and anxiety, disgust, shame, and devaluation. Significantly fewer experienced validation, hope, relief, assurance, optimism, confidence, and satisfaction (Berman et al., 2003). Only about half of the women in the study by Berman et al. (2003) reported that their doctor was willing to hear their concerns, listened carefully to them, and was not reluctant to address and treat their issues. Few women felt that their doctor acknowledged the importance of their concern, tried to reduce their nervousness, or asked if they had ever received mental health care (Berman et al., 2003). Some women experience doctors who seemed disinterested, rushed, impersonal, and embarrassed; however, most women report that their doctor seemed concerned, caring, and professional (Nusbaum et al., 2004). However, many doctors do not adequately assess women's psychological history or relationship quality, perform a thorough physical examination and appropriate medical tests, make a diagnosis, develop a treatment plan, or follow up with them (Berman et al., 2003). Further, women who do seek help may be told that their problem is all in their heads (Boatman, 2020; Graziottin, 2008; Jackowich, Boyer, et al., 2021; Sadownik et al., 2012); that they just need a glass of wine (Boatman, 2020); that they should have expected this with aging, parenting, or marriage (Berman et al., 2003); that orgasms are not necessary for women (Barbach, 2000); or that they do not need treatment because they lack a partner (The SexMed Advocate, 2020). Some people do not receive help because their healthcare providers are either dismissive, their diagnoses and treatments do not resolve their concerns, or they do not have treatments to offer. These unhelpful responses lead to women seeking help from one healthcare provider after another (Healy et al., 2019; Jackowich, Boyer, et al., 2021; Reed et al., 2012; Sadownik et al., 2012), which likely results in the belief that seeking further help is futile. In fact, if people believe that there is no cure, they stop seeking help

(Healy et al., 2019) and sometimes they become suicidal or die by suicide (Aswath et al., 2016; Grey, 2020; Healy, 2020; Hengartner et al., 2020; Jackowich & Pukall, 2020a; Jackowich, Pukall, et al., 2021; PSSD Canada, n.d.; Reisman, 2017; Rxisk, 2019).

Recent research on healthcare experiences of people with PGAD/GPD and PSSD has shone light on a new area of FSD help-seeking. People with PGAD/GPD, PVD, or PSSD have approached several healthcare providers (Healy et al., 2019; Jackowich, Boyer, et al., 2021; Reed et al., 2012), with more than half of people with PGAD/GPD having approached six or more healthcare providers. Two thirds of people seeking help for PGAD/GPD received a formal diagnosis, and it took over a year for 20% to receive their diagnosis (Jackowich, Boyer, et al., 2021), compared to one third of women with PVD who waited three or more years for a diagnosis (Connor et al., 2013). Many women experienced healthcare providers who were not knowledgeable or understanding about PGAD/GPD or PSSD, who responded uncomfortably (e.g., avoiding eye contact) or inappropriately (e.g., laughing), and who failed to acknowledge the distress and impairment that PGAD/GPD or PSSD symptoms can cause (Healy et al., 2019; Jackowich, Boyer, et al., 2021). Many women with PGAD/GPD had not sought help at all and long wait times for referrals were common (Jackowich, Boyer, et al., 2021). It is worth noting, particularly for the purposes of this project, that advocating for referrals or reading about PGAD/GPD on their own was perceived as a useful help-seeking strategy practiced by some women (Jackowich, Boyer, et al., 2021; R. Jackowich, personal communication, May 4, 2021).

Given that women's negative experiences seeking help for PGAD/GPD seem to be associated with a lack of research on the condition (Jackowich, Boyer, et al., 2021), it is expected that women will have similar or worse help-seeking experiences when seeking help

for conditions for which there is a similar lack of research. Indeed, Queens Sex Lab, which has done significant research on PGAD/GPD, also posted a blog which shares an anecdote about healthcare provider's dismissiveness when a woman sought help for PSSD (Grey, 2020).

A variety of treatment options exist for FSD (although women may not necessarily receive the treatments that are available). The most common medical treatments for women's sexual function problems are prescription hormone injections, topical creams, or gels (McCool et al., 2016; Rosen et al., 2012); changing birth control method or medication; and starting, changing, or ending hormone replacement therapy (McCool et al., 2016). Healthcare providers may infrequently recommend sildenafil/Viagra (despite a lack of evidence), antidepressants (even though they can cause sexual dysfunctions), and herbal supplements infrequently (Rosen et al., 2012). OB/GYNs commonly recommend education and practical tips, the use of dilators and/or dildos, and self-help resources such as literature, videos, and sex shops (McCool et al., 2016). OB/GYNs use other approaches less frequently, including physical therapy, hypnosis, exercise, homeopathic medicine, and permission-giving for self-exploration (McCool et al., 2016). Doctors can recommend the Eros Therapy Device to help increase blood flow to the female genitals (NuGyn Inc., n.d.-a). Women are infrequently referred to other professionals or treated by the OB/GYN from whom they initially sought help (McCool et al., 2016). Few women receive nondrug therapy such as marriage therapy, sex therapy, counselling, or behaviour therapy (McCool et al., 2016; Rosen et al., 2012; Shifren et al., 2009), and many women do not receive any treatment for their problems (Rosen et al., 2012; Shifren et al., 2009). Research has also demonstrated that some natural products and treatments may be effective in treating FSD (particularly in postmenopausal

women), including L-arginine, ginseng, maca, DHEA and DHEAS, black cohosh (*cimicifuga racemosa*), chasteberry fruit (*vitex agnus-castus*), acupuncture, and yoga (Dording & Sangermano, 2018). See Table 2 below for a list of treatment options and important considerations for specific *DSM-5* FSD diagnoses.

Table 2

Treatment Options for Female Sexual Dysfunctions

DSM-5 FSD	Treatment Options	Considerations
Female sexual interest/ arousal disorder (FSIAD)	Psychological and behavioral interventions	There is evidence for modified Masters and Johnson treatment [167], behavioral sex therapy [168], cognitive-behavioral therapy [169,170], and mindfulness-based approaches [171,172]
	Flibanserin Testosterone, buspirone, bremelanotide	Flibanserin is only approved by the Food and Drug Administration (FDA) for the treatment of hypoactive sexual desire disorder in premenopausal women. The clinical effects are somewhat limited, there are notable side effects and medication interactions, and women taking the medication cannot use alcohol [173–176]
Female orgasmic disorder (FOD)	Psychological and behavioral interventions	There is evidence for directed masturbation [177–180] and sensate focus. Anxiety reduction techniques (systematic desensitization, cognitive behavioral therapy) if anxiety is co-occurring [181,182]
	Sexual aids, such as vibrators [183]	These may be refused by some women (e.g., women who belong to conservative religions or cultures); their partners may be threatened by these devices
Genito-pelvic pain/ penetration disorder (GPPPD)	Psychological and behavioral interventions	There is evidence for mindfulness-based approaches [184,185] and cognitive-behavioral therapy/biofeedback [186–190]
	Treatment of genitourinary syndrome of menopause, if present (i.e., vaginal estrogen, ospemifene) [191–193]	
	Pelvic floor physical therapy [188]	It must be conducted by a specially-trained physical therapist
	Topical lidocaine [190]	It often causes burning when first applied
	Tricyclic antidepressants [194]	These can interact with other medications and cause sleepiness, dry mouth, or urinary retention (the latter more common in older patients)
	Vestibulectomy	There are high reported success rates, but it is usually not performed until less invasive treatments have failed [195–199]

Note. Adapted from Thomas and Thurston (2016, p. 56) and Dording and Sangermano (2018).

This section described various ways that women sought help for FSD and the barriers

they have faced when doing so. Barriers faced by both women seeking help and healthcare providers giving help included a lack of knowledge, discomfort with discussing sexual topics, and systemic problems. I also described women's experiences when they have sought help for sexual dysfunction, which have been negative overall, but, for some women, have been positive. The next section will address the specific sociocultural and political contexts of Alberta that shape women's sexual health experiences.

Sociocultural and Political Context

Information on Albertan women's sexual dysfunctions, help-seeking behaviour, and help-seeking experiences does not exist; however, we can look at broader research on Canadian, American, and other Western women. Canadian women's help-seeking behaviours are dependent on biopsychosocial factors, including their knowledge that there is a problem, the severity and type of FSD, their faith in healthcare professionals, their comfort level with doctors, their access to healthcare, and their physician's comfort level with sexual topics (Brock et al., 2006). Sociocultural, economic, and service-related factors also influence women's help-seeking behaviour (Azar et al., 2013). Albertan women's experiences also depend on these factors. The healthcare services that women are offered are dependent on what services are available (locally, provincially, and nationally), whether healthcare providers are aware of these services, and whether healthcare providers are willing and able to refer patients to these services. The services that are accessible to women will depend on a number of factors, including their location, their personal financial situation, their insurance coverage, congruence of services with values (e.g., personal, religious), and/or whether the services are covered by Alberta Health Care. In this section, I will explore the sociocultural and political factors that impact Albertan women's likelihood of experiencing a sexual

dysfunction, their help-seeking behaviour, and their help-seeking experiences.

Political and Religious Climate

As I outlined above, religious and cultural practices impact women's sexuality (Atallah et al., 2016; Kingsberg & Rezaee, 2013) and women's help-seeking behaviours (Azar et al., 2013). Also, political affiliation is correlated with religion and accuracy of sexual health education; specifically, the more politically conservative a parent is, the less medically accurate their SHE knowledge (Eisenberg et al., 2004). Historically, Alberta has been, and continues to be, politically conservative (Elections Alberta, n.d.), having had a conservative government for 44 of the last 48 years (Albertans took a brief hiatus from conservative governments from 2015 to 2019 with the election of the New Democratic Party in 2015). Given the correlation between political conservativism and inaccurate sexual health knowledge (Eisenberg et al., 2004) and that highly religious Albertans are more likely to vote for the United Conservative Party (DeCillia, 2019), it is likely that highly religious Albertans are also providing inaccurate sexual health education to their children. Interestingly, Albertans without a religious affiliation or with low religiosity are not more likely to vote for the New Democratic Party (DeCillia, 2019).

Research indicates that 68% of Albertans identify with a religion (71% of women and 66% of men); specifically, three percent of Albertans identified as Muslim and 60% as Christian (Statistics Canada, 2013). Twenty-four percent of Christians identified their religion as Catholic, eight percent as United Church, three percent as Lutheran, four percent as Anglican, as 15% as Other Christian (Statistics Canada, 2013). There is also a large Latter-day Saint (LDS) population in Southern Alberta, with some towns having LDS populations as high as 78% (Rosen & Skriver, 2015). Over half of Canada's LDS population lives in

Alberta (Statistics Canada, 2019a). According to the CoJCoLDS, two percent of Albertans are LDS (2018a), compared to 0.5% of Canadians (2018b). These religions tend to place restrictions on sexual behaviour. For example, LDS members in good standing must refrain from all sexual activity before marriage, including masturbation, and may only engage in partnered sexual activity within a heterosexual marriage (CoJCoLDS, 2011). Some Muslim and Christian traditions position sex as a woman's duty to her husband (Azar et al., 2013; Kinsey et al., 1953), thus inhibiting her sexual autonomy. Further, religious fundamentalists are much more restrictive of sexual behaviour than the non-religious and non-fundamentalists (Crooks & Baur, 2011a). Given the impact of religious and cultural practices on women's sexuality (Atallah et al., 2016; Kingsberg & Rezaee, 2013) and help-seeking behaviours (Azar et al., 2013), it is likely that some religious Albertan women experience these impacts as well.

Gender and Inequality

Gender alone impacts health outcomes (Last, 2006; PHAC, 2018), though let me be clear: women are not inherently less healthy than men. Gender impacts health outcomes because of the various structural inequalities that underprivilege women's health. Unfortunately, Alberta is one of the worst Canadian provinces to be a woman. In a report titled *The Best and Worst Places to be a Woman in Canada 2016* and its newer version from 2019, 25 metropolitan areas in Canada were ranked according to women's access to economic security, education, health, leadership, and security, and given an overall rank (McInturff, 2016; Scott, 2019). Calgary and Edmonton were the only cities included from Alberta, and they ranked 21st and 25th overall in 2019—out of 26. A deeper look at these numbers also shows that Canadian women usually hold fewer leadership positions than

Canadian men in general, but that this effect is especially pronounced in Alberta (McInturff, 2016; Scott, 2019). For example, from the 2019 report, of the Alberta cities included, women occupied only five of the 28 city council seats (Scott, 2019; K. Scott, personal communication, October 7, 2019). Hunter (2014) points out the impact this has on women's sexuality: "We like to think women are empowered in [the West] and yet we are underrepresented in board rooms and in parliament…. Is it any wonder, then, that women find it hard to negotiate their own sexual satisfaction?" (paras. 19–20). And how can we expect laws and policies to reflect Albertan women's perspectives and take Albertan women's needs into account when there is so little representation from actual women?

Alberta's Sexual Healthcare

Another factor impacting the likelihood of Albertan women experiencing a sexual dysfunction and their help-seeking behaviours and experiences is the state of Alberta's sexual healthcare and SHE. Sexual health is dependent on the SHE and the sexual healthcare available (WHO, n.d.-b) and Alberta is no exception. Alberta Health provides a basic patient resource (Healthwise Staff, n.d.) on women's sexual function problems, which recommends that a woman seek out a family doctor, gynecologist, sex therapist, psychologist, or urologist if she has a sexual function problem. This website also provides a list of treatment options for women's sexual problems, which includes many standard treatments: treatment of physical causes, education, couples counselling, psychotherapy, and sex therapy (Healthwise Staff, n.d.). Unfortunately, the resource is not comprehensive and its emphasis on psychological/interpersonal treatments reflects a longstanding myth that psychological problems are responsible for most FSDs. Regardless, can Albertan women access the healthcare they need when they do seek help? Based on my understanding of the

biopsychosocial model and the contexts impacting Albertan women, I expected the following factors will be among barriers that Albertan women may face in seeking help for FSD:

- The presence of sexual medicine services. In Alberta, we have the Foothills Sexual Function Clinic in Okotoks and Jablonski Health at Peak Specialty and Pinnacle Medical Centre in Calgary, which appear to be helpful but small and difficult-to-find services. (Searching Google for "Alberta sexual problems" or similar terms does not yield results with these services.) As of Sept 16, 2019, AHS (2019) reported 176 "sexual and reproductive health services" available to Albertans. Readers may be fooled into thinking that women with FSD have an abundance of options, but careful analysis of these services and their areas of focus suggest that few of these services deal with FSD (or the clitoris) and none of the services are exclusively for FSD. Foothills Sexual Function Clinic and Jablonski Health did not appear in this list of sexual and reproductive services, so it is possible that more sexual health services exist but are not included in these lists. Outside of AHS, there are private services that do address sexual functioning issues, including many services that address pelvic pain (e.g., Cura Physical Therapies in Edmonton), but Alberta Health Care does not cover private services, so cost becomes an issue. There are currently only a few certified sex therapists in Alberta (see https://www.aasect.org/referral-directory), limiting competent mental healthcare options for sexual problems. Private gynecologists (e.g., Allan Centre in Calgary) and private urologists exist (e.g., Southern Alberta Institute of Urology, Alberta Urology Institute), but it is unclear how many of these services address FSD. When women do not know what is causing their problem, they are forced to trust that their family doctor can direct them to the right service or pursue

options that may end up being a waste of time and money.

- Referrals. The Alberta Referral Directory (https://albertareferraldirectory.ca/) is helpful for finding appropriate referrals but only if doctors use it. Doctors may not know what referral options are available or they may have limited referral options (McCool et al., 2016; Pauls et al., 2005), and that is likely related to why medical professionals infrequently refer women to sexuality professionals (McCool et al., 2016). In fact, Alberta Health's website (Healthwise Staff, n.d.) does not suggest referring to sexual medicine centres (even though the Foothills Sexual Function Clinic is covered by Alberta Health Care), and many centres outside Alberta do not accept referrals from outside their province (e.g., BC Centre for Vulvar Health), so Albertan women have limited options and may not even receive referrals to services that do exist. Referral to an appropriate counsellor or therapist presents similar issues due to the dire lack of training in sexuality that they receive and the shortage of certified sex therapists in the province. If a woman receives a referral, it is possible that she will find herself with a professional without the necessary background to treat her.
- Wait times. Wait times for provincial healthcare can be long, and interventions relevant to sexual dysfunction are no exception. From August 2019 to August 2020, AHS wait times for procedures that may be related to FSD varied from 14 weeks to 53 weeks (Alberta Health, n.d.). While waiting for treatments, women continue to experience the negative impacts of FSD (e.g., on mental health, relationships) and when that wait is over, they may still encounter medical personnel that are unfamiliar with their concerns.

- Personal access issues. Many Albertan women do not have health insurance, and many insurance companies do not cover FSD, especially if the treatment is for a pre-existing condition. Further, women may be expected to pay up front as pharmacies are unable to direct bill insurance companies for compounded drugs (Lakeside Medicine Centre Pharmacy, 2019; MEDS Pharmacy, n.d.), which are often used in the treatment of FSD (CareFirst Specialty Pharmacy, n.d.), and Alberta Health Care only covers services offered by Alberta Health. Distance to services may also be an issue for many women. About 16% of Albertans live in rural parts of the province (Statistics Canada, 2017, 2019b) and women in these areas may not have access to doctors, let alone sexual medicine practitioners. On top of that, many services—such as Alberta Health services that deal with more than incontinence and pelvic organ prolapse or AASECT-certified sex therapy—are not even available in Alberta's third-biggest city, Lethbridge.
- Qualifying for services that are available. Just because a service is available does not mean that a woman's symptoms or diagnostic tests will qualify her for treatment. For example, Lethbridge has a pelvic floor clinic, but women can only be referred there for incontinence or pelvic organ prolapse (AHS, n.d.-a), not for sexual pain, which is a common symptom of pelvic floor dysfunction (Prendergast & Rummer, 2016). Another example is that many urology services focus on men's bodies, not women's. For example, Alberta Urology Institute (n.d.) mentions men or male organs 39 times but makes no mention of women or female organs. Thus, Albertan women may not qualify for some urology services or urologists may be unfamiliar with women's bodies or FSD. Because FSD is not widely understood, there are systemic barriers to

what services can be provided.

When seeking help for FSD, it is likely that many Albertan women will not receive the help they need. These women are likely to face multiple barriers specific to living in Alberta, including a lack of sexual medicine services, a lack of doctors' referral knowledge, long wait times, long travel distances, financial issues, and issues qualifying for available services.

Alberta's Sexual Health Education

Comprehensive sexual health education (SHE) is important for women's sexuality for many reasons. Most importantly, it enhances sexual health (SIECCAN, 2020)—physical, emotional, mental, and social well-being in relation to sexuality (WHO, 2006)—which is linked to overall health and well-being (Laumann et al., 1994; Laumann et al., 2006; SIECCAN, 2019). Comprehensive SHE for teens results in increased contraceptive use, delays first sexual activity, and decreases negative sexual health outcomes, including STIs, unintended pregnancy, and sexual violence (SIECCAN, 2020). The SHE that women receive also impacts their help-seeking behaviours, as SHE impacts whether women know what normal and healthy sexual functioning is (e.g., sex should not hurt), whether they know who to ask for help, and whether they know that sexual health (and pleasure) is a human right (SIECCAN, 2020). Unfortunately, in SHE, females are generally presented either as vessels of reproduction (Beyer et al., 1996; Levine, 2002) or victims of coercion (Beyer et al., 1996; Fine, 1988; Fine & McClelland, 2006).

While there are excellent international guidelines for SHE (e.g., United Nations Educational, Scientific and Cultural Organization [UNESCO], 2018) and Canada has their own comprehensive guidelines (i.e., SIECCAN, 2019), SHE is the domain of provincial

governments, not federal governments (Humphreys, 2017). Unfortunately, Canadian SHE has usually focused on the physical aspects of sexual health, such as reproduction and STI prevention (SIECCAN, 2019), thereby limiting or excluding information on many important topics like pleasure and FSD. The quality of SHE that Canadian students actually receive varies depending on several factors, including province, teacher comfort, teacher expertise (Humphreys, 2017), school board, principal, teacher values, and whether community health centres and groups offer support (Action Canada for Sexual Health & Rights [ACSHR], 2020).

AHS (n.d.-b) provides a website with a variety of sexual health resources, including TeachingSexualHealth.ca, which was created in 2001 to assist parents and teachers in teaching sexual education (Teaching Sexual Health, personal communication, September 12, 2019). While it claimed to be comprehensive when it was first created, it was not until 2017, two years into the NDP's brief leadership stint, that the resource was massively overhauled to include a significantly more comprehensive SHE, including information on topics such as consent, sexual orientation, gender identity, abortion, and polyamory (AHS, n.d.-c). Of course, for students to benefit from this resource, parents or teachers must use it, or students must find it themselves.

Alberta's SHE is encompassed within Alberta Learning's two classes: Health and Life Skills (kindergarten to grade 9) and Career and Life Management (grades 10 to 12). Neither the programs of studies (Alberta Learning, 2002a, 2002d) nor the teacher implementation guides (Alberta Learning, 2002b, 2002c) make any mention of pleasure or sexual function, instead choosing to focus on preventing negative outcomes, mostly through abstinence strategies. Robinson et al. (2019) noted that, while the Program of Studies

contains a variety of SHE outcomes, in reality some outcomes are covered only briefly.

Alberta Learning (2002b) rationalizes this omission of information and shirks responsibility by stating that "adolescents rely on parents to provide guidance about sexual issues, ideas, opinions and values. The family is the primary sexuality educator" (p. 19). Unfortunately, this means that many Albertan adolescents are completely missing out on quality SHE, as 22% of American females aged 15 to 19 have never discussed any sexual health topics with a parent (Lindberg et al., 2016) and parents often fail to teach their daughters the location, function, or existence of the clitoris (Kreinin, 2002; Ogletree & Ginsburg, 2000) or the potential pleasure of sex for women (Brock & Jennings, 1993; Tolman, 1994). Even if parents do teach their children about SHE, parents' knowledge of sexual health may be inaccurate or incomplete, especially if the parent is politically conservative (Eisenberg et al., 2004). Some Albertan women may have missed out on SHE in junior high and high school, as 10% of Albertan women do not have a high school diploma, and there are areas of Alberta where as high as 19% of women do not have a high school diploma (Statistics Canada, 2016). These graduation statistics are particularly relevant to FSD, as higher rates of FSD are correlated with lower educational attainment (Abdo et al., 2004; Laumann et al., 1999; Lou et al., 2017; Safarinejad, 2006; Shifren et al., 2008). Considering all these factors, it is likely that many students are not getting comprehensive SHE, some are getting inaccurate SHE, and some are getting no SHE at all.

Indeed, ACSHR (2020) argued that the SHE received by young Canadians is not meeting international standards or SIECCAN's guidelines, is not comprehensive, is not monitored or evaluated, is outdated, and is offered by educators with little to no support. This is reflected in a quote from a 24-year-old Calgarian when asked about their SHE experience:

> "My sex-ed was a failure. I didn't learn about body parts and their proper names…. I never learned that sex shouldn't or doesn't have to hurt. I never heard about reproductive control, like birth control and abortion. I was left to my own devices, many of which were unreliable, biased, and inaccurate, in learning about these topics" (ACSHR, 2020, p. 19).

While this person's experience is not necessarily representative of all Albertan SHE (and we do not know for sure that they were educated in Alberta), it demonstrates the personal impacts of poor SHE, which is likely what many Albertans have received.

Research has consistently demonstrated that neither parents nor schools teach about women's sexual pleasure (Beyer et al., 1996; Brock & Jennings, 1993; Fine, 1988; Fine & McClelland, 2006; Kreinin, 2002; Ogletree & Ginsburg, 2000; Tolman, 1994; Wade et al., 2005), so it is not surprising that none of the aforementioned Alberta Learning SHE resources mentioned sexual dysfunction. This is a disservice to Albertan women *and girls* because teens are also at risk of experiencing FSDs (Moreau et al., 2016) and may experience difficulties with first-time vaginal penetration by tampons, menstrual cups, specula, and a sexual partner's finger or penis.

In post-secondary institutions, human sexuality education is a requirement only in some programs, such as psychology, sociology, or women and gender studies (Humphreys, 2017). Because 25% of Albertan women have only a high school education (Statistics Canada, 2016), universities and colleges are not filling in the SHE gaps left by high schools. Courses like these are likely to address basic sexual functioning complaints, but not less common problems. Perhaps worst of all, women's sexual anatomy is still underrepresented even in medical (e.g., Agur & Dalley, 2017; Brennan et al., 2020; Moore & Agur, 2018) and

OB/GYN textbooks (e.g., Baggish & Karram, 2016), meaning that healthcare providers likely lack the knowledge to aid women who do seek help.

Given that SHE in primary and secondary school does not cover sexual dysfunctions and that lower educational attainment is associated with higher rates of sexual dysfunction (Abdo et al., 2004; Laumann et al., 1999; Lou et al., 2017; Safarinejad, 2006; Shifren et al., 2008), people with less education experience a dual calamity: they are at higher risk of FSDs while having little to no knowledge about FSDs. Because SHE has been used to treat FSD (Behboodi Moghadam et al., 2015; Kaviani et al., 2014; Zippan et al., 2020) and may help prevent some FSDs in women who are at risk, such as pregnant women (Afshar et al., 2012), the lack of comprehensive SHE in Alberta has likely impacted the sexual function of many girls and women.

Chapter Summary

Based on the research on FSD and help-seeking covered in this literature review, I argue that women are in dire need of clear guidance on how to seek help for sexual function problems, and that a web-based guide is one effective way to meet this need. The literature review of this final project involved critical analysis of several important topics important to help-seeking and FSD. I began by defining several important terms and describing the ways FSD can impact women's mental health, sexual function, relationships, and partners, and its relationship to women's physical health. Next, to explain the function of female sexual organs, especially those involved in sexual pleasure, I described female sexual anatomy. A brief discussion followed on my use of intersectional feminism and the biopsychosocial model as theoretical lenses for this project. I also described sexual response models relevant to FSD, with special attention to Basson's (2000, 2001, 2005) circular model of sexual

response, with which women with FSD identify most strongly (DeRogatis et al., 2016; Giles & McCabe, 2009; Sand & Fisher, 2007), and the DCM/STP model (Bancroft et al., 2009; Perelman, 2009), which provides a framework to understand inhibitory and excitatory influences on sexual response. I then described healthy female sexual function, followed by a detailed discussion on the nomenclature and definitions of FSDs created by sexual medicine experts.

The next topic discussed was Western sociocultural barriers to women's sexuality and women's help-seeking behaviours, barriers, and experiences. This information is especially relevant to the creation of the web-based guide, as there are many barriers to receiving adequate healthcare for sexual dysfunction that women face, as evidenced by the negative experiences reported by women who have sought help for FSD (Berman et al., 2003; Mitchell et al., 2017; Sadownik et al., 2012) and also the number of women who do not seek help for sexual function complaints (Berman et al., 2003; Brock et al., 2006). Further, healthcare providers often have limited time with patients, and healthcare providers who are not sexual medicine specialists are unlikely to pursue professional development on FSD. I concluded this chapter by discussing sociocultural and political factors that impact Albertan women's sexual function, help-seeking behaviours, and help-seeking experiences, such as the lack of inclusion of information on FSD and female sexual function in elementary or secondary SHE, which inhibits women from learning accurate information about their sexual function from trusted sources.

Delving into these topics has helped me to see where problems arise in women's help-seeking, allowing me to provide more effective guidance to women. Women should and must have access to information about female sexual function and how to seek help if they

have concerns. Arming women with the knowledge and confidence to self-advocate and seek assistance will support them in navigating through the healthcare systems that are currently ill-equipped to assist due to inadequate professional training, short appointment times, expensive treatments, and a system that turns a blind eye to many women who require information and treatment. Empowering women to advocate for themselves will assist them in pursuing and accessing better healthcare for FSD and may also help women and healthcare providers use their time together more efficiently, which will lead to faster and more appropriate diagnoses, referrals, and treatments.

Chapter III: Methods

This chapter outlines the methods performed in the construction of this final project. First, I will describe my methods for acquiring relevant peer-reviewed and evidence-based research on FSD and help-seeking, followed by an explanation of the creation of the content of the web-based guide. Next, I will explain how this information will be made available to women. I will conclude be explaining important implications for this project and web-based guide.

Review of the Literature

The goal of this final project is to create an in-depth literature review which will inform the creation of an online self-help guide, entitled *What to Do When Sex Doesn't Feel Right*. I conducted an extensive literature review on the topic of healthy and unhealthy sexual functioning in women, women's help-seeking behaviours and experiences, and women's sexuality in Western society. I searched databases available at the University of Lethbridge library website, including PsychInfo, JSTOR, PubMed, ERIC, and EBSCO, and I used Google Scholar, interlibrary loans, or the Lethbridge Public Library to acquire resources that are not available through the University of Lethbridge. Keywords used in the aforementioned database searches included: *female sexual dysfunction, female sexual disorder, sexual concerns, sexual pleasure, low desire, anorgasmia, sexual function, women's sexuality, help-seeking, barriers, experiences, impact, sex therapy, stigma, pain, sexism, healthcare*.

Preliminary searches were followed by further assessment of the references in the relevant sources from the original search. I analyzed the literature and synthesized it in a way that supports the purpose of this project, a resource to support Albertan women who are seeking help for sexual function problems.

Creation of the Guide Content

Based on the information in the literature review, I was able to identify many ways in which women's help-seeking experiences FSD are hindered. Some of these issues are systemic and thus outside the scope of this guide, so my goal was to empower women to work within the current system. Based on this goal, I identified the information that women would need in order to overcome these barriers. I have synthesized relevant information from the literature to address three main topics in the web-based guide:

1. Why women should read the guide and seek help for FSDs,
2. Information on female sexuality, and
3. How to seek help effectively and efficiently.

It is my hope that synthesizing the information from the literature review in this way will support women in exhibiting more effective help-seeking behaviours, leading to more positive help-seeking experiences.

Knowledge Transfer

After I created the content of the web-based guide, I organized it into a website which is available for free on the Web at www.femalesexualproblems.ca. A website is the ideal method of dissemination as it allows for continual updating, no page limit, and easy access to other online resources (i.e., instead of typing a long URL from a pamphlet, hyperlinks can be clicked quickly and easily).

To ensure that this web-based guide is found by those who need it, I purchased a domain (www.femalesexualproblems.ca) instead of using free web hosting. This allowed me to choose a domain that would state the main idea of the website ("female sexual problems") while providing more specific information in the title of the website ("*What to Do When Sex*

Doesn't Feel Right"). I have also tried to take advantage of search engine optimization (SEO) by including relevant SEO keywords, including specific female sexual dysfunctions (e.g., female orgasmic illness syndrome), acronyms (e.g., PGAD/GPD), the names of cities in Alberta (e.g., Calgary), healthcare provider occupations (e.g., gynecologist), sex therapy terms (e.g., sex education), female sexual response terms (e.g., pleasure), help-seeking terms (e.g., help), and female genital anatomy terms (e.g., vagina). When SEO is done well, it increases the likelihood that the website will appear in search results when a user searches with relevant keywords. Good SEO also increases the likelihood that the website will be among the first search results (Moz, n.d.). Finally, I have linked to the web-based guide on my personal website and hope to find other professionals who will be willing to provide a link to the guide on their sites.

The web-based guide will not be formally disseminated at this time, but if I encounter anyone who is seeking information on FSD, I will direct them to the guide website. I plan on sharing my web-based guide on social media and web forums, particularly in spaces dedicated to FSDs. Sharing this resource with Albertan women's healthcare providers (e.g., therapists, family doctors, gynecologists) may also lead to these professionals sharing this resource with those who need it.

Implications of the Project

Many women do not know what is normal, when they should seek help, what help is available, where to seek help, what they can try before seeking help, or what resources are reliable. Some people have misconceptions about what happens when they receive help, such as mistakenly believing that sex therapy involves having sex in front of or even with the therapist (Milbrand, 2020)! There is a need for a bridge between these women and the

healthcare available for these conditions, especially since women who seek help for sexual dysfunctions are doing so in a system which is not designed with their needs in mind.

In providing women with knowledge about female sexuality, barriers to help-seeking, and solutions to these barriers, this web-based guide has the potential to help women avoid the negative experiences that are so common when women have sought help for sexual dysfunctions. As education about female sexuality is almost as effective as evidenced-based treatments for desire and arousal disorders (Zippan et al., 2020), this web-based guide also has the potential to help women with FSD without them having to see a healthcare professional. Finally, this project and web-based guide may also provide important information to women's partners about FSD and to healthcare providers about ways they can help women better.

Chapter IV: Overview of the Web-Based Guide

The aim of this final project is to create a resource to support women who are seeking help for sexual dysfunction. The web-based guide, titled *What to Do When Sex Doesn't Feel Right*, is available for free at www.femalesexualproblems.ca/. This web-based guide was designed based on the synthesized literature covered in this project. As women face many barriers when seeking help for FSD (Donaldson & Meana, 2011; Gott & Hinchliff, 2003; Ibine et al., 2020) and often have negative experiences when they do seek help (Berman et al., 2003; Mitchell et al., 2017; Sadownik et al., 2012), this guide strives to empower women with the information they need in order to know why, when, where, and how to seek help effectively and efficiently.

Description of the Contents and Function of the Web-Based Guide

This web-based guide is organized in a way that allows women to read only the sections that seem most relevant to them. The content is arranged under 10 broad questions that women will likely have about seeking help for sexual dysfunction. Each of these questions is on a separate webpage, and there are more specific questions on each webpage to help women narrow down the location of the information they are seeking. Each page of the web-based guide contains hyperlinks to external resources or other relevant areas within the guide itself. I have organized these 10 questions into categories in order to discuss them here.

Welcome Page

This page of the web-based guide briefly explains who the guide is for, including women with sexual function concerns and their partners, women are not sure if they have a problem or where to go for help, and women who have sought help unsuccessfully in the past. This page also explains how to use the guide, specifically explaining the use of

questions as headings and stating that reading the entire guide is not necessary.

Rationale Pages

As I was completing the writing of this web-based guide, I realized that I had not yet included information on why women should spend the time reading this guide or why they should even bother seeking help, especially if they have previously had negative experiences. Out of this, two questions emerged:

- *Why should I read this guide?*
- *Why should I seek help?*

The first question, *Why should I read this guide?*, addresses the rationale for this web-based guide. Specifically, I argue that women lack adequate knowledge about their bodies, FSD, and how to seek help, and that this guide fills in these gaps. I also address the prevalence of FSDs and the intended benefits of reading this web-based guide.

Why should I seek help? addresses the broad range of negative impacts that FSD can have on women's mental health, physical health, general wellbeing, self-esteem, sexual self-esteem, quality of life, relationships, and partners. If these arguments are not enough to convince a woman to seek help for her sexual dysfunction, the final section on this page addresses barriers to seeking help, including not believing that her symptoms are a problem, being too uncomfortable to discuss the problem with someone, and lacking enough time or money, and provides suggestions on how to combat these barriers using this guide.

Sexual Health Education Pages

This web-based guide has four pages with different questions to address necessary sexual health information that will support women in seeking help for sexual dysfunction:

- *Is it my fault that I have sexual problems?*

- *What anatomy is involved in female sexual pleasure?*
- *What does healthy sexual function look like?*
- *How do I know when it's time to seek help?*

The purpose of the first sexual health education question, *Is it my fault that I have sexual problems?*, is to tell women that their sexual function problems are not their fault. This page of the web-based guide begins by looking briefly at the physiological, psychological, sociocultural, and interpersonal factors that influence female sexual function. Then I include a deeper look at several sociocultural factors that interfere with women experiencing sexually fulfilling lives, including the fact that sexual health education rarely, if ever, mentions women's sexual pleasure; that heterosexual women and men prioritize men's sexual pleasure over women's sexual pleasure; that Western society mistakenly believes female sexuality is complicated; and that many Western women are not empowered to ask for or demand pleasure.

The second sexual health education question, *What anatomy is involved in female sexual pleasure?*, includes detailed information on external and internal female genital anatomy. An understanding of female genital anatomy is important for a woman's sexual function, and accurate terminology is imperative for effective communication with healthcare providers. This section emphasizes the importance of the clitoris in female sexual pleasure while also drawing attention to the roles of other organs that are involved in female sexual pleasure.

What does healthy sexual function look like? is the third sexual health education question in this web-based guide. This page begins with a discussion of sexual response models, explaining the utility of Basson's (2000, 2001, 2005) circular model of sexual

response and the DCM/STP model (Bancroft et al., 2009; Perelman, 2009) in looking at female sexual function and dysfunction. Next, I address several questions about various aspects of healthy sexual function, including willingness and consent, desire, arousal, orgasm, pain, pleasure, and absence of attraction to other people.

The final question addressing sexual health education is *How do I know when it's time to seek help?*. On this page, I explain the nomenclature and definitions of the FSDs described by sexual medicine experts and how these definitions relate to the nomenclature and definitions in the *DSM-5*. I also explain specifically when seeking help might be warranted, based on these definitions. After women are empowered with information about sexual health from these webpages, I provide them with information on effective and efficient help-seeking on the next webpages.

Help-Seeking Pages

This web-based guide has four pages to address the questions that women will have when seeking help for sexual dysfunction:

- *Where do I go for help?*
- *How do I seek help?*
- *What can I expect when seeking help?*
- *What self-help options do I have?*

The page with the first help-seeking question, *Where do I go for help?*, begins by giving women step-by-step instructions how to choose a professional. This involves general recommendations on how to match the profession to a woman's sexual function concern and specific recommendations (i.e., people or businesses) for specific professions (pelvic floor physiotherapy, sex therapy and mental health, urologists, and sexual medicine specialists). I

also include detailed instructions on how to interview professionals. Next, I address where to be careful seeking help, as seeking help from some people could either be a waste of time or iatrogenic. Finally, I provide information and recommendations on seeking help within cultures specific to Alberta, including Christian; Post-Christian; First Nations, Métis, and Inuit; Jewish, Latter-day Saint (LDS); and Muslim cultures.

What can I expect when seeking help? is the second help-seeking question. The intent of this page is to prepare women for their appointment by giving them information on what to expect and why. This begins with addressing the potential for negative experiences with healthcare providers, why some healthcare providers fail to provide good help, and how to mitigate these potentially negative experiences. This page ends with information on possible referral options and treatment options.

The goal of the third help-seeking question, *How do I seek help?,* is to help women have a positive experience when seeking help for sexual dysfunction. This page of the web-based guide begins by providing information on how to prepare for the appointment with their chosen healthcare provider, followed by resources that women could bring to support their self-advocacy. This page concludes with step-by-step instructions about what to do at the appointment, how women can maximize time with their healthcare providers, and how women can get their needs met at the appointment.

The final help-seeking question, *What self-help options do I have?*, addresses ways women can seek help without talking to anyone else. I begin by addressing two very easy and effective ways to treat many women's sexual function problems: masturbation and vibrators. This is followed by recommendations to help women learn about general female sexual function, new ways to experience pleasure, other women's sexual experiences, and sexual

health education. Next, I provide self-help resources for problems with partnered sex, desire, orgasm, pain and penetration, and sexual abuse. This page ends with recommendations and links to support groups or social media accounts that share information about sexual health and women's sexual health.

Chapter Summary

This web-based guide was designed to support women with sexual dysfunctions in determining why, when, where, and how to seek help. In this web-based guide, I address women's questions about why they should read this guide and seek help, questions about sexual function and dysfunction, and questions about seeking help. Women face many barriers when seeking help for FSD (Donaldson & Meana, 2011; Gott & Hinchliff, 2003; Ibine et al., 2020) and negative experiences when seeking help are common (Berman et al., 2003; Mitchell et al., 2017; Sadownik et al., 2012), but this web-based guide provides some antidotes to some of these problems.

Chapter V: Discussion

This chapter includes a summary of this final project. The final project includes an extensive literature review and the web-based guide derived from it, *What to Do When Sex Doesn't Feel Right.* This chapter begins with a summary of discussion, followed by my reflections on the process of researching and designing this project. Next, I address accessibility of the web-based guide. The project's strengths and limitations are then described, supporting the subsequent recommendations for future research. This chapter ends with a discussion of the significance of this project.

Summary of Discussion

The purpose of this project was to create a resource that would support women with FSD in understanding why, when, how, and where to seek help and to provide this information in a way that would be accessible to as many Albertan women as possible. This guide may also benefit healthcare providers and women's partners, friends, and family, as other people may seek help on behalf of women with FSD and healthcare providers may benefit from learning about FSD and women's help-seeking barriers, behaviours, and experiences. Providing this information could allow these people to support the women in their lives who have FSD in seeking help. While this guide is directed specifically at Albertan women, much of the information will also benefit women from any country in seeking help for sexual dysfunction. Further, some of the information in this web-based guide may be useful for transgender men and transgender women, given that transgender men had or still have female genitals and that transgender women have lived experiences as women. The web-based guide and the literature review on which it was based were developed by me, with essential guidance from my supervisor, Dr. Noëlla Piquette, and my

committee, Dr. Toupey Luft.

Reflections on the Guide and Project

This project began as a thesis on the experiences of Albertan women seeking help for sexual dysfunction. While preparing for graduate school, I enrolled in a course called *Psychology of Women*. One of the assignments was to develop a research proposal on one of the topics we covered in the course. As this course contributed to my growth as a feminist and increased my recognition of the injustices that women face in every aspect of their lives, when I found Berman et al.'s (2003) study on women's negative help-seeking experiences, I knew I had found my topic. Later, when Dr. Kaitlyn Hillier suggested that it could be a thesis topic, I resolved to study this during my Master of Education (Counselling Psychology) at the University of Lethbridge. During the development of the research proposal, I spoke with many female friends, acquaintances, and even strangers about their help-seeking experiences and found that there were many women who had had negative experiences and would be willing to be interviewed. Unfortunately, several significant barriers, including the Covid-19 pandemic, inhibited my completion of this thesis, and I switched to a project so that I would be able to complete my degree more quickly and begin my career. This was a difficult and heartbreaking decision, but I believe that it was the right choice, as this final project will likely have a more direct impact on women seeking help for FSD.

Accessibility

To ensure that this annual is broadly accessible, I decided to make the information available on the internet as a webpage. This also allows me the ability to update the web-based guide whenever important new information, such as helpful healthcare providers or new treatments, becomes available. Thus, the guide contents included in Appendix B: What

to Do When Sex Doesn't Feel Right are the contents of the guide at the time of completion of this project.

To increase the website's navigability, the guide's first- and second-level headings are included in the website menu (see Appendix A: Screen Capture of the Web-Based Guide's Welcome Page). This allows users to see the subheadings of each page without scrolling through the entire page searching for information. I also included a search bar on each page in case users want to search the site for specific terms.

The language used within the guide includes some terminology, such as genital anatomy, that may be new to some women. However, I have attempted to explain these terms with diagrams and clear explanations. Regardless, the language may not be accessible to all readers, particularly those for whom English is a second language. Whenever possible, I have attempted to use language that would be understood by high-school aged Albertans. Checking the readability of the web-based guide on https://readabilityformulas.com/freetests/six-readability-formulas.php confirmed that the guide is appropriate for students in grade 11 to college.

Strengths and Limitations

Completing an extensive search for relevant articles and resources ensured that a comprehensive literature review was performed to support the creation of the web-based guide. Research from many disciplines was used, including medicine, gynecology, urology, nursing, psychology, counselling, education, sociology, neuroscience, and public health. This ensured that the web-based guide reflects the literature on FSD from many professional perspectives.

The research synthesized for the literature review included qualitative studies,

quantitative studies, and meta-analyses. Including different research methodologies ensures that I have investigated topics from multiple angles, including different timelines (e.g., cross-sectional versus longitudinal studies) and circumstances (e.g., all sexual function problems versus diagnosable FSDs). This allowed for the web-based guide to be relevant to women regardless of whether they meet specific thresholds for diagnosis, as some diagnoses require symptoms for six months or more.

While the majority of the articles and studies examined in this literature review were published within the last decade (and a significant portion were from the last five years), a dearth of research on some topics meant that it was sometimes necessary to examine older or less relevant literature. Thus, some of the studies may not reflect contemporary social trends or Albertans/Canadians and this may limit the relevance of some of the recommendations I make in my web-based guide. For example, the there is little research on Canadians or Albertans regarding prevalence of FSD, prevalence of specific FSDs, help-seeking behaviours, help-seeking barriers, and help-seeking experiences. If I found research, it was often quite dated (e.g., Brock et al., 2006). As a result, I often relied on research on Americans or other Western cultures. Regardless, I made significant efforts to ensure that contemporary and relevant literature was included whenever possible.

Another potential limitation is the broad range of FSDs examined. Because each FSD has many risk factors and treatment options of its own, explaining the individual risk factors for each FSD and the possible treatment options would have been intensive and often redundant. As a result, I simply described risk factors for all FSDs in the four biopsychosocial categories and described treatment options in terms of three broad categories (desire, arousal, and orgasm disorders). This may limit the ability of women to identify their

risk factors or the specific treatments they should pursue, but their healthcare providers should be the one to make these decisions.

Recommendations for Future Research

The limitations in my project signify several important gaps in the research. In general, new research is needed on FSD, particularly treatments for FSD. Women have significantly fewer treatment options for FSD than men do for sexual dysfunctions (Kingsberg, 2020), and this needs to change. Research on Albertan women's help-seeking behaviours, barriers, and experiences is also needed, and updated research is needed on these same topics for Canadian women.

The literature review also demonstrates the need for research on more recently recognized sexual dysfunctions, including PGAD/GPD and PSSD/PRSD/PFS. Research on PGAD/GPD has exploded in the last several years (e.g., Aswath et al., 2016; Jackowich, Boyer, et al., 2021; Komisaruk & Lee, 2012; Oaklander et al., 2020) and future research may involve the effectiveness of help-seeking behaviours and strategies (R. Jackowich, May 4, 2021, personal communication). However, significant research on PSSD/PRSD/PFS is needed in order to legitimize the condition, find treatment options for this debilitating condition, improve the quality of life of those plagued by these symptoms, and prevent their deaths by suicide.

Significance of the Project

Many women experience problems with sexual function, including low desire, arousal and orgasm difficulties, sexual pain, and diminished pleasure. These problems can have a negative impact on many areas of women's lives, including their mental health, other areas of sexual function, romantic relationships (e.g., Ayling & Ussher, 2008), quality of life

(e.g., Atallah et al., 2016), social lives (Xie et al., 2012), and partners (e.g., Sadownik et al., 2017). Further, FSD may have implications for women's physical health (e.g., Thomas & Thurston, 2016) and finances (e.g., Xie et al., 2012). Many barriers interfere with women seeking help for these kinds of problems, including discomfort with discussing sexual issues (e.g., Brock et al., 2006), lack of awareness, systemic barriers (e.g., Shifren et al., 2009), and healthcare providers who do not know how to help or are unable to help (e.g., McCool et al., 2016). Women are also likely to have negative experiences when they seek help (e.g., Berman et al., 2003; Jackowich, Boyer, et al., 2021). Taken together, it is evident that women may struggle to receive the help they need if they ever do seek help for FSD.

This problem may be mitigated by empowering women with the knowledge of why, when, where, and how to seek help for FSD. I expect that my web-based guide will facilitate better help-seeking experiences for women who use it. Making a web-based resource available to women with information about female sexual function and dysfunction will provide them with an accurate understanding of healthy female sexual function against which they can compare their own experiences. This will help women to understand whether they should seek help and when to do so. Further, sharing information with women about where and how to seek help will guide them in seeking help effectively and should save women time and money by limiting the number futile treatments pursued. It is my hope that this will diminish the negative impacts experienced by women with FSD, and lead to women's improved mental health, quality of life, sexual function, relationships, and physical health.

References

Abdo, C. H. N., Oliveira, J. W. M., Moreira, J. E. D., & Fittipaldi, J. A. S. (2004). Prevalence of sexual dysfunctions and correlated conditions in a sample of Brazilian women-results of the Brazilian study on sexual behavior (BSSB). *International Journal of Impotence Research, 16*(2), 160–166. https://doi.org/10.1038/sj.ijir.3901198

Abdolrasulnia, M., Shewchuk, R. M., Roepke, N., Granstaff, U. S., Dean, J., Foster, J. A., Goldstein, A. T., & Casebeer, L. (2010). Management of female sexual problems: Perceived barriers, practice patterns, and confidence among primary care physicians and gynecologists. *The Journal of Sexual Medicine, 7*(7), 2499–2508. https://doi.org/10.1111/j.1743-6109.2010.01857.x

Action Canada for Sexual Health & Rights. (2020). *The state of sex-ed in Canada*. https://www.actioncanadashr.org/resources/reports-analysis/2020-04-03-state-sex-ed-report

Aerts, L., Rubin, R. S., Randazzo, M., Goldstein, S. W., & Goldstein, I. (2018). Retrospective study of the prevalence and risk factors of clitoral adhesions: Women's health providers should routinely examine the glans clitoris. *Sexual Medicine, 6*(2), 115–122. https://doi.org/10.1016/j.esxm.2018.01.003

Afshar, M., Mohammad-Alizadeh-Charandabi, S., Merghti-Khoei, E.-S., & Yavarikia, P. (2012). The effect of sex education on the sexual function of women in the first half of pregnancy: A randomized controlled trial. *Journal of Caring Sciences, 1*(4), 173–181. https://doi.org/10.5681/jcs.2012.025

Agur, A. M. R., & Dalley, A. F. (2017). *Grant's atlas of anatomy* (14th ed.). Wolters Kluwer.

Albaugh, J. (2014). Female sexual dysfunction. *International Journal of Urological Nursing, 8*(1), 38–43. https://doi.org/10.1111/ijun.12027

Alberta Health. (n.d.). *Alberta wait times reporting*. Retrieved October 6, 2020, from http://waittimes.alberta.ca/WaitTimeTrends.jsp

Alberta Health Services. (2019). *Find healthcare*. Retrieved September 23, 2019, from https://www.albertahealthservices.ca/findhealth/results.aspx?type=service&id=30&locationPostalCode=T1J%200T2&radius=all#contentStart

Alberta Health Services. (n.d.-a). *Chinook Regional Hospital: Pelvic floor clinic*. Retrieved August 23, 2020, from https://www.albertahealthservices.ca/findhealth/Service.aspx?id=1076741&serviceAtFacilityID=1119536

Alberta Health Services. (n.d.-b). *Sexual & reproductive health*. Retrieved September 11, 2020, from https://www.albertahealthservices.ca/services/page13737.aspx

Alberta Health Services. (n.d.-c). *Teaching sexual health*. Retrieved from Internet Archive website: https://web.archive.org/web/20170315171105/http://teachingsexualhealth.ca/

Alberta Learning. (2002a). *Career and life management (senior high): Program of studies* [PDF]. https://education.alberta.ca/media/160199/calm.pdf

Alberta Learning. (2002b). *Career and life management for senior high school: Guide to implementation* [PDF]. https://education.alberta.ca/media/1477141/calmgi.pdf

Alberta Learning. (2002c). *Health and life skills for kindergarten to grade 9: Guide to implementation* [PDF]. https://education.alberta.ca/media/1477143/healthgi.pdf

Alberta Learning. (2002d). *Health and life skills kindergarten to grade 9: Program of studies* [PDF]. https://education.alberta.ca/media/160196/health.pdf

Alberta Urology Institute. (n.d.). *General patient information*. Retrieved October 5, 2020, from https://www.aburologyinstitute.com/general/index.asp

Alexander, M. G., & Fisher, T. D. (2003). Truth and consequences: Using the bogus pipeline to examine sex differences in self-reported sexuality. *The Journal of Sex Research: Gender and Sexuality, 40*(1), 27–35. https://doi.org/10.1080/00224490309552164

Althof, S. E., Leiblum, S. R., Chevret-Measson, M., Hartmann, U., Levine, S. B., McCabe, M., Plaut, M., Rodrigues, O., & Wylie, K. (2005). Psychological and interpersonal dimensions of sexual function and dysfunction. *The Journal of Sexual Medicine, 2*(6), 793–800. https://doi.org/10.1111/j.1743-6109.2005.00145.x

American Psychiatric Association. (1980). *Diagnostic and statistical manual of mental disorders* (3rd ed.). Author.

American Psychiatric Association. (2013). Sexual dysfunctions. In *Diagnostic and statistical manual of mental disorders* (5th ed.). Author. https://doi.org/10.1176/appi.books.9780890425596.dsm13

American Psychological Association. (2019). *Standards of accreditation for health service psychology and accreditation operating procedures*. Retrieved July 1, 2020, from https://irp-cdn.multiscreensite.com/a14f9462/files/uploaded/APA-Principles-Accreditation-SoA-AOP_200124.pdf

Andrejek, N., & Fetner, T. (2019). The gender gap in orgasms: Survey data from a mid-sized Canadian city. *International Journal of Sexual Health, 31*(1), 26–35. https://doi.org/10.1080/19317611.2018.1563014

Angier, N. (2000). *Woman: An intimate geography* (1st ed.). Anchor Books.

Armstrong, E. A., England, P., & Fogarty, A. C. K. (2012). Accounting for women's orgasm and sexual enjoyment in college hookups and relationships. *American Sociological Review, 77*(3), 435–462. https://doi.org/10.1177/0003122412445802

Aslan, E., & Fynes, M. (2008). Female sexual dysfunction. *International Urogynecology Journal, 19*(2), 293–305. https://doi.org/10.1007/s00192-007-0436-3

Aswath, M., Pandit, L. V., Kashyap, K., & Ramnath, R. (2016). Persistent genital arousal disorder. *Indian Journal of Psychological Medicine, 38*(4), 341–343. https://doi.org/10.4103/0253-7176.185942

Atallah, S., Johnson-Agbakwu, C., Rosenbaum, T., Abdo, C., Byers, E. S., Graham, C., Nobre, P., Wylie, K., & Brotto, L. (2016). Ethical and sociocultural aspects of sexual function and dysfunction in both sexes. *The Journal of Sexual Medicine, 13*(4), 591–606. https://doi.org/10.1016/j.jsxm.2016.01.021

Ayling, K., & Ussher, J. M. (2008). "If sex hurts, am I still a woman?" The subjective experience of vulvodynia in hetero-sexual women. *Archives of Sexual Behavior, 37*(2), 294–304. https://doi.org/10.1007/s10508-007-9204-1

Azar, M., Bradbury-Jones, C., & Kroll, T. (2013). Patterns of help-seeking in women when problems arise in their sexual life: A discussion paper. *Journal of Clinical Nursing, 22*(23–24), 3587–3596. https://doi.org/10.1111/jocn.12374

Baggish, M. S., & Karram, M. M. (2016). *Atlas of pelvic anatomy and gynecologic surgery* (4th ed.). Elsevier.

Bailey, J. V., Farquhar, C., Owen, C., & Whittaker, D. (2003). Sexual behaviour of lesbians and bisexual women. *Sexually Transmitted Infections, 79*(2), 147–150. https://doi.org/10.1136/sti.79.2.147

Balon, R. (2017). Burden of sexual dysfunction. *Journal of Sex & Marital Therapy, 43*(1), 49–55. https://doi.org/10.1080/0092623X.2015.1113597

Balon, R., & Clayton, A. H. (2014). Female sexual interest/arousal disorder: A diagnosis out of thin air. *Archives of Sexual Behavior, 43*(7), 1227–1229. https://doi.org/10.1007/s10508-013-0247-1

Bancroft, J. (1999). Central inhibition of sexual response in the male: A theoretical perspective. *Neuroscience and Biobehavioral Reviews, 23*(6), 763–784. https://doi.org/10.1016/s0149-7634(99)00019-6

Bancroft, J., Graham, C. A., Janssen, E., & Sanders, S. A. (2009). The Dual Control Model: Current status and future directions. *The Journal of Sex Research, 46*(2–3), 121–142. https://doi.org/10.1080/00224490902747222

Barbach, L. G. (2000). *For yourself: The fulfillment of female sexuality (revised and updated)*. Penguin Publishing Group.

Barmak, S. (2016, October 27). *The uncomplicated truth about women's sexuality* [Video]. TEDxToronto. https://www.ted.com/talks/sarah_barmak_the_uncomplicated_truth_about_women_s_sexuality?language=en

Barrett, M., McKay, A., Dickson, C., Seto, J., Fisher, W., Read, R., Steben, M., Gale-Rowe, M., & Wong, T. (2012). Sexual health curriculum and training in Canadian medical schools: A study of family medicine, obstetrics and gynaecology and undergraduate medicine programs in 2011 with comparisons to 1996. *The Canadian Journal of Human Sexuality, 21*(2), 63–73. https://search.proquest.com/openview/d12989dd856da6669a537685173fdde3/

Basson, R. (2000). The female sexual response: A different model. *Journal of Sex & Marital Therapy, 26*(1), 51–65. https://doi.org/10.1080/009262300278641

Basson, R. (2001). Female sexual response: The role of drugs in the management of sexual dysfunction. *Obstetrics and Gynecology, 98*(2), 350. https://doi.org/10.1016/s0029-7844(01)01452-1

Basson, R. (2005). Women's sexual dysfunction: Revised and expanded definitions. *Canadian Medical Association Journal, 172*(10), 1327–1333. https://doi.org/10.1503/cmaj.1020174

Basson, R. (2006). Sexual desire and arousal disorders in women. *The New England Journal of Medicine, 354*(14), 1497–1506. https://doi.org/10.1056/NEJMcp050154

Basson, R. (2008). Women's sexual function and dysfunction: Current uncertainties, future directions. *International Journal of Impotence Research, 20*(5), 466–478. https://doi.org/10.1038/ijir.2008.23

Basson, R., Berman, J., Burnett, A., Derogatis, L., Ferguson, D., Fourcroy, J., Goldstein, I., Graziottin, A., Heiman, J., & Laan, E. (2000). Report of the international consensus

development conference on female sexual dysfunction: Definitions and classifications. *The Journal of Urology, 163*(3), 888–893. https://doi.org/10.1016/S0022-5347(05)67828-7

Bauer, M., McAuliffe, L., Nay, R., & Chenco, C. (2013). Sexuality in older adults: Effect of an education intervention on attitudes and beliefs of residential aged care staff. *Educational Gerontology, 39*(2), 82–91. https://doi.org/10.1080/03601277.2012.682953

Beaber, T. E., & Werner, P. D. (2009). The relationship between anxiety and sexual functioning in lesbians and heterosexual women. *Journal of Homosexuality, 56*(5), 639–654. https://doi.org/10.1080/00918360903005303

Behboodi Moghadam, Z., Rezaei, E., Khaleghi Yalegonbadi, F., Montazeri, A., Arzaqi, S. M., Tavakol, Z., & Yari, F. (2015). The effect of sexual health education program on women sexual function in Iran. *Journal of Research in Health Sciences, 15*(2), 124. http://eprints.skums.ac.ir/6051/1/92.pdf

Bell, J. (2018, January 9). Masturbation: Common questions and misconceptions. *Clue*. https://helloclue.com/articles/sex/masturbation-common-questions-misconceptions

Bergvall, L., & Himelein, M. J. (2014). Attitudes toward seeking help for sexual dysfunctions among US and Swedish college students. *Sexual and Relationship Therapy, 29*(2), 215–228. https://doi.org/10.1080/14681994.2013.860222

Berman, L., Berman, J., Felder, S., Pollets, D., Chhabra, S., Miles, M., & Powell, J. A. (2003). Seeking help for sexual function complaints: What gynecologists need to know about the female patient's experience. *Fertility and Sterility, 79*(3), 572–576. https://doi.org/10.1016/S0015-0282(02)04695-2

Beyer, C. E., Ogletree, R. J., Ritzel, D. O., Drolet, J. C., Gilbert, S. L., & Brown, D. (1996). Gender representation in illustrations, text, and topic areas in sexuality education curricula. *The Journal of School Health, 66*(10), 361–364. https://doi.org/10.1111/j.1746-1561.1996.tb03393.x

Biblical Gender Roles. (2018, December 20). Why a wife should endure painful sex with her husband [Blog post]. *Biblical Gender Roles*. https://biblicalgenderroles.com/2018/12/20/why-a-wife-should-endure-painful-sex-with-her-husband/

Blair, B., Arnow, B. A., Haas, A., & Millheiser, L. (2013). Improving women's sexual health: A quantitative evaluation of an educational intervention for healthcare professionals. *Sex Education: Sexuality, Society and Learning, 13*(5), 535–547. https://doi.org/10.1080/14681811.2013.771774

Blair, K. L., Cappell, J., & Pukall, C. F. (2017). Not all orgasms were created equal: Differences in frequency and satisfaction of orgasm experiences by sexual activity in same-sex versus mixed-sex relationships. *The Journal of Sex Research, 55*(6), 719–733. https://doi.org/10.1080/00224499.2017.1303437

Blumstein, P., & Schwartz, P. (1983). *American couples: Money, work, sex*. Morrow.

Boatman, B. [@txsensualhealth]. (2020, June 18). *ditto. As a sex therapist I'm also constantly enraged by the things I hear from my clients that docs said.* [Tweet]. Twitter. Retrieved June 18, 2020, from https://twitter.com/txsensualhealth/status/1273702742968750081

Bogaert, A. F. (2004). Asexuality: Prevalence and associated factors in a national probability sample. *The Journal of Sex Research, 41*(3), 279–287. www.jstor.org/stable/4423785

Bornstein, J., Goldstein, A., & Coady, D. (2015). *2015 Consensus terminology and classification of persistent vulvar pain* [PDF]. https://www.isswsh.org/images/PDF/Consensus_Terminology_of_Vulvar_Pain.pdf

Bornstein, J., Goldstein, A. T., Stockdale, C. K., Bergeron, S., Pukall, C., Zolnoun, D., & Coady, D. (2016). 2015 ISSVD, ISSWSH and IPPS consensus terminology and classification of persistent vulvar pain and vulvodynia. *Obstetrics and Gynecology, 127*(4), 745–751. https://doi.org/10.1097/AOG.0000000000001359

Braun, V., & Kitzinger, C. (2001). "Snatch," "Hole," or "Honey-pot"? Semantic categories and the problem of nonspecificity in female genital slang. *The Journal of Sex Research, 38*(2), 146–158. https://doi.org/10.1080/00224490109552082

Brennan, P. A., Strandring, S. M., & Wiseman, S. M. (2020). *Gray's surgical anatomy* (1st ed.). Elsevier.

Breyer, B. N., Smith, J. F., Eisenberg, M. L., Ando, K. A., Rowen, T. S., & Shindel, A. W. (2010). The impact of sexual orientation on sexuality and sexual practices in North American medical students. *The Journal of Sexual Medicine, 7*(7), 2391–2400. https://doi.org/10.1111/j.1743-6109.2010.01794.x

Brian, L. N. (2009). *Do men ever say no to sex? Questioning stereotypes about sexual gatekeeping* [Unpublished doctoral dissertation]. University of Kansas. http://hdl.handle.net/1808/5970

Brock, G., Moreira Jr., E. D., Glasser, D. B., Gingell, C., & GSSAB Investigators' Group. (2006). Sexual disorders and associated help-seeking behaviors in Canada. *The Canadian Journal of Urology, 13*(1), 2953–2961. https://www.canjurol.com/

Brock, L. J., & Jennings, G. H. (1993). Sexuality education: What daughters in their 30s wish their mothers had told them. *Family Relations, 42*(1), 61–65. https://doi.org/10.2307/584923

Brooks, A. (2007). Feminist standpoint epistemology: Building knowledge and empowerment through women's lived experiences. In S. Nagy Hesse-Biber (Ed.), *Feminist research practice* (2nd ed., pp. 53–82). SAGE Publications.

Brotto, L. A. (2010). The DSM diagnostic criteria for hypoactive sexual desire disorder in women. *Archives of Sexual Behavior, 39*(2), 221–239. https://doi.org/10.1007/s10508-009-9543-1

Brotto, L. A., Bitzer, J., Laan, E., Leiblum, S., & Luria, M. (2010). Women's sexual desire and arousal disorders. *The Journal of Sexual Medicine, 7*(1), 586–614. https://doi.org/10.1111/j.1743-6109.2009.01630.x

Brotto, L. A., Heiman, J. R., & Tolman, D. L. (2009). Narratives of desire in mid-age women with and without arousal difficulties. *The Journal of Sex Research, 46*(5), 387–398. https://doi.org/10.1080/00224490902792624

Brotto, L. A., Knudson, G., Inskip, J., Rhodes, K., & Erskine, Y. (2010). Asexuality: A mixed-methods approach. *Archives of Sexual Behavior, 39*(3), 599–618. https://doi.org/10.1007/s10508-008-9434-x

Brotto, L. A., Yong, P., Smith, K. B., & Sadownik, L. A. (2015). Impact of a multidisciplinary vulvodynia program on sexual functioning and dyspareunia. *The Journal of Sexual Medicine, 12*(1), 238–247. https://doi.org/10.1111/jsm.12718

Burd, I. D., Nevadunsky, N., & Bachmann, G. (2006). Impact of physician gender on sexual history taking in a multispecialty practice. *The Journal of Sexual Medicine, 3*(2), 194–200. https://doi.org/10.1111/j.1743-6109.2005.00168.x

Burnes, T. R., Singh, A. A., & Witherspoon, R. G. (2017). Graduate counseling psychology training in sex and sexuality: An exploratory analysis. *The Counseling Psychologist, 45*(4), 504–527. https://doi.org/10.1177/0011000017714765

Buster, J. E. (2013). Managing female sexual dysfunction. *Fertility and Sterility, 100*(4), 905–915. https://doi.org/10.1016/j.fertnstert.2013.08.026

Byrd, J. E., Hyde, J. S., DeLamater, J. D., & Plant, E. A. (1998). Sexuality during pregnancy and the year postpartum. *The Journal of Family Practice, 47*(4), 143–151. https://www.jstor.org/stable/3813687

Cacchioni, T., & Wolkowitz, C. (2011). Treating women's sexual difficulties: the body work of sexual therapy [Report]. *Sociology of Health & Illness, 33*(2), 266–279. https://doi.org/10.1111/j.1467-9566.2010.01288.x

Cairns, K. V. (1993). Sexual entitlement and sexual accommodation: Implications for female and male experience of sexual coercion. *Canadian Journal of Human Sexuality, 2*(4), 203–213.

Campos, P. E., Brasfield, T. L., & Kelly, J. A. (1989). Psychology training related to AIDS: Survey of doctoral graduate programs and predoctoral internship programs. *Professional Psychology: Research and Practice, 20*(4), 214–220. https://doi.org/10.1037//0735-7028.20.4.214

Canadian Automobile Association. (n.d.). *CAA, health insurance, dental plan, drug plan, build your own plan, packages for different ages*. Retrieved July 16, 2020, from https://www.caalifeandhealth.ca/caa/health-and-dental-plans.jsp

Canadian Counselling and Psychotherapy Association. (2019). *Certification guide*. Retrieved June 30, 2020, from https://www.ccpa-accp.ca/wp-content/uploads/2019/06/CertificationGuide_EN_APRIL2019-1.pdf

Canadian Institutes of Health Research, Natural Sciences and Engineering Research Council of Canada, & Social Sciences and Humanities Research Council of Canada. (2014). *Tri-council policy statement: Ethical conduct for research involving humans* (2nd ed.). http://www.pre.ethics.gc.ca/pdf/eng/tcps2-2014/TCPS_2_FINAL_Web.pdf

CareFirst Specialty Pharmacy. (n.d.). *Sexual health*. Retrieved April 28, 2021 from https://www.cfspharmacy.pharmacy/human-medicine/sexual-health

Carpenter, D., Janssen, E., Graham, C., Vorst, H., & Wicherts, J. (2008). Women's scores on the Sexual Inhibition/Sexual Excitation Scales (SIS/SES): Gender similarities and differences. *The Journal of Sex Research, 45*(1), 36–48. https://doi.org/10.1080/00224490701808076

Carroll, J. L. (2018). *Sexuality now: Embracing diversity*. Cengage Learning.

Carter, A., Ford, J. V., Luetke, M., Fu, T.-c. J., Townes, A., Hensel, D. J., Dodge, B., & Herbenick, D. (2019). “Fulfilling his needs, not mine”: Reasons for not talking about painful sex and associations with lack of pleasure in a nationally representative sample of women in the United States. *The Journal of Sexual Medicine, 16*(12), 1953–1965. https://doi.org/10.1016/j.jsxm.2019.08.016

Cassano, O. (2018, February 28). Not all women masturbate, and that's fine: 6 women tell us why they don't. *Metro*. https://metro.co.uk/2018/02/28/not-all-women-masturbate-and-thats-fine-6-women-tell-us-why-they-dont-7335394/

CBC Comedy. (2019, September 30). *Perimenopause | Baroness von Sketch Show* [Video]. YouTube. https://youtu.be/t17sJAY1vro

Chadwick, S. B., & van Anders, S. M. (2017). Do women's orgasms function as a masculinity achievement for men? *The Journal of Sex Research, 54*(9), 1141–1152. https://doi.org/10.1080/00224499.2017.1283484

Chalker, R. (2018). *The clitoral truth*. Seven Stories Press.

Chew, P. Y., Choy, C. L., Sidi, H. B., Abdullah, N., Che Roos, N. A., Salleh Sahimi, H. M., Abdul Samad, F. D., & Ravindran, A. (2021). The association between female sexual dysfunction and sexual dysfunction in the male partner: A systematic review and meta-analysis. *The Journal of Sexual Medicine, 18*(1), 99–112. https://doi.org/10.1016/j.jsxm.2020.10.001

Chivers, M. L., Seto, M. C., Lalumière, M. L., Laan, E., & Grimbos, T. (2010, 2010/02/01). Agreement of self-reported and genital measures of sexual arousal in men and women: A meta-analysis. *Archives of Sexual Behavior, 39*(1), 5–56. https://doi.org/10.1007/s10508-009-9556-9

Christopher, F. S., & Sprecher, S. (2000). Sexuality in marriage, dating, and other relationships: A decade review. *Journal of Marriage and Family, 62*(4), 999–1017. https://doi.org/10.1111/j.1741-3737.2000.00999.x

Ciarrocchi, J. W. (1993). *A minister's handbook of mental disorders*. Paulist Press.

Clayton, A. H., DeRogatis, L., Rosen, R., Pyke, R., Garcia, M., & Sand, M. (2010). Do clinical research data support sexual desire and arousal disorders as distinct diagnoses? *The Journal of Sexual Medicine, 7*(Suppl. 3), S143–S144. https://doi.org/10.1111/j.1743-6109.2010.01828_4.x

Coleman, E. M., Hoon, P. W., & Hoon, E. F. (1983). Arousability and sexual satisfaction in lesbian and heterosexual women. *The Journal of Sex Research, 19*(1), 58–73. https://doi.org/10.1080/00224498309551169

College of Alberta Psychologists. (2017). *Criteria for evaluating academic credentials*. Retrieved June 30, 2020, from https://www.cap.ab.ca/LinkClick.aspx?fileticket=_oGXACieTOY%3d&portalid=0

Connor, J. J., Brix, C. M., & Trudeau-Hern, S. (2013). The diagnosis of provoked vestibulodynia: Steps and roadblocks in a long journey. *Sexual and Relationship Therapy, 28*(4), 324–335. https://doi.org/10.1080/14681994.2013.842969

Connor, J. J., Robinson, B., & Wieling, E. (2008). Vulvar pain: A phenomenological study of couples in search of effective diagnosis and treatment. *Family Process, 47*(2), 139–155. https://doi.org/10.1111/j.1545-5300.2008.00245.x

Cordes, C. C., Mona, L. R., Syme, M. L., Cameron, R. P., & Smith, K. (2013). Sexuality and sexual health among women with physical disabilities. In D. Castañeda (Ed.), *The essential handbook of women's sexuality* (Vol. 2, pp. 71–92). Praeger.

Crenshaw, K. (2017). *On intersectionality: Essential writings*. New Press.

Creswell, J. W., & Creswell, J. D. (2018). *Research design: Qualitative, quantitative, and mixed methods approaches* (5th ed.). SAGE.

Crooks, R., & Baur, K. (2011a). Perspectives on sexuality. In *Our sexuality* (11th ed., pp. 1–27). Wadsworth, Cengage Learning.

Crooks, R., & Baur, K. (2011b). Sexual arousal and response. In *Our sexuality* (11th ed., pp. 144–179). Wadsworth, Cengage Learning.

Crosby, J. W., & Bossley, N. (2012). The religiosity gap: Preferences for seeking help from religious advisors. *Mental Health, Religion & Culture, 15*(2), 141–119. https://doi.org/10.1080/13674676.2011.561485

Davis, C. M., Blank, J., Lin, H.-Y., & Bonillas, C. (1996). Characteristics of vibrator use among women. *The Journal of Sex Research, 33*(4), 313–320. https://doi.org/10.1080/00224499609551848

Davis, S. R., & Braunstein, G. D. (2012). Efficacy and safety of testosterone in the management of hypoactive sexual desire disorder in postmenopausal women. *The Journal of Sexual Medicine, 9*(4), 1134–1148. https://doi.org/10.1111/j.1743-6109.2011.02634.x

Davison, J. (2013). Gaining intimate citizenship: Sexuality and women with enduring mental illness. In D. Castañeda (Ed.), *The essential handbook of women's sexuality* (Vol. 2, pp. 293–309). Praeger.

DeCillia, B. (2019, April 15). How rural, religious and other identities affect the way Albertans vote. *CBC Calgary*. https://www.cbc.ca/news/canada/calgary/rural-religious-identities-alberta-vote-1.5097949

Dennerstein, L., Dudley, E., & Burger, H. (2001). Are changes in sexual functioning during midlife due to aging or menopause? *Fertility and Sterility, 76*(3), 456–460. https://doi.org/10.1016/S0015-0282(01)01978-1

DeRogatis, L. R., Clayton, A., Rosen, R., Sand, M., Garcia, M., & Pyke, R. (2010). Do multiple convergent measures of female sexual dysfunction (FSD) support sexual desire and arousal disorders as distinct diagnoses? *The Journal of Sexual Medicine, 7*(Suppl. 3), S142–S143. https://doi.org/10.1111/j.1743-6109.2010.01828_4.x

DeRogatis, L. R., Clayton, A. H., Rosen, R. C., Sand, M., & Pyke, R. E. (2011). Should sexual desire and arousal disorders in women be merged? *Archives of Sexual Behavior, 40*(2), 217–219. https://doi.org/10.1007/s10508-010-9677-1

DeRogatis, L. R., Sand, M., Balon, R., Rosen, R., & Parish, S. J. (2016). Toward a more evidence-based nosology and nomenclature for female sexual dysfunctions—Part I. *The Journal of Sexual Medicine, 13*(12), 1881–1887. https://doi.org/10.1016/j.jsxm.2016.09.014

Dhand, S. (2015, October 10). Why we need to stop calling physicians "providers". *KevinMD*. https://www.kevinmd.com/blog/2015/10/why-we-need-to-stop-calling-physicians-providers.html

Di Marino, V., & Lepidi, H. (2014). *Anatomic study of the clitoris and the bulbo-clitoral organ*. Springer.

Djajic-Horváth, A. (2015). Sexology. *Encyclopedia Britannica*. https://www.britannica.com/science/sexology

Dodson, B. (2002). *Orgasms for two: The joy of partnersex*. Harmony Books.

Dodson, B. (2015). Masturbation. In P. Whelehan & A. Bolin (Eds.), *The international encyclopedia of human sexuality* (1st ed.). Wiley. http://ezproxy.uleth.ca/login?url=https://search.credoreference.com/content/entry/wileyhs/masturbation/0?institutionId=2649

Donaghue, C. (2015). *Sex outside the lines: Authentic sexuality in a sexually dysfunctional culture*. Benbella Books.

Donaldson, R. L., & Meana, M. (2011). Early dyspareunia experience in young women: Confusion, consequences, and help-seeking barriers. *The Journal of Sexual Medicine, 8*(3), 814–823. https://doi.org/10.1111/j.1743-6109.2010.02150.x

Dording, C. M., & Sangermano, L. (2018). Female sexual dysfunction: Natural and complementary treatments. *Focus 16*(1), 19–23. https://doi.org/10.1176/appi.focus.20170049

Dunn, K. M., Croft, P. R., & Hackett, G. I. (2000). Satisfaction in the sex life of a general population sample. *Journal of Sex & Marital Therapy, 26*(2), 141–151. https://doi.org/10.1080/009262300278542

Dyer, K., & das Nair, R. (2013). Why don't healthcare professionals talk about sex? A systematic review of recent qualitative studies conducted in the United Kingdom. *The Journal of Sexual Medicine, 10*(11), 2658–2670. https://doi.org/10.1111/j.1743-6109.2012.02856.x

Ehrenreich, B., & English, D. (2005). The sexual politics of sickness. In *For her own good: Two centuries of the experts' advice to women* (2nd ed., pp. 111–154). Anchor Books.

Eisenberg, M. E., Bearinger, L. H., Sieving, R. E., Swain, C., & Resnick, M. D. (2004). Parents' beliefs about condoms and oral contraceptives: Are they medically accurate? *Perspectives on Sexual and Reproductive Health, 36*(2), 50–57. https://www.guttmacher.org/sites/default/files/pdfs/pubs/journals/3605004.pdf

Elbay, R. Y. (2017). Female patients with sexual dysfunction: An experience in a general psychiatry outpatient clinic. *Klinik Psikofarmakoloji Bulteni, 27*(1), 219–220. https://doi.org/10.4103/0019-5545.148522

Elections Alberta. (n.d.). *Candidate summary of results (general elections 1905-2015)*. Retrieved October 2, 2019, from http://www.elections.ab.ca/news-reports/reports/statistics/candidate-summary-of-results-general-elections/

Ellsworth, R. M., & Bailey, D. H. (2013). Human female orgasm as evolved signal: A test of two hypotheses. *Archives of Sexual Behavior, 42*(8), 1545–1554. https://doi.org/10.1007/s10508-013-0152-7

Etaugh, C. (2013). Women and sexuality in the middle and later years. In D. Castañeda (Ed.), *The essential handbook of women's sexuality* (Vol. 1, pp. 125–139). Praeger.

Faubion, S. S., & Rullo, J. E. (2015). Sexual dysfunction in women: A practical approach. *American Family Physician, 92*(4), 281–288. http://www.aafp.org/afp/2015/0815/p281.html

Febos, M. (2021, March 31). I spent my life consenting to touch I didn't want. *The New York Times Magazine*. https://www.nytimes.com/2021/03/31/magazine/consent.html

Federation of Feminist Women's Health Centers. (1991). *A new view of a woman's body: A fully illustrated guide*. Feminist Press.

Feldhaus-Dahir, M. (2009). Female sexual dysfunction: Barriers to treatment. *Urologic Nursing, 29*(2), 81–85. http://www.tuleoffice.com/images/editor/File/pdf/book/IMPOTENCY/38714459-web.pdf

Fine, M. (1988). Sexuality, schooling, and adolescent females: The missing discourse of desire. *Harvard Educational Review, 58*(1), 29–53. https://doi.org/10.17763/haer.58.1.u0468k1v2n2n8242

Fine, M., & McClelland, S. I. (2006). Sexuality education and desire: Still missing after all these years. *Harvard Educational Review, 76*(3), 297–338. https://doi.org/10.17763/haer.76.3.w5042g23122n6703

Fitter, J., Hayter, M., & Wylie, K. R. (2009). What factors influence individuals and couples to seek help for sexual and/or relationship difficulties from primary care professionals: An exploratory qualitative study. *Sexual & Relationship Therapy, 24*(3/4), 333–346. https://doi.org/10.1080/14681990902829547

Frederick, D. A., John, H. K. S., Garcia, J. R., & Lloyd, E. A. (2017). Differences in orgasm frequency among gay, lesbian, bisexual, and heterosexual men and women in a U.S. national sample. *Archives of Sexual Behavior, 47*(1), 273–288. https://doi.org/10.1007/s10508-017-0939-z

Frederick, D. A., Lever, J., Gillespie, B. J., & Garcia, J. R. (2017). What keeps passion alive? Sexual satisfaction is associated with sexual communication, mood setting, sexual variety, oral sex, orgasm, and sex frequency in a aational U.S. study. *The Journal of Sex Research, 54*(2), 186–201. https://doi.org/10.1080/00224499.2015.1137854

Freud, S. (1905). *Three essays on the theory of sexuality*. Verso Books.

Freud, S. (1961). Female sexuality. In J. Strachey (Ed.), *The standard edition of the complete psychological works of Sigmund Freud* (Vol. 21, pp. 225–243). Hogarth Press.

Fronek, P., Booth, S., Kendall, M., Miller, D., & Geraghty, T. (2005). The effectiveness of a sexuality training program for the interdisciplinary spinal cord injury rehabilitation team. *Sexuality and Disability, 23*(2), 51–63. https://doi.org/10.1007/s11195-005-4669-0

Fronek, P., Kendall, M., Booth, S., Eugarde, E., & Geraghty, T. (2010). A longitudinal study of sexuality training for the interdisciplinary rehabilitation team. *Sexuality and Disability, 29*(2), 87–100. https://doi.org/10.1007/s11195-010-9177-1

Fugl-Meyer, A. R., & Fugl-Meyer, K. S. (2005). Prevalence data in Europe. In I. Goldstein, C. M. Meston, S. Davis, & A. Traish (Eds.), *Women's sexual function and dysfunction: Study, diagnosis and treatment* (pp. 34–41). CRC Press.

Fugl-Meyer, K. S., Oberg, K., Lundberg, P. O., Lewin, B., & Fugl-Meyer, A. (2006). On orgasm, sexual techniques, and erotic perceptions in 18- to 74-year-old Swedish women. *The Journal of Sexual Medicine, 3*(1), 56–68. https://doi.org/10.1111/j.1743-6109.2005.00170.x

Gangestad, S. W., & Simpson, J. A. (2000). The evolution of human mating: Trade-offs and strategic pluralism. *Behavioral and Brain Sciences, 23*(4), 573–587. https://doi.org/10.1017/S0140525X0000337X

Garcia, J. R., Lloyd, E. A., Wallen, K., & Fisher, H. E. (2014). Variation in orgasm occurrence by sexual orientation in a sample of U.S. singles. *The Journal of Sexual Medicine, 11*(11), 2645–2652. https://doi.org/10.1111/jsm.12669

Gates, E. A., & Galask, R. P. (2001). Psychological and sexual functioning in women with vulvar vestibulitis. *Journal of Psychosomatic Obstetrics & Gynecology, 22*(4), 221–228. https://doi.org/10.3109/01674820109049977

Gavey, N., McPhillips, K., & Braun, V. (1999). Interruptus coitus: Heterosexuals accounting for intercourse. *Sexualities, 2*(1), 35–68. https://doi.org/10.1177/136346099002001003

Giatti, S., Diviccaro, S., Panzica, G., & Melcangi, R. C. (2018). Post-finasteride syndrome and post-SSRI sexual dysfunction: two sides of the same coin? *Endocrine, 61*(2), 180–193. https://doi.org/10.1007/s12020-018-1593-5

Giles, K. R., & McCabe, M. P. (2009). Conceptualizing women's sexual function: Linear vs. circular models of sexual response. *The Journal of Sexual Medicine, 6*(10), 2761–2771. https://doi.org/10.1111/j.1743-6109.2009.01425.x

GMS Health Insurance. (2019). *Personal health coverage* [PDF]. https://www.gms.ca/Portals/0/documents/health-insurance/GMSI-Personal-Health-Policy-Booklet-CA.pdf?v=2020-07-16-16-09-36

Goldmeier, D., Malik, F., Phillips, R., & Green, J. (2004). Cost implications of sexual dysfunction: The female picture. *International Journal of Impotence Research, 16*(2), 130–134. https://doi.org/10.1038/sj.ijir.3901179

Goldstein, I., Clayton, A. H., Goldstein, A. T., Kim, N. N., & Kingsberg, S. A. (2018). *Textbook of female sexual function and dysfunction: Diagnosis and treatment*. John Wiley & Sons.

Goldstein, I., Komisaruk, B. R., Rubin, R. S., Goldstein, S. W., Elliott, S., Kissee, J., & Kim, C. W. (2017). A novel collaborative protocol for successful management of penile pain mediated by radiculitis of sacral spinal nerve roots trom Tarlov cysts. *Sexual Medicine, 5*(3), e203–e211. https://doi.org/10.1016/j.esxm.2017.04.001

Goop. (n.d.). *Tikkun Spa*. Retrieved July 14, 2020, from https://goop.com/place/california/los-angeles/santa-monica-health-and-beauty/tikkun-spa/

Gott, M. (2004). "Opening a can of worms": GP and practice nurse barriers to talking about sexual health in primary care. *Family Practice, 21*(5), 528–536. https://doi.org/10.1093/fampra/cmh509

Gott, M., & Hinchliff, S. (2003). Barriers to seeking treatment for sexual problems in primary care: A qualitative study with older people. *Family Practice, 20*(6), 690–695. https://doi.org/10.1093/fampra/cmg612

Government of Alberta. (n.d., 2021). *Health care services covered in Alberta*. Retrieved May 6, 2021, from https://www.alberta.ca/ahcip-what-is-covered.aspx

Graham, C. A., Sanders, S. A., Milhausen, R. R., & McBride, K. R. (2004). Turning on and turning off: A focus group study of the factors that affect women's sexual arousal. *Archives of Sexual Behavior, 33*(6), 527–538. https://doi.org/10.1023/B:ASEB.0000044737.62561.fd

Graziottin, A. (2008). Dyspareunia and vaginismus: Review of the literature and treatment. *Current Sexual Health Reports, 5*(1), 43–50. https://doi.org/10.1007/s11930-008-0008-7

Great-West Llife. (n.d.). *Prescription drug coverage*. Retrieved July 16, 2020, from https://www.greatwestlife.com/flexbox/product-details/prescription-drug

Green Shield Canada. (n.d.). *LINK: Benefit & coverage details* [PDF]. https://assets.greenshield.ca/greenshield/Individuals_Shop%20for%20Coverage/link/HA%20LINK-PlanComp-EnglishApril12019D.pdf

Grey, E. (2020, October 17). When antidepressants leave lasting damage: Living with post-SSRI/SNRI sexual dysfunction. *A Blot About Sex, Relationships, and Health*. https://www.sexlab.ca/blog/2020/10/17/when-antidepressants-leave-lasting-damage-living-with-post-ssrisnri-sexual-dysfunction

Gunter, J. (2015, January 27). Gwyneth Paltrow says steam your vagina, an OB/GYN says don't. *Blog | Dr. Jen Gunter*. https://drjengunter.com/2015/01/27/gwyneth-paltrow-says-steam-your-vagina-an-obgyn-says-dont/

Gunter, J. (2019). *The vagina bible: The vulva and the vagina—separating the myth from the medicine*. Citadel Press.

Haavio-Mannila, E., & Kontula, O. (1997). Correlates of increased sexual satisfaction. *Archives of Sexual Behavior, 26*(4), 399–419. https://doi.org/10.1023/A:1024591318836

Hamilton, L. D. (2021, March 5–8). *Stress and sex: The relationship between stress hormones, androgens, estrogens, and female sexual function* [Lecture]. ISSWSH Annual Meeting, Dallas, TX, United States. https://www.isswshmeeting.org/2021/program?where_days=1&where_person=27

Hanzlik, M. P., & Gaubatz, M. (2012). Clinical PsyD trainees' comfort discussing sexual issues with clients. *American Journal of Sexuality Education, 7*(3), 219–236. https://doi.org/10.1080/15546128.2012.707080

Hartman, L. M. (1983). Effects of sex and marital therapy on sexual interaction and marital happiness. *Journal of Sex & Marital Therapy, 9*(2), 137–151. https://doi.org/10.1080/00926238308405841

Hawkes, G. (2004). *Sex and pleasure in Western culture*. Polity Press.

Hayes, R. D. (2011). Circular and linear modeling of female sexual desire and arousal. *The Journal of Sex Research, 48*(2–3), 130–141. https://doi.org/10.1080/00224499.2010.548611

HealthLinkBC. (2019). *Provincial and territorial helplines and websites*. Retrieved July 14, 2020, from https://www.healthlinkbc.ca/health-topics/abo4579

Healthwise Staff. (n.d.). *Sexual problems in women*. Retrieved August 21, 2020, from https://myhealth.alberta.ca/health/pages/conditions.aspx?Hwid=uh1854

Healy, D. (2019). Post-SSRI sexual dysfunction & other enduring sexual dysfunctions. *Epidemiology and Psychiatric Sciences, 29*, e55. https://doi.org/10.1017/S2045796019000519

Healy, D. (2020). Antidepressants and sexual dysfunction: A history. *Journal of the Royal Society of Medicine, 113*(4), 133–135. https://doi.org/10.1177/0141076819899299

Healy, D., Le Noury, J., & Mangin, D. (2018). Enduring sexual dysfunction after treatment with antidepressants, 5α-reductase inhibitors and isotretinoin: 300 cases. *The International Journal of Risk & Safety in Medicine, 29*(3–4), 125–134. https://doi.org/10.3233/JRS-180744

Healy, D., Le Noury, J., & Mangin, D. (2019). Post-SSRI sexual dysfunction: Patient experiences of engagement with healthcare professionals. *The International Journal of Risk & Safety in Medicine, 30*(3), 167–178. https://doi.org/10.3233/JRS-191005

Heiman, J. R., & Meston, C. M. (1997). Empirically validated treatment for sexual dysfunction. *Annual Review of Sex Research, 8*(1), 148–195. https://doi.org/10.1007/s11930-016-0088-8

Heinemann, J., Atallah, S., & Rosenbaum, T. (2016). The impact of culture and ethnicity on sexuality and sexual function. *Current Sexual Health Reports, 8*(3), 144–150. https://doi.org/10.1007/s11930-016-0088-8

Hengartner, M. P., Schulthess, L., Sorensen, A., & Framer, A. (2020). Protracted withdrawal syndrome after stopping antidepressants: a descriptive quantitative analysis of consumer narratives from a large internet forum. *Therapeutic Advances in Psychopharmacology, 10*, 1–13. https://doi.org/10.1177/2045125320980573

Hensley, P. L., & Nurnberg, H. G. (2002). SSRI sexual dysfunction: A female perspective. *Journal of Sex & Marital Therapy, 28*(sup1), 143–153. https://doi.org/10.1080/00926230252851267

Herbenick, D., Bowling, J., Fu, T. J., Dodge, B., Guerra-Reyes, L., & Sanders, S. (2017). Sexual diversity in the United States: Results from a nationally representative probability sample of adult women and men. *PLoS One, 12*(7), e0181198. https://doi.org/10.1371/journal.pone.0181198

Herbenick, D., Fu, T.-C., Arter, J., Sanders, S. A., & Dodge, B. (2018). Women's experiences with genital touching, sexual pleasure, and orgasm: Results from a U.S. probability sample of women ages 18 to 94. *Journal of Sex & Marital Therapy, 44*(2), 201–212. https://doi.org/10.1080/0092623X.2017.1346530

Herbenick, D., Reece, M., Sanders, S., Dodge, B., Ghassemi, A., & Fortenberry, J. D. (2009). Prevalence and characteristics of vibrator use by women in the United States: Results from a nationally representative study. *The Journal of Sexual Medicine, 6*(7), 1857–1866. https://doi.org/10.1111/j.1743-6109.2009.01318.x

Herbenick, D., Reece, M., Schick, V., Sanders, S. A., Dodge, B., & Fortenberry, J. D. (2010). Sexual behavior in the United States: Results from a national probability sample of men and women ages 14–94. *The Journal of Sexual Medicine, 7*, 255–265. https://doi.org/10.1111/j.1743-6109.2010.02012.x

Higgins, A., Sharek, D., Nolan, M., Sheerin, B., Flanagan, P., Slaicuinaite, S., Mc Donnell, S., & Walsh, H. (2012). Mixed methods evaluation of an interdisciplinary sexuality education programme for staff working with people who have an acquired physical disability. *Journal of Advanced Nursing, 68*(11), 2559–2569. https://doi.org/10.1111/j.1365-2648.2012.05959.x

Higgins, J. A., Mullinax, M., Trussell, J., Davidson, S. J. K., & Moore, N. B. (2011). Sexual satisfaction and sexual health among university students in the United States. *American Journal of Public Health, 101*(9), 1643–1654. https://doi.org/10.2105/AJPH.2011.300154

Hinchliff, S., Gott, M., & Galena, E. (2004). GPs' perceptions of the gender-related barriers to discussing sexual health in consultations: A qualitative study. *European Journal of General Practice, 10*(2), 56–60. https://doi.org/10.3109/13814780409094233

Hite, S. (1981). *The Hite report on male sexuality* (1st ed.). Knopf.

Hite, S. (2004). *The Hite report: A nationwide study of female sexuality*. Seven Stories Press.

Hoare, B. S., & Khan, Y. S. (2020). *Anatomy, abdomen and pelvis, female internal genitalia*. StatPearls Publishing. https://www.ncbi.nlm.nih.gov/books/NBK554601/

hooks, b. (1981). *Ain't I a woman: Black women and feminism*. South End Press.

hooks, b. (2000). *Feminist theory: From margin to center* (2nd ed.). South End Press.

Humphreys, T. (2017). The state of Canadian sexuality education. *The Journal of Sexual Medicine, 14*(5), e231. https://doi.org/https://doi.org/10.1016/j.jsxm.2017.04.116

Hunter, S. (2014). Female sexual dysfunction or not konwing how to ask for what feels good? *The Conversation*. https://theconversation.com/female-sexual-dysfunction-or-not-knowing-how-to-ask-for-what-feels-good-34651

Hurlbert, D. F., Apt, C., & Rabehl, S. M. (1993). Key variables to understanding female sexual satisfaction: An examination of women in nondistressed marriages. *Journal of Sex & Marital Therapy, 19*(2), 154–165. https://doi.org/10.1080/00926239308404899

Hurlbert, D. F., White, L. C., Powell, R. D., & Apt, C. (1993). Orgasm consistency training in the treatment of women reporting hypoactive sexual desire: An outcome comparison of women-only groups and couples-only groups. *Journal of Behavior Therapy and Experimental Psychiatry, 24*(1), 3–13. https://doi.org/10.1016/0005-7916(93)90003-F

Ibine, B., Sefakor Ametepe, L., Okere, M., & Anto-Ocrah, M. (2020). "I did not know it was a medical condition": Predictors, severity and help seeking behaviors of women with female sexual dysfunction in the Volta region of Ghana. *PloS One, 15*(1), 1–25. https://doi.org/10.1371/journal.pone.0226404

Impett, E. A., & Peplau, L. A. (2006). "His" and "her" relationships? A review of the empirical evidence. In A. L. Vangelisti & D. Perlman (Eds.), *The Cambridge handbook of personal relationships*. Cambridge University Press. https://doi.org/10.1017/CBO9780511606632

Jackowich, R., Pink, L., Gordon, A., Poirier, É., & Pukall, C. F. (2018). Symptom characteristics and medical history of an online sample of women who experience symptoms of persistent genital arousal. *Journal of Sex & Marital Therapy, 44*(2), 111-126. https://doi.org/10.1080/0092623X.2017.1321598

Jackowich, R. A., Boyer, S. C., Bienias, S., Chamberlain, S., & Pukall, C. F. (2021). Healthcare experiences of individuals with persistent genital arousal disorder/genito-pelvic dysesthesia. *Sexual Medicine, 9*(3), 100335. https://doi.org/https://doi.org/10.1016/j.esxm.2021.100335

Jackowich, R. A., & Pukall, C. F. (2020a). Persistent genital arousal disorder: A biopsychosocial framework. *Current Sexual Health Reports, 12*(3), 127–135. https://doi.org/10.1007/s11930-020-00268-2

Jackowich, R. A., & Pukall, C. F. (2020b). Prevalence of persistent penital arousal disorder in 2 North American samples. *The Journal of Sexual Medicine, 17*(12), 2408–2416. https://doi.org/10.1016/j.jsxm.2020.09.004

Jackowich, R. A., Pukall, C. F., & Goldstein, I. (2021). Persistent genital arousal disorder. In A. T. Goldstein (Ed.), *Female Sexual Pain Disorders: Evaluation and Management* (2nd ed.). John Wiley & Sons Ltd.

Jackson, G. (2019, November 13). The female problem: How male bias in medical trials ruined women's health. *The Guardian*.

https://www.theguardian.com/lifeandstyle/2019/nov/13/the-female-problem-male-bias-in-medical-trials

Jackson, M. (1984). Sex research and the construction of sexuality: A tool of male supremacy? *Women's Studies International Forum, 7*(1), 43–51. https://doi.org/10.1016/0277-5395(84)90083-9

Jadan, P. (2016, March). *Tight does not equal strong*. Retrieved March 22, 2021, from https://thrivenowphysio.com/tight-does-not-equal-strong/

Jannini, E. A., Buisson, O., & Rubio-Casillas, A. (2014). Beyond the G-spot: Clitourethrovaginal complex anatomy in female orgasm. *Nature Reviews Urology, 11*(9), 531–538. https://doi.org/10.1038/nrurol.2014.193

Jannini, E. A., Wise, N., Frangos, E., & Komisaruk, B. R. (2018). Peripheral and central neural bases of orgasm. In I. Goldstein, A. H. Clayton, A. T. Goldstein, N. N. Kim, & S. A. Kingsberg (Eds.), *Textbook of female sexual function and dysfunction: Diagnosis and treatment* (pp. 179–198). John Wiley & Sons.

Jantos, M., & White, G. (1997). The vestibulitis syndrome. Medical and psychosexual assessment of a cohort of patients. *The Journal of Reproductive Medicine, 42*(3), 145–152.

Jawed-Wessel, S. (2016, October 8). *The lies we tell pregnant women*. TEDxOmaha. https://www.ted.com/talks/sofia_jawed_wessel_the_lies_we_tell_pregnant_women

Jones, H. W., & Rock, J. A. (2015). *Te Linde's operative gynecology* (11th ed.). Wolters Kluwer.

Jonsdottir, J. I., Zoëga, S., Saevarsdottir, T., Sverrisdottir, A., Thorsdottir, T., Einarsson, G. V., Gunnarsdottir, S., & Fridriksdottir, N. (2015). Changes in attitudes, practices and barriers among oncology health care professionals regarding sexual health care: Outcomes from a 2-year educational intervention at a University Hospital. *European Journal of Oncology Nursing, 21*, 24–30. https://doi.org/10.1016/j.ejon.2015.12.004

Kaplan, H. S. (1979). *Disorders of sexual desire and other new concepts and techniques in sex therapy*. Brunner/Mazel.

Karney, B. R., & Bradbury, T. N. (1995). The longitudinal course of marital quality and stability: A review of theory, method, and research. *Psychological Bulletin, 118*(1), 3–34. https://doi.org/10.1037/0033-2909.118.1.3

Katz, S. R. (1995). *The experience of chronic vulvar pain: Psychosocial dimensions and the sense of self* (Publication Number 304260795) [Doctoral dissertation, The Fielding Institute]. ProQuest Dissertations & Theses A&I.

Kaviani, M., Rahnavard, T., Azima, S., Emamghoreishi, M., Asadi, N., & Sayadi, M. (2014). The effect of education on sexual health of women with hypoactive sexual desire disorder: A randomized controlled trial. *International Journal of Community Based Nursing and Midwifery, 2*(2), 94–102.

Kelly, M. P., Strassberg, D. S., & Turner, C. M. (2004). Communication and associated relationship issues in female anorgasmia. *Journal of Sex & Marital Therapy, 30*(4), 263–276. https://doi.org/10.1080/00926230490422403

Kerner, I. (2010). *She comes first: The thinking man's guide to pleasuring a woman*. HarperCollins Publishers.

Khajehei, M., Doherty, M., & Tilley, P. J. M. (2015). An update on sexual function and dysfunction in women [Report]. *Archives of Women's Mental Health, 18*(3), 423–433. https://doi.org/10.1007/s00737-015-0535-y

Kingsberg, S. (2020, March 5–8). *NAMS lecture: Sex, drugs, and rock and roll* [Conference session]. ISSWSH Annual Meeting, Orlando, FL, United States. http://www.isswshmeeting.org

Kingsberg, S. A. (2014). Attitudinal survey of women living with low sexual desire. *Journal of Women's Health, 23*(10), 817–823. https://doi.org/10.1089/jwh.2014.4743

Kingsberg, S. A., & Althof, S. E. (2018). Psychological management of hypoactive sexual desire disorder. In I. Goldstein, A. H. Clayton, A. T. Goldstein, N. N. Kim, & S. A. Kingsberg (Eds.), *Textbook of female sexual function and dysfunction: Diagnosis and treatment* (pp. 53–57). John Wiley & Sons.

Kingsberg, S. A., & Rezaee, R. L. (2013). Hypoactive sexual desire in women. *Menopause, 20*(12), 1284–1300. https://doi.org/10.1097/gme.0000000000000131

Kinsey, A. C., Pomeroy, W. B., & Martin, C. E. (1948). *Sexual behavior in the human male*. Saunders.

Kinsey, A. C., Pomeroy, W. B., Martin, C. E., & Gabhard, P. H. (1953). *Sexual behavior in the human female*. Saunders.

Knudson, G. A., Brotto, L. A., & Inskip, J. (2007, April 15–19). *Understanding asexuality: Sexual characteristics and personality profiles of asexual men and women* [Paper

presentation]. 18th Congress of the World Association for Sexual Health, Sydney, Australia. https://www.jstor.org/stable/20620347

Komisaruk, B. R., & Lee, H. J. (2012). Prevalence of sacral spinal (Tarlov) cysts in persistent genital arousal disorder. *The Journal of Sexual Medicine, 9*(8), 2047–2056. https://doi.org/10.1111/j.1743-6109.2012.02765.x

Kreinin, T. (2002). Pleasure is ultimate secret of sexuality. *SIECUS Report, 30*(4), 5–6.

Laan, E., & Both, S. (2008). What makes women experience desire? *Feminism & Psychology, 18*(4), 505–514. https://doi.org/10.1177/0959353508095533

Laan, E., & Rellini, A. H. (2011). Can we treat anorgasmia in women? The challenge to experiencing pleasure. *Sexual and Relationship Therapy, 26*(4), 329–341. https://doi.org/10.1080/14681994.2011.649691

Lakeside Medicine Centre Pharmacy. (2019, May 28). *Frequently asked questions about compounded medications*. Retrieved April 28, 2021, from https://www.lakesidepharmacy.ca/blog/post/7/Frequently_asked_questions_about_compounded_medications/

Last, J. M. (2006). *A dictionary of public health*. Oxford University Press.

Laumann, E. O., Gagnon, J. H., Michael, R. T., & Michaels, S. (1994). *The social organization of sexuality: Sexual practices in the United States*. University of Chicago Press.

Laumann, E. O., Glasser, D. B., Neves, R. C. S., Moreira, E. D., Jr., & GSSAB Investigators' Group. (2009). A population-based survey of sexual activity, sexual problems and associated help-seeking behavior patterns in mature adults in the United States of America [Survey]. *International Journal of Impotence Research, 21*(3), 171–178. https://doi.org/10.1038/ijir.2009.7

Laumann, E. O., Paik, A., Glasser, D. B., Kang, J.-H., Wang, T., Levinson, B., Moreira Jr, E. D., Nicolosi, A., & Gingell, C. (2006). A cross-national study of subjective sexual well-being among older women and men: Findings from the Global Study of Sexual Attitudes and Behaviors. *Archives of Sexual Behavior, 35*(2), 143–159. https://doi.org/10.1007/s10508-005-9005-3

Laumann, E. O., Paik, A., & Rosen, R. C. (1999). Sexual dysfunction in the United States: Prevalence and predictors. *Journal of the American Medical Association, 281*(6), 537–544. https://doi.org/10.1001/jama.281.6.537

Lawrance, K.-A., & Byers, E. S. (1995). Sexual satisfaction in long-term heterosexual relationships: The interpersonal exchange model of sexual satisfaction. *Personal Relationships, 2*(4), 267–285. https://doi.org/10.1111/j.1475-6811.1995.tb00092.x

Leiblum, S. R. (2001). An established medical school human sexuality curriculum: Description and evaluation. *Sexual and Relationship Therapy, 16*(1), 59–70. https://doi.org/10.1080/14681990020021566

Lerner, H. E. (1976). Parental mislabeling of female genitals as a determinant of penis envy and learning inhibitions in women. *Journal of the American Psychoanalytic Association, 24*(5 Suppl.), 269–283.

LeVay, S., Baldwin, J. I., & Baldwin, J. D. (2019). *Discovering human sexuality* (4th ed.). Sinauer Associates.

Levesque, R. J. R. (2011). Masturbation. In R. J. R. Levesque (Ed.), *Encyclopedia of Adolescence* (Vol. 3, pp. 1654–1655). Springer. https://doi.org/10.1007/978-1-4419-1695-2_565

Levin, R. J. (2019). The clitoris—An appraisal of its reproductive function during the fertile years: Why was it, and still is, overlooked in accounts of female sexual arousal. *Clinical Anatomy, 33*(1), 136–145. https://doi.org/10.1002/ca.23498

Levin, R. J., & van Berlo, W. (2004). Sexual arousal and orgasm in subjects who experience forced or non-consensual sexual stimulation – a review. *Journal of Clinical Forensic Medicine, 11*(2), 82–88. https://doi.org/10.1016/j.jcfm.2003.10.008

Levine, J. (2002). *Harmful to minors: The perils of protecting children from sex*. University of Minnesota Press.

Levy, M. (2010). *Man, Woman* [Sculpture]. http://bjdejong.squarespace.com/blog/tag/miller-levy

Lindau, S. T., Schumm, L. P., Laumann, E. O., Levinson, W., O'Muircheartaigh, C. A., & Waite, L. J. (2007). A study of sexuality and health among older adults in the United States. *The New England Journal of Medicine, 357*(8), 762–774. https://doi.org/10.1056/NEJMoa067423

Lindberg, L. D., Maddow-Zimet, I., & Boonstra, H. (2016). Changes in adolescents' receipt of sex education, 2006–2013. *Journal of Adolescent Health, 58*(6), 621–627. https://doi.org/10.1016/j.jadohealth.2016.02.004

Lips, H. M. (2020). Sexual lives and orientations. In *Sex and gender: An introduction* (pp. 265–320). Waveland Press, Inc.

Lloyd, E. A. (2005). *The case of the female orgasm: Bias in the science of evolution*. Harvard University Press.

Loofbourow, L. (2018, January 25). The female price of male pleasure. *The Week*. https://theweek.com/articles/749978/female-price-male-pleasure

Lorenz, T., & Finley, N. (2020). Mind-body-spirit model for the medical management of female sexual well-being. *Current Sexual Health Reports*, 1–9. https://doi.org/10.1007/s11930-020-00291-3

Lou, W.-J., Chen, B., Zhu, L., Han, S.-M., Xu, T., Lang, J.-H., & Zhang, L. (2017). Prevalence and factors associated with female sexual dysfunction in Beijing, China. *中华医学杂志：英文版 (Chinese Medical Journal), 130*(12), 1389–1394. https://doi.org/10.4103/0366-6999.207466

MacNeil, S., & Byers, E. S. (1997). The relationships between sexual problems, communication, and sexual satisfaction. *The Canadian Journal of Human Sexuality, 6*(4), 277–283.

Manulife. (n.d.). *Compare plan coverage*. https://www.manulife.ca/carp/hdi/hdi-follow/details.html

Marcus, B. S. (2011). Changes in a woman's sexual experience and expectations following the introduction of electric vibrator assistance. *The Journal of Sexual Medicine, 8*(12), 3398–3406. https://doi.org/10.1111/j.1743-6109.2010.02132.x

Martz, G. (2004). Masturbation. In S. Loue & M. Sajatovic (Eds.), *Encyclopedia of Women's Health* (pp. 396–397). Kluwer Academic/Plenum Publishers. http://ezproxy.uleth.ca/login?url=https://search.credoreference.com/content/entry/sprwh/masturbation/0?institutionId=2649

Marwick, C. (1999). Survey says patients expect little physician help on sex. *Journal of the American Medical Association, 281*(23), 2173–2174. https://doi.org/10.1001/jama.281.23.2171c

Masheb, R. M., Brondolo, E., & Kerns, R. D. (2002). A multidimensional, case-control study of women with self-identified chronic vulvar pain. *Pain Medicine, 3*(3), 253–259. https://doi.org/10.1046/j.1526-4637.2002.02032.x

Masters, W. H., & Johnson, V. E. (1966). *Human sexual response* (1st ed.). Little, Brown.

Masters, W. H., & Johnson, V. E. (1970). *Human sexual inadequacy* (1st ed.). Little, Brown.

Masters, W. H., Johnson, V. E., & Kolodny, R. C. (1986). *Masters and Johnson on sex and human loving*. Little, Brown And Company.

Matlin, M. W. (2012). *The psychology of women* (7th ed.). Wadsworth.

McCabe, M. P., Sharlip, I. D., Atalla, E., Balon, R., Fisher, A. D., Laumann, E., Lee, S. W., Lewis, R., & Segraves, R. T. (2016). Definitions of sexual dysfunctions in women and men: A consensus statement from the Fourth International Consultation on Sexual Medicine 2015. *The Journal of Sexual Medicine, 13*(2), 135–143. https://doi.org/10.1016/j.jsxm.2015.12.019

McClelland, S. I. (2009). *Intimate justice: Sexual satisfaction in young adults* (Publication Number UMI Microform 3365820) The City University of New York]. ProQuest Dissertations & Theses A&I. New York, NY.

McCool, M. E., Apfelbacher, C., Brandstetter, S., Mottl, M., & Loss, J. (2016). Diagnosing and treating female sexual dysfunction: A survey of the perspectives of obstetricians and gynaecologists. *Sexual Health, 13*(3), 234–240. https://doi.org/10.1071/SH15187

McInturff, K. (2016). *The best and worst places to be a woman in Canada 2016: The gender gap in Canada's 25 biggest cities* [PDF]. Canadian Centre for Policy Alternatives. https://www.policyalternatives.ca/sites/default/files/uploads/publications/National%20Office/2016/10/Best_and_Worst_Places_to_Be_a_Woman2016.pdf

McPhillips, K., Braun, V., & Gavey, N. (2001). Defining (hetero)sex: How imperative is the "coital imperative"? *Women's Studies International Forum, 24*(2), 229–240. https://doi.org/10.1016/S0277-5395(01)00160-1

Meana, M., Binik, Y. M., Khalife, S., & Cohen, D. R. (1997). Biopsychosocial profile of women with dyspareunia. *Obstetrics and Gynecology, 90*(4, Pt. 1), 583–589. https://doi.org/10.1016/s0029-7844(98)80136-1

MEDS Pharmacy. (n.d.). *FAQ's*. Retrieved April 28, 2021, from https://www.medspharmacy.ca/faqs

Meston, C. M., Levin, R. J., Sipski, M. L., Hull, E. M., & Heiman, J. R. (2004). Women's orgasm. *Annual Review of Sex Research, 15*, 173–257. http://citeseerx.ist.psu.edu/viewdoc/download?doi=10.1.1.361.2552&rep=rep1&type=pdf

Meston, C. M., & Stanton, A. M. (2019). Understanding sexual arousal and subjective-genital arousal desynchrony in women. *Nature Reviews Urology*. https://doi.org/10.1038/s41585-018-0142-6

Milbrand, L. (2020). *12 things sex therapists wish you knew*. Retrieved January 20, 2021, from https://www.thehealthy.com/sex/things-sex-therapists-wish-you-knew/

Miller, S. A., & Byers, E. S. (2008). An exploratory examination of the sexual intervention self-efficacy of clinical psychology graduate students. *Training and Education in Professional Psychology, 2*(3), 137–144. https://doi.org/10.1037/1931-3918.2.3.137

Miller, S. A., & Byers, E. S. (2009). Psychologists' continuing education and training in sexuality. *Journal of Sex & Marital Therapy, 35*(3), 206–219. https://doi.org/10.1080/00926230802716336

Miller, S. A., & Byers, E. S. (2010). Psychologists' sexual education and training in graduate school. *Canadian Journal of Behavioural Science, 42*(2), 93–100. https://doi.org/10.1037/a0018571

Mind Body Training Institute, & Buehler, S. (2021). *Key myths about female sexuality* [Video]. https://mindbodytraininginstitute.com/

Mintz, L. (2015, October 4). The orgasm gap: Simple truth & sexual solutions. *Psychology Today*. https://www.psychologytoday.com/gb/blog/stress-and-sex/201510/the-orgasm-gap-simple-truth-sexual-solutions

Mintz, L. (2017). *Becoming cliterate: Why orgasm equality matters—and how to get it*. Harper Collins.

Mintz, L. (2021a, March 22). Are there different types of female orgasm? *Psychology Today*. https://www.psychologytoday.com/ca/blog/stress-and-sex/202103/are-there-different-types-female-orgasm

Mintz, L. [@DrLaurieMintz]. (2021b, March 11). *Faced this same thing writing Becoming Cliterate. Could not find source. So, here's what I say (next tweet):* [Tweet]. Twitter. https://twitter.com/DrLaurieMintz/status/1370150337747771395

Mitchell, K. R., Geary, R., Graham, C. A., Datta, J., Wellings, K., Sonnenberg, P., Field, N., Nunns, D., Bancroft, J., Jones, K. G., Johnson, A. M., & Mercer, C. H. (2017). Painful sex (dyspareunia) in women: Prevalence and associated factors in a British population probability survey. *British Journal of Obstetrics and Gynaecology, 124*(11), 1689–1697. https://doi.org/10.1111/1471-0528.14518

Mitchell, K. R., Jones, K. G., Wellings, K., Johnson, A. M., Graham, C. A., Datta, J., Copas, A. J., Bancroft, J., Sonnenberg, P., Macdowall, W., Field, N., & Mercer, C. H. (2016). Estimating the prevalence of sexual function problems: The impact of morbidity criteria. *The Journal of Sex Research, 53*(8), 955–967. https://doi.org/10.1080/00224499.2015.1089214

Moore, K. L. D., Arthur F., & Agur, A. M. R. (2018). *Clinically oriented anatomy* (8th ed.). Wolters Kluwer.

Moore, T. (2018). Why some women don't masturbate. *Mel*. https://melmagazine.com/en-us/story/why-some-women-dont-masturbate

Moreau, C., Kågesten, A. E., & Blum, R. W. (2016). Sexual dysfunction among youth: An overlooked sexual health concern. *BMC Public Health, 16*(1), 1170–1170. https://doi.org/10.1186/s12889-016-3835-x

Moreira, E. D., Brock, G., Glasser, D. B., Nicolosi, A., Laumann, E. O., Paik, A., Wang, T., Gingell, C., & GSSAB Investigators' Group. (2005). Help-seeking behaviour for sexual problems: The Global Study of Sexual Attitudes and Behaviors. *International Journal of Clinical Practice, 59*(1), 6–16. https://doi.org/10.1111/j.1742-1241.2005.00382.x

Morgan, C. (2020, February 27). Wife claims most women TOLERATE sex as an 'obligation' to stop their partner from 'straying' – but critics claim her husband must 'not be doing it right'. *Daily Mail*. https://www.dailymail.co.uk/femail/article-8051301/Woman-claims-mose-females-TOLERATE-sex-relationships.html

Moriyama, I. M., Loy, R. M., Robb-Smith, A. H. T., Rosenberg, H. M., & Hoyert, D. L. (2011). *History of the statistical classification of diseases and causes of death*. National Center for Health Statistics.

Moz. (n.d.). *The beginner's guide to SEO*. https://moz.com/beginners-guide-to-seo

Muehlenhard, C. L., & Shippee, S. K. (2010). Men's and women's reports of pretending orgasm. *The Journal of Sex Research, 47*(6), 552–567. https://doi.org/10.1080/00224490903171794

Nagoski, E. (2015). *Come as you are: The surprising new science that will transform your sex life*. Simon and Schuster.

Nappi, R. E., Cucinella, L., Martella, S., Rossi, M., Tiranini, L., & Martini, E. (2016). Female sexual dysfunction (FSD): Prevalence and impact on quality of life (QoL). *Maturitas, 94*, 87–91. https://doi.org/10.1016/j.maturitas.2016.09.013

Nappi, R. E., Kingsberg, S., Maamari, R., & Simon, J. (2013). The CLOSER (CLarifying Vaginal Atrophy's Impact On SEx and Relationships) Survey: Implications of vaginal discomfort in postmenopausal women and in male partners. *The Journal of Sexual Medicine, 10*(9), 2232−2241. https://doi.org/10.1111/jsm.12235

Nathan, S. G. (1986). Are clinical psychology graduate students being taught enough about sexuality? A survey of doctoral programs. *The Journal of Sex Research, 22*(4), 520–524. https://doi.org/10.1080/00224498609551332

Nguyen, J., & Duong, H. (2020). *Anatomy, abdomen and pelvis, female external genitalia*. StatPearls Publishing. https://www.ncbi.nlm.nih.gov/books/NBK547703/

Nicolosi, A., Laumann, E. O., Glasser, D. B., Brock, G., King, R., Gingell, C., & GSSAB Investigators' Group. (2006). Sexual activity, sexual disorders and associated help-seeking behavior among mature adults in five anglophone countries from the Global Survey of Sexual Attitudes and Behaviors (GSSAB). *Journal of Sex & Marital Therapy, 32*(4), 331–342. https://doi.org/10.1080/00926230600666469

NuGyn Inc. (n.d.-a). *Eros device | NuGyn Eros-Therapy | Female sexual dysfunction*. Retrieved December 11, 2017, from http://eros-therapy.com/products-page/eros-products/eros-therapy-device/

NuGyn Inc. (n.d.-b). *For healthcare providers*. Retrieved July 7, 2020, from https://eros-therapy.com/for-healthcare-providers/

Nusbaum, M. R. H., Helton, M. R., & Ray, N. (2004). The changing nature of women's sexual health concerns through the midlife years. *Maturitas, 49*(4), 283–291. https://doi.org/10.1016/j.maturitas.2004.06.014

Nuwer, R. (2016, July 1). The enduring enigma of female sexual desire. *BBC Future*. http://www.bbc.com/future/story/20160630-the-enduring-enigma-of-female-desire

Nylanderlundqvist, E., & Bergdahl, J. (2003). Vulvar vestibulitis: Evidence of depression and state anxiety in patients and partners. *Acta Dermato-Venereologica, 83*(5), 369–373. https://doi.org/10.1080/00015550310003764

O'Connell, H. E., Eizenberg, N., Rahman, M., & Cleeve, J. (2008). The anatomy of the distal vagina: Towards unity. *The Journal of Sexual Medicine, 5*(8), 1883–1891. https://doi.org/10.1111/j.1743-6109.2008.00875.x

O'Connell, H. E., Hutson, J. M., Anderson, C. R., & Plenter, R. J. (1998). Anatomical relationship between urethra and clitoris. *The Journal of Urology, 159*(6), 1892–1897. https://doi.org/10.1016/S0022-5347(01)63188-4

Oaklander, A. L., Sharma, S., Kessler, K., & Price, B. H. (2020). Persistent genital arousal disorder: A special sense neuropathy. *Pain Reports, 5*(1), e801-e801. https://doi.org/10.1097/PR9.0000000000000801

Oakley, S. H., Mutema, G. K., Crisp, C. C., Estanol, M. V., Kleeman, S. D., Fellner, A. N., & Pauls, R. N. (2013). Innervation and histology of the clitoral–urethal complex: A cross-sectional cadaver study. *The Journal of Sexual Medicine, 10*(9), 2211–2218. https://doi.org/10.1111/jsm.12230

Ogletree, S. M., & Ginsburg, H. J. (2000). Kept under the hood: Neglect of the clitoris in common vernacular. *Sex Roles, 43*(11), 917–926. https://doi.org/10.1023/A:1011093123517

OHCHR, UNAIDS, UNDP, UNECA, UNESCO, UNFPA, UNHCR, UNICEF, UNIFEM, & WHO. (2008). *Eliminating female genital mutilation: An interagency statement*. https://apps.who.int/iris/bitstream/handle/10665/43839/9789241596442_eng.pdf

Ohl, L. E. (2007). Essentials of female sexual dysfunction from a sex therapy perspective. *Urologic Nursing, 27*(1), 57–64. http://0-search.ebscohost.com.aupac.lib.athabascau.ca/login.aspx?direct=true&db=rzh&AN=106273025&site=eds-live (CNE Series)

Orenstein, P. (2016a). *Girls & sex: Navigating the complicated new landscape* (1st ed.). Harper.

Orenstein, P. (2016b, October 26). *What young women believe about their own sexual pleasure* [Video]. TED Conferences. https://www.ted.com/talks/peggy_orenstein_what_young_women_believe_about_their_own_sexual_pleasure?language=en

Parish, S. J., Cottler-Casanova, S., Clayton, A. H., McCabe, M. P., Coleman, E., & Reed, G. M. (2020). The evolution of the female sexual disorder/dysfunction definitions, nomenclature, and classifications: A review of DSM, ICSM, ISSWSH, and ICD. *Sexual Medicine Reviews*, Advance online publication. https://doi.org/10.1016/j.sxmr.2020.05.001

Parish, S. J., Goldstein, A. T., Goldstein, S. W., Goldstein, I., Pfaus, J., Clayton, A. H., Giraldi, A., Simon, J. A., Althof, S. E., Bachmann, G., Komisaruk, B., Levin, R., Spadt, S. K., Kingsberg, S. A., Perelman, M. A., Waldinger, M. D., & Whipple, B. (2016). Toward a more evidence-based nosology and nomenclature for female sexual dysfunctions—Part II. *The Journal of Sexual Medicine, 13*(12), 1888–1906. https://doi.org/10.1016/j.jsxm.2016.09.020

Parish, S. J., Hahn, S. R., Goldstein, S. W., Giraldi, A., Kingsberg, S. A., Larkin, L., Minkin, M. J., Brown, V., Christiansen, K., Hartzell-Cushanick, R., Kelly-Jones, A., Rullo, J., Sadovsky, R., & Faubion, S. S. (2019). The International Society for the Study of Women's Sexual Health process of care for the identification of sexual concerns and problems in women. *Mayo Clinic Proceedings, 94*(5), 842–856. https://doi.org/10.1016/j.mayocp.2019.01.009

Parish, S. J., Meston, C. M., Althof, S. E., Clayton, A. H., Goldstein, I., Goldstein, S. W., Heiman, J. R., McCabe, M. P., Segraves, R. T., & Simon, J. A. (2019). Toward a more evidence-based nosology and nomenclature for female sexual dysfunctions—Part III. *The Journal of Sexual Medicine, 16*(3), 452–462. https://doi.org/10.1016/j.jsxm.2019.01.010

Pascoal, P. M. (2017). Directed masturbation. In A. Wenzel (Ed.), *The SAGE encyclopedia of abnormal and clinical psychology* (Vol. 3, pp. 1108–1110). SAGE Reference.

Pauls, R. N., Kleeman, S. D., Segal, J. L., Silva, W. A., Goldenhar, L. M., & Karram, M. M. (2005). Practice patterns of physician members of the American Urogynecologic Society regarding female sexual dysfunction: Results of a national survey. *International Urogynecology Journal, 16*(6), 460–467. https://doi.org/10.1007/s00192-005-1286-5

Peixoto, M. M., & Nobre, P. (2015). Prevalence of sexual problems and associated distress among lesbian and heterosexual women. *Journal of Sex & Marital Therapy, 41*(4), 427–439. https://doi.org/10.1080/0092623X.2014.918066

Peplau, L. A., Rubin, Z., & Hill, C. T. (1977). Sexual intimacy in dating relationships. *Journal of Social Issues, 33*(2), 86–109. https://doi.org/10.1111/j.1540-4560.1977.tb02007.x

Perelman, M. A. (2009). The Sexual Tipping Point®: A mind/body model for sexual medicine. *The Journal of Sexual Medicine, 6*(3), 629–632. https://doi.org/10.1111/j.1743-6109.2008.01177.x

Pfaus, J. G. (2009). Pathways of sexual desire. *The Journal of Sexual Medicine, 6*(6), 1506. https://doi.org/10.1111/j.1743-6109.2009.01309.x

Pfaus, J. G., & Jones, S. L. (2018). Central nervous system anatomy and neurochemistry. In I. Goldstein, A. H. Clayton, A. T. Goldstein, N. N. Kim, & S. A. Kingsberg (Eds.), *Textbook of female sexual function and dysfunction: Diagnosis and treatment* (pp. 25–52). John Wiley & Sons Ltd.

Pfaus, J. G., Kippin, T. E., Coria-Avila, G. A., Gelez, H., Afonso, V. M., Ismail, N., & Parada, M. (2012). Who, what, where, when (and maybe even why)? How the

experience of sexual reward connects sexual desire, preference, and performance. *Archives of Sexual Behavior, 41*(1), 31–62. https://doi.org/10.1007/s10508-012-9935-5

Pin, J. (2019, June 28). The gendered double standard I hate most. *Medium*. https://medium.com/@jessica86/the-gendered-double-standard-i-hate-most-1283d8f685af

PinkCherry. (n.d.). *Clitoral suction stimulator sex toys*. Retrieved July 7, 2020, from https://www.pinkcherry.ca/collections/vibrators-clitoral-suction-stimulation

Planned Parenthood. (n.d.). *Sexual consent*. Retrieved April 29, 2021, from https://www.plannedparenthood.org/learn/relationships/sexual-consent

Planned Parenthood Federation of America. (2003). Masturbation: From myth to sexual health. *Contemporary Sexuality, 37*(3), i–vii.

Pope Paul VI. (1968). *Humanae vitae*. http://w2.vatican.va/content/paul-vi/en/encyclicals/documents/hf_p-vi_enc_25071968_humanae-vitae.html

Post, M. W. M., Gianotten, W. L., Heijnen, L., Lambers, E. J. H. R., & Willems, M. (2008). Sexological competence of cifferent rehabilitation disciplines and effects of a discipline-specific sexological training. *Sexuality and Disability, 26*(1), 3–14. https://doi.org/10.1007/s11195-007-9068-2

Prendergast, S. A., & Rummer, E. H. (2016). *Pelvic pain explained: What everyone needs to know*. Rowman & Littlefield.

PSSD Canada. (n.d.). *Mental health support*. Retrieved May 2, 2021, from https://www.pssdcanada.ca/mentalhealthsupport

Public Health Agency of Canada. (2018). *Key health inequalities in Canada: A national portrait*. https://www.canada.ca/content/dam/phac-aspc/documents/services/publications/science-research/key-health-inequalities-canada-national-portrait-executive-summary/key_health_inequalities_full_report-eng.pdf

Pukall, C. (2021, March 5–7). *Post-SSRI/SNRI sexual dysfunction: A review* [Research presentation]. ISSWSH Annual Meeting, Dallas, TX, United States. https://www.isswshmeeting.org/2021/abstract-page?where_days=3&where_person=57

Pukall, C. F., Goldstein, A. T., Bergeron, S., Foster, D., Stein, A., Kellogg-Spadt, S., & Bachmann, G. (2016). Vulvodynia: Definition, prevalence, impact, and pathophysiological Factors. *The Journal of Sexual Medicine, 13*(3), 291–304. https://doi.org/10.1016/j.jsxm.2015.12.021

Puppo, V. (2013). Anatomy and physiology of the clitoris, vestibular bulbs, and labia minora with a review of the female orgasm and the prevention of female sexual dysfunction. *Clinical Anatomy, 26*(1), 134–152. https://doi.org/10.1002/ca.22177

Quinn-Nilas, C., Milhausen, R. R., McKay, A., & Holzapfel, S. (2018). Prevalence and predictors of sexual problems among midlife Canadian adults: Results from a national survey. *The Journal of Sexual Medicine, 15*(6), 873–879. https://doi.org/10.1016/j.jsxm.2018.03.086

Quinn, C., & Happell, B. (2012). Getting BETTER: Breaking the ice and warming to the inclusion of sexuality in mental health nursing care. *International Journal of Mental Health Nursing, 21*(2), 154–162. https://doi.org/10.1111/j.1447-0349.2011.00783.x

Rape Abuse and Incest National Network. (n.d.). *What consent looks like*. Retrieved April 29, 2021, from https://www.rainn.org/articles/what-is-consent

Rasmussen, B. K., & Olesen, J. (1992). Symptomatic and nonsymptomatic headaches in a general population. *Neurology, 42*(6), 1225–1231. https://doi.org/10.1212/wnl.42.6.1225

Rasmussen, M. L. (2012). Pleasure/desire, sexularism and sexuality education. *Sex Education, 12*(4), 469–481. https://doi.org/10.1080/14681811.2012.677204

Reed, B. D., Advincula, A. P., Fonde, K. R., Gorenflo, D. W., & Haefner, H. K. (2003). Sexual activities and attitudes of women with vulvar dysesthesia. *Obstetrics and Gynecology, 102*(2), 325–331. https://doi.org/10.1016/s0029-7844(03)00571-4

Reed, B. D., Harlow, S. D., Sen, A., Legocki, L. J., Edwards, R. M., Arato, N., & Haefner, H. K. (2012). Prevalence and demographic characteristics of vulvodynia in a population-based sample. *American Journal of Obstetrics and Gynecology, 206*(2), 170.e1–170.e9. https://doi.org/10.1016/j.ajog.2011.08.012

Reed, B. D., Legocki, L. J., Plegue, M. A., Sen, A., Haefner, H. K., & Harlow, S. D. (2014). Factors associated with vulvodynia incidence. *Obstetrics and Gynecology, 123*(2 Pt 1), 225–231. https://doi.org/10.1097/AOG.0000000000000066

Regnerus, M., Price, J., & Gordon, D. (2017). Masturbation and partnered sex: Substitutes or complements? *Archives of Sexual Behavior, 46*(7), 2111–2121. https://doi.org/10.1007/s10508-017-0975-8

Rehman, U. S., Fallis, E. E., & Byers, E. S. (2013). Sexual satisfaction in heterosexual women. In D. Castañeda (Ed.), *The essential handbook of women's sexuality* (Vol. 1, pp. 25–45). Praeger.

Reisman, Y. (2017). Sexual consequences of post-SSRI Syndrome. *Sexual Medicine Reviews, 5*(4), 429–433. https://doi.org/10.1016/j.sxmr.2017.05.002

Reissing, E. D., Binik, Y. M., Khalif, S., Cohen, D., & Amsel, R. (2003). Etiological correlates of vaginismus: Sexual and physical abuse, sexual knowledge, sexual self-schema, and relationship adjustment. *Journal of Sex & Marital Therapy, 29*(1), 47–59. https://doi.org/10.1080/713847095

Reissing, E. D., & Di Giulio, G. (2010). Practicing clinical psychologists' provision of sexual health care services. *Professional Psychology: Research and Practice, 41*(1), 57–63. https://doi.org/10.1037/a0017023

Richters, J. (2016, May 29). Health check: Is it normal not to want sex? *The Conversation*. https://theconversation.com/health-check-is-it-normal-not-to-want-sex-56503

Richters, J., de Visser, R., Rissel, C., & Smith, A. (2006). Sexual practices at last heterosexual encounter and occurrence of orgasm in a national survey. *The Journal of Sex Research, 43*(3), 217–226. https://doi.org/10.1080/00224490609552320

Richters, J., de Visser, R. O., Badcock, P. B., Smith, A. M. A., Rissel, C., Simpson, J. M., & Grulich, A. E. (2014). Masturbation, paying for sex, and other sexual activities: The Second Australian Study of Health and Relationships. *Sexual Health, 11*(5), 461–471. https://doi.org/10.1071/SH14116

Robinson, D. B., MacLaughlin, V., & Poole, J. (2019). Sexual health education outcomes within Canada's elementary health education curricula: A summary and analysis. *The Canadian Journal of Human Sexuality, 28*(3), 243–256. https://doi.org/10.3138/cjhs.2018-0036

Robinson, I. (2017, 7 July). Don't enjoy sex? You're not alone. *The Femedic*. https://thefemedic.com/sexual-health/dont-enjoy-sex/

Roos, A.-M., Thakar, R., Sultan, A. H., & Scheer, I. (2009). Female sexual dysfunction: Are urogynecologists ready for it? *International Urogynecology Journal, 20*(1), 89–101. https://doi.org/10.1007/s00192-008-0735-3

Rose, S. M., & Eaton, A. A. (2013). Lesbian love, sex, and relationships. In D. Castañeda (Ed.), *The essential handbook of women's sexuality* (Vol. 2, pp. 3–28). Praeger.

Rosen, N., & Skriver, C. (2015). Vowel patterning of Mormons in Southern Alberta, Canada. *Language & communication, 42*, 104–115. https://doi.org/10.1016/j.langcom.2014.12.007

Rosen, R. C., & Barsky, J. L. (2006). Normal sexual response in women. *Obstetrics and Gynecology Clinics of North America, 33*(4), 515–526. https://doi.org/10.1016/j.ogc.2006.09.005

Rosen, R. C., Connor, M. K., Miyasato, G., Link, C., Shifren, J. L., Fisher, W. A., Derogatis, L. R., & Schobelock, M. J. (2012). Sexual desire problems in women seeking healthcare: A novel study design for ascertaining prevalence of hypoactive sexual desire disorder in clinic-based samples of U.S. women. *Journal of Women's Health, 21*(5), 505–515. https://doi.org/10.1089/jwh.2011.3002

Rosen, R. C., Kountz, D., Post-Zwicker, T., Leiblum, S., & Wiegel, M. (2006). Sexual communication skills in residency training: The Robert Wood Johnson Model. *The Journal of Sexual Medicine, 3*, 37–46. https://doi.org/10.1111/j.1743-6109.2005.00135.x

Rubin, R., King, S., Winter, A., Minton, J., Gagnon, C., & Goldstein, I. (2017). In office treatment of clitorodynia: Lysis of clitoral adhesions to adjacent skin following dorsal nerve block. *The Journal of Sexual Medicine, 14*(6), e362. https://doi.org/10.1016/j.jsxm.2017.04.037

Rubin, R. S. [@rachelsrubin1]. (2017, February 26). *#urologists treat phimosis.Who examines and treats female prepucial issues? #whoownstheclitoris @AmerUrological @jsexmed @ISSWSH @ISSM_INFO* [Tweet]. Retrieved October 5, 2020, from https://twitter.com/rachelsrubin1/status/835884232593522689

Rxisk. (2019, April 1). Assisted dying: Going gentle or not so gentle. *RxISK Blog*. https://rxisk.org/assisted-dying-going-gentle-or-not-so-gentle/

Sackett, S., Gates, E., Heckman-Stone, C., Kobus, A. M., & Galask, R. (2001). Psychosexual aspects of vulvar vestibulitis. *The Journal of Reproductive Medicine, 46*(6), 593–598.

Sadownik, L. A. (2000). Clinical profile of vulvodynia patients. A prospective study of 300 patients. *Journal of Reproductive Medicine, 45*(8), 679–684. https://www.researchgate.net/profile/Leslie_Sadownik/publication/12335011_Clinical_profile_of_vulvodynia_patients_A_prospective_study_of_300_patients/links/5ae7661f0f7e9b837d392b96/Clinical-profile-of-vulvodynia-patients-A-prospective-study-of-300-patients.pdf

Sadownik, L. A., Seal, B. N., & Brotto, L. A. (2012). Provoked vestibulodynia: A qualitative exploration of women's experiences. *British Columbia Medical Journal, 54*(1). https://www.bcmj.org/sites/default/files/public/BCMJ_54_Vol1_provoked.pdf

Sadownik, L. A., Smith, K. B., Hui, A., & Brotto, L. A. (2017). The impact of a woman's dyspareunia and its treatment on her intimate partner: A qualitative analysis. *Journal of Sex & Marital Therapy, 43*(6), 529–542. https://doi.org/10.1080/0092623X.2016.1208697

Safarinejad, M. R. (2006). Female sexual dysfunction in a population-based study in Iran: prevalence and associated risk factors. *International Journal of Impotence Research, 18*(4), 382–395. https://doi.org/10.1038/sj.ijir.3901440

Salisbury, C. M. A., & Fisher, W. A. (2013). "Did you come?" A qualitative exploration of gender differences in beliefs, experiences, and concerns regarding female orgasm occurrence during heterosexual sexual interactions. *The Journal of Sex Research, 51*(6), 616–631. https://doi.org/10.1080/00224499.2013.838934

Sánchez-Fuentes, M. d. M., Santos-Iglesias, P., & Sierra, J. C. (2014). A systematic review of sexual satisfaction. *International Journal of Clinical and Health Psychology, 14*(1), 67–75. https://doi.org/10.1016/S1697-2600(14)70038-9

Sand, M., & Fisher, W. A. (2007). Women's endorsement of models of female sexual response: The nurses' sexuality study. *The Journal of Sexual Medicine, 4*(3), 708–719. https://doi.org/10.1111/j.1743-6109.2007.00496.x

Sansone, R. A., & Wiederman, M. W. (2000). Sexuality training for psychiatry residents: A national survey of training directors. *Journal of Sex & Marital Therapy, 26*(3), 249–256. https://doi.org/10.1080/00926230050084641

Saral, T. B. (2015). Masturbation. In P. Moglia (Ed.), *Adolescent Health & Wellness* (1st ed., Vol. 3, pp. 971–972). Salem Press. http://search.ebscohost.com.ezproxy.uleth.ca/login.aspx?direct=true&db=nlebk&AN=1063058&site=ehost-live&scope=site

Sarkadi, A., & Rosenqvist, U. (2001). Contradictions in the medical encounter: Female sexual dysfunction in primary care contacts. *Family Practice, 18*(2), 161–166. https://doi.org/10.1093/fampra/18.2.161

ScotiaLife Financial. (n.d.). *ScotiaLife Health & Dental Insurance*. Retrieved July 16, 2020, from https://www.scotialifefinancial.com/en/home/health-insurance/scotialife-health-and-dental-insurance.html

Scott, K. (2019). *The best and worst places to be a woman in Canada 2019: The gender gap in Canada's 25 biggest cities* [PDF]. https://www.policyalternatives.ca/sites/default/files/uploads/publications/National%20Office/2019/03/Best%20and%20Worst%20Places%20to%20Be%20a%20Woman%202019.pdf

Segnini, I., & Kukkonen, T. M. (2005). Psychological management of arousal disorders. In I. Goldstein, C. M. Meston, S. Davis, & A. Traish (Eds.), *Women's sexual function and dysfunction: Study, diagnosis and treatment* (pp. 127–144). CRC Press.

Sex and U. (n.d.). *What is consent?* https://www.sexandu.ca/consent/what-is-consent/

Sex Information & Education Council of Canada. (2019). *Canadian guidelines for sexual health education*. http://sieccan.org/wp-content/uploads/2019/06/SIECCAN-Canadian-Guidelines-for-Sexual-Health-Education.pdf

Sex Information & Education Council of Canada. (2020). *Questions & answers: Sexual health education in schools and other settings*. http://sieccan.org/wp-content/uploads/2020/08/Questions-and-Answers-Sexual-Health-Education-in-Schools-and-Other-Settings.pdf

Sex Sense. (n.d.). *Everyone has questions about sex. We want you to ASK US!* Retrieved July 14, 2020, from https://www.optionsforsexualhealth.org/sex-sense/

Sharma, J. B., & Kalra, B. (2016). Female sexual dysfunction: Assessment. *Journal of the Pakistan Medical Association, 66*(5), 623–626. http://jpma.org.pk/PdfDownload/7759.pdf

Sheppard, C., Hallam-Jones, R., & Wylie, K. (2008). Why have you both come? Emotional, relationship, sexual and social issues raised by heterosexual couples seeking sexual therapy (in women referred to a sexual difficulties clinic with a history of vulval pain). *Sexual and Relationship Therapy, 23*(3), 217–226. https://doi.org/10.1080/14681990802227974

Sherfey, M. J. (1973). *The nature and evolution of female sexuality*. Vintage Books New York.

Shifren, J. L., Johannes, C. B., Monz, B. U., Russo, P. A., Bennett, L., & Rosen, R. (2009). Help-seeking behavior of women with self-reported distressing sexual problems. *Journal of Women's Health, 18*(4), 461–468. https://doi.org/10.1089/jwh.2008.1133

Shifren, J. L., Monz, B. U., Russo, P. A., Segreti, A., & Johannes, C. B. (2008). Sexual problems and distress in United States women: Prevalence and correlates. *Obstetrics and Gynecology, 112*(5), 970–978. https://doi.org/10.1097/AOG.0b013e3181898cdb

Shindel, A. W., Rowen, T. S., Lin, T. C., Li, C. S., Robertson, P. A., & Breyer, B. N. (2012). An internet survey of demographic and health factors associated with risk of sexual dysfunction in women who have sex with women. *The Journal of Sexual Medicine, 9*(5), 1261–1271. https://doi.org/10.1111/j.1743-6109.2012.02659.x

Sigusch, V., & Schmidt, G. (1971). Lower-class sexuality: Some emotional and social aspects in West German males and females. *Archives of sexual behavior, 1*(1), 29–44. https://doi.org/10.1007/BF01540935

Simon, J. A. (2020, March 5–8). *How the US government and the media conspired to convince women that menopausal hormone therapy was dangerous* [Conference session]. ISSWSH Annual Meeting, Orlando, FL, United States. https://www.isswshmeeting.org/2020/program

Smith, K. B., & Pukall, C. F. (2014). Sexual function, relationship adjustment, and the relational impact of pain in male partners of women with provoked vulvar pain. *The Journal of Sexual Medicine, 11*(5), 1283–1293. https://doi.org/10.1111/jsm.12484

Solursh, D. S., Ernst, J. L., Lewis, R. W., Prisant, L. M., Mills, T. M., Solursh, L. P., Jarvis, R. G., & Salazar, W. H. (2003). The human sexuality education of physicians in North American medical schools. *International Journal of Impotence Research, 15*(S5), S41–S45. https://doi.org/10.1038/sj.ijir.3901071

Spolia, T. (2016, February 16). Myth: Girls don't masturbate. *The Gazette*. https://westerngazette.ca/culture/myth-girls-dont-masturbate/article_53f28b68-2f15-11e9-9664-6ff49b961a4f.html

Sprecher, S., & Hatfield, E. (1996). Premarital sexual standards among U.S. college students: Comparison with Russian and Japanese students. *Archives of Sexual Behavior, 25*(3), 261–288. https://doi.org/10.1007/BF02438165

Stanford. (2007, December 12). *What our mothers never taught us: Changes in female sexual function throughout the lifespan* [Video]. YouTube. https://www.youtube.com/watch?v=nlP5rY2pfG0

Statistics Canada. (2013). *National household survey (NHS) profile, 2011* (Catalogue no. 99-004-XWE). http://www12.statcan.gc.ca/nhs-enm/2011/dp-pd/prof/index.cfm?Lang=E

Statistics Canada. (2016). *Education highlight tables, 2016 census: Highest level of educational attainment (general) by selected age groups 25 to 64, female, % distribution 2016, Canada, Alberta and census metropolitan areas and census agglomerations, 2016 Census – 25% Sample data*. https://www12.statcan.gc.ca/census-recensement/2016/dp-pd/hlt-fst/edu-sco/Table.cfm?Lang=E&T=12&SP=1&geo=48&view=2&age=2&sex=3

Statistics Canada. (2017). *2016 Census of Canada: Population and dwelling release*. https://open.alberta.ca/dataset/7d02c106-a55a-4f88-8253-4b4c81168e9f/resource/e435dd59-2dbd-4bf2-b5b6-3173d9bd6c39/download/2016-census-population-and-dwelling-counts.pdf

Statistics Canada. (2019a). *2011 Census of Canada: Topic-based tabulations. Conjugal Status and Opposite/Same-sex Status (7), Sex (3) and Age Groups (7A) for Persons Living in Couples in Private Households of Canada, Provinces, Territories and Census Metropolitan Areas, 2011 Census* (Catalogue no. 98-312-XCB2011045.). https://www12.statcan.gc.ca/census-recensement/2011/dp-pd/tbt-tt/Rp-eng.cfm?LANG=E&APATH=7&DETAIL=0&DIM=0&FL=C&FREE=0&GC=0&GID=0&GK=0&GRP=1&PID=102574&PRID=0&PTYPE=101955&S=0&SHOWALL=0&SUB=0&Temporal=2011&THEME=0&VID=0&VNAMEE=Conjugal%20status%20and%20oppos

Statistics Canada. (2019b, February 20). *Population and dwelling count highlight tables, 2016 census: Population counts, for Canada, provinces and territories, census divisions, population centre size groups and rural areas, 2016 Census – 100% data*. Retrieved October 6, 2020, from https://www12.statcan.gc.ca/census-recensement/2016/dp-pd/hlt-fst/pd-pl/Table.cfm?Lang=Eng&T=703&SR=1&S=87&O=A&RPP=25

Stein, A. (2009). *Heal Pelvic Pain: The Proven Stretching, Strengthening, and Nutrition*. McGraw-Hill.

Sun Life Assurance Company of Canada. (n.d.-a). *Extended health care and dental insurance*. Retrieved July 16, 2020, from https://www.sunlife.ca/slf/sunaffinity/Insurance+Products/Extended+Health+Care+Insurance?vgnLocale=en_CA

Sun Life Assurance Company of Canada. (n.d.-b). *Plan comparison*. Retrieved July 16, 2020, from https://www.sunlife.ca/slfas/Health/Personal+health+insurance/PHI/Plan+comparison?vgnLocale=en_CA

Sun Life Financial. (2014). *Your group benefits* [PDF]. https://www.sunlife.ca/static/canada/Planadvisor/About%20Group%20Benefits/Advis

or%20communications/Advisor%20Communications%202014/Advisor%20Communications%202015/February/Changes%20to%20Group%20Insurance%20Contracts/Member%20sample%20booklet%20-%20English.pdf

Sung, S.-C., & Lin, Y.-C. (2013). Effectiveness of the sexual healthcare education in nursing students' knowledge, attitude, and self-efficacy on sexual healthcare. *Nurse education today, 33*(5), 498–503. https://doi.org/10.1016/j.nedt.2012.06.019

Sutherland, O. (2012). Qualitative analysis of heterosexual women's experience of sexual pain and discomfort. *Journal of Sex & Marital Therapy, 38*(3), 223–244. https://doi.org/10.1080/0092623X.2011.606880

Taylor, R. B. (2001). Please don't call me 'provider'. *American Family Physician, 63*(12), 2340–2343. https://www.aafp.org/afp/2001/0615/p2340.html

TEDx Talks. (2016a, October 29). *The pleasure principle: The secret to a better sex life | Laurie Betito | TEDxMontrealWomen* [Video]. YouTube. https://www.youtube.com/watch?v=lnigGtrwAfs

TEDx Talks. (2016b, December 13). *Women's sexuality isn't 'complicated' | Sarah Barmak | TEDxToronto* [Video file]. YouTube. https://www.youtube.com/watch?v=cQqmMVOsriI

TENGA, OCW, & PSB. (2019). *TENGA 2019 self-pleasure report: How Americans masturbate and its role in self-care*. http://www.feelmore.global/wp-content/uploads/2019/05/us_report.pdf

ter Kuile, M. M., Melles, R., de Groot, H. E., Tuijnman-Raasveld, C. C., & van Lankveld, J. J. D. M. (2013). Therapist-aided exposure for women with lifelong vaginismus: A randomized waiting-list control trial of efficacy. *Journal of Consulting and Clinical Psychology, 81*(6), 1127–1136. https://doi.org/10.1037/a0034292

The Alan Guttmacher Institute. (1994). *Uneven and unequal: Insurance coverage and reproductive health services*. Author.

The Asexual Visibility & Education Network. (n.d.-a). *Asexuals and attitudes toward sex*. Retrieved June 10, 2020 from https://www.asexuality.org/?q=attitudes.html

The Asexual Visibility & Education Network. (n.d.-b). *Overview*. Retrieved June 10, 2020, from https://www.asexuality.org/?q=overview.html

The Church of Jesus Christ of Latter-day Saints. (1995, September 23). *The family: A proclamation to the world*. https://www.churchofjesuschrist.org/study/scriptures/the-

family-a-proclamation-to-the-world/the-family-a-proclamation-to-the-world?lang=eng

The Church of Jesus Christ of Latter-day Saints. (2011). *For the strength of youth* [PDF]. The Church of Jesus Christ of Latter-day Saints. https://www.lds.org/bc/content/shared/content/english/pdf/ForTheStrengthOfYouth-eng.pdf

The Church of Jesus Christ of Latter-Day Saints. (2018a, September 1). *Alberta - LDS statistics and church facts*. Retrieved September 16, 2020, from https://news-ca.churchofjesuschrist.org/facts-and-statistics/province/alberta

The Church of Jesus Christ of Latter-Day Saints. (2018b, September 1). *Canada - LDS statistics and church facts*. Retrieved September 16, 2020, from https://news-ca.churchofjesuschrist.org/facts-and-statistics/country/canada

The SexMed Advocate [@SexMedAdvocate]. (2020, June 17). ✕ *Please don't tell a female patient that she doesn't need surgery right now to fix her vulvar PAIN...because she* [GIF attached; Tweet]. Twitter. Retrieved June 17, 2020, from https://twitter.com/SexMedAdvocate/status/1273273369232900096

The SexMed Advocate [@SexMedAdvocate]. (2021). *A depressing thread popped up today in one of the #vestibulodynia support groups. Patients are saying how many years, doctors* [Tweet]. Retrieved March 3, 2021, from https://twitter.com/SexMedAdvocate/status/1367196802793963520

The Vatican. (n.d.). *Catechism of the Catholic Church. Part three: Life in Christ. Section two: The ten commandmaents. Chapter two: "You shall love your neighbour as yourself." Article 6: The sixth commandment.* http://www.vatican.va/archive/ccc_css/archive/catechism/p3s2c2a6.htm

Things I Learned Researching Sex [@Things1Learned]. (2021, March 7). *Dr. Irwin Goldstein of @SDSexualMed responded: We are also studying #PSSD - the key to us is that despite the #anxiety* [Tweet]. https://twitter.com/Things1Learned/status/1368644181564948481

Thomas, C. M., Crook, T. M., & Cobia, D. C. (2013). Counseling African American women: Let's talk about sex! In D. Castañeda (Ed.), *The essential handbook of women's sexuality* (Vol. 2, pp. 153–168). Praeger.

Thomas, H. N., & Thurston, R. C. (2016). A biopsychosocial approach to women's sexual function and dysfunction at midlife: A narrative review. *Maturitas, 87*, 49–60. https://doi.org/10.1016/j.maturitas.2016.02.009

Thomtén, J. (2014). Living with genital pain: Sexual function, satisfaction, and help-seeking among women living in Sweden. *Scandinavian Journal of Pain, 5*(1), 19–25. https://doi.org/10.1016/j.sjpain.2013.10.002

Tiefer, L. (2002). Arriving at a "new view" of women's sexual problems: Background, theory, and activism. *Women & Therapy, 24*(1–2), 63–98. https://doi.org/10.1300/J015v24n01_12

Tikkun Holistic Spa. (n.d.). *Specialty treatments: Brief history and health benefits of Mugwort V Steam therapy*. Retrieved July 14, 2020, from https://www.tikkunspa.com/treatments/specialty-treatments/

Tolman, D. L. (1994). Doing desire: Adolescent girls' struggles for/with sexuality. *Gender & Society, 8*(3), 324–342. https://doi.org/10.1177/089124394008003003

Tolman, D. L. (2002). *Dilemmas of desire: Teenage girls talk about sexuality*. Harvard University Press.

TVO. (2007, July 1). *Elisabeth Lloyd on the case of the female orgasm* [Video]. Big Ideas. https://www.tvo.org/video/archive/elisabeth-lloyd-on-the-case-of-the-female-orgasm

Tyagi, V., Scordo, M., Yoon, R. S., Liporace, F. A., & Greene, L. W. (2017). Revisiting the role of testosterone: Are we missing something? *Reviews in Urology, 19*(1), 16–24. https://doi.org/10.3909/riu0716

United Nations Educational, Scientific and Cultural Organization, UNAIDS Secretariat, United Nations Population Fund, United Nations Children's Fund, UN Women, & World Health Organization. (2018). *International technical guidance on sexuality education*. https://www.unaids.org/sites/default/files/media_asset/ITGSE_en.pdf

Ussher, J. M., Gilbert, E., & Perz, J. (2013). The experience and construction of changes to women's sexuality after breast cancer. In D. Castañeda (Ed.), *The essential handbook of women's sexuality* (Vol. 2, pp. 171–195). Praeger.

van Lankveld, J. J., Weijenborg, P. T., & ter Kuile, M. M. (1996). Psychologic profiles of and sexual function in women with vulvar vestibulitis and their partners. *Obstetrics and Gynecology, 88*(1), 65–70. https://www.academia.edu/1828260/Psychologic_profiles_of_and_sexual_function_in_women_with_vulvar_vestibulitis_and_their_partners

Verrastro, V., Saladino, V., Petruccelli, F., & Eleuteri, S. (2020). Medical and health care professionals' sexuality education: State of the art and recommendations.

International Journal of Environmental Research and Public Health, 17(7), 1–11. https://doi.org/10.3390/ijerph17072186

Visser, R. O., Smith, A. M. A., Rissel, C. E., Richters, J., & Grulich, A. E. (2003). Sex in Australia: Heterosexual experience and recent heterosexual encounters among a representative sample of adults. *Australian and New Zealand Journal of Public Health, 27*(2), 146–154. https://doi.org/10.1111/j.1467-842X.2003.tb00802.x

Volpe, A. (2019, April 22). The enduring myth of 'complicated' female sexuality. *Elemental*. https://elemental.medium.com/the-enduring-myth-of-complicated-female-sexuality-736db9233fd0

Vulvar Healing [@healingvulva]. (2021, March 25). *Enough said* [Instagram image]. Retrieved March 25, 2021, from https://www.instagram.com/p/CM1IoYkAxrC/

Wade, L. D., Kremer, E. C., & Brown, J. (2005). The incidental orgasm: The presence of clitoral knowledge and the absence of orgasm for women. *Women & Health, 42*(1), 117–138. https://doi.org/10.1300/j013v42n01_07

Wallin, P. (1960). A study of orgasm as a condition of women's enjoyment of intercourse. *The Journal of Social Psychology, 51*(1), 191–198. https://doi.org/10.1080/00224545.1960.9922028

Waterman, C. K., & Chiauzzi, E. J. (1982). The role of orgasm in male and female sexual enjoyment. *The Journal of Sex Research, 18*(2), 146–159. https://doi.org/10.1080/00224498209551145

Weerakoon, P., & Stiernborg, M. (1996). Sexuality education for health care professionals: A critical review of the literature. *Annual Review of Sex Research, 7*(1), 181–217. http://search.ebscohost.com/login.aspx?direct=true&db=a9h&AN=9705250162&site=ehost-live&scope=site

Weiss, S. (2016, January 18). 7 myths about women and masturbation it's time to unlearn right now. *Everyday Feminism*. https://everydayfeminism.com/2016/01/myths-women-masturbation/

Weisskopf, S. (1980). Maternal sexuality and asexual motherhood. *Signs, 5*(4), 766–782. https://doi.org/10.1086/493763

Wells, K. (2006). Masturbation. In K. Krapp & J. Wilson (Eds.), *Gale Encyclopedia of Children's Health: Infancy through Adolescence* (Vol. 3, pp. 1148–1151). Gale. https://link-gale-

com.ezproxy.uleth.ca/apps/doc/CX3447200356/GVRL?u=leth89164&sid=GVRL&xid=647fc3de

Wetzel, G. (2018, February 3). *Let's talk about sex: The reality of the sexual pleasure disparity* [Video]. TEDxStLawrenceU. https://www.ted.com/talks/grace_wetzel_let_s_talk_about_sex_the_reality_of_the_sexual_pleasure_disparity/transcript?language=en

White, G., & Jantos, M. (1998). Sexual behavior changes with vulvar vestibulitis syndrome. *Journal of Reproductive Medicine, 43*(9), 783–789.

White, J. N. (2002). The contraception misconception: Why prescription contraceptives should be covered by employer insurance plans. *Hofstra Law Review, 31*(1), 271–302. http://scholarlycommons.law.hofstra.edu/hlr/vol31/iss1/8

Wiederman, M. W., & Sansone, R. A. (1999). Sexuality training for professional psychologists: A national survey of training directors of doctoral programs and predoctoral internships. *Professional Psychology: Research and Practice, 30*(3), 312–317. https://doi.org/10.1037//0735-7028.30.3.312

Williams, D. T. [@doc_thoughts]. (2020, January 6). *My biggest fear is sociology paying more attention to identity (race, gender, class) and not the structures (white supremacy, patriarchy,* [Tweet]. https://twitter.com/doc_thoughts/status/1346891286125674499

Winston, S. (2010). *Women's anatomy of arousal*. Mango Garden Press.

Winter, A. [@AshleyGWinter]. (2017, February 26). *In healthcare, "WHO TAKES OWNERSHIP FOR THE CLITORIS?" #whoownstheclitoris #sexmed* [Tweet]. Retrieved October 5, 2020, from https://twitter.com/AshleyGWinter/status/835857429783007233

Wojnarowska, F. (1997). Psychological characteristics and outcome of patients attending a clinic for vulval disease. *Journal of the European Academy of Dermatology and Venereology, 8*(2), 121–129. https://doi.org/10.1016/S0926-9959(96)00574-0

Wood, J. R., McKay, A., Komarnicky, T., & Milhausen, R. R. (2016). Was it good for you too?: An analysis of gender differences in oral sex practices and pleasure ratings among heterosexual Canadian university students. *The Canadian Journal of Human Sexuality, 25*(1), 21–29. https://doi.org/10.3138/cjhs.251-A2

World Health Organization. (1992). Sexual dysfunction, not caused by organic disorder or disease. In *International statistical classification of diseases and related health problems* (10th ed.). http://apps.who.int/classifications/icd10/browse/2016/en#/F52

World Health Organization. (2006). *Defining sexual health: Report of a technical consultation on sexual health, January 28-31, 2002, Geneva*. https://www.who.int/reproductivehealth/topics/gender_rights/defining_sexual_health/en/

World Health Organization. (2018). *International classification of diseases for mortality and morbidity statistics*. https://icd.who.int/

World Health Organization. (n.d.-a). *International Classification of Diseases (ICD) information sheet*. https://www.who.int/classifications/icd/factsheet/en/

World Health Organization. (n.d.-b). *Sexual health: Overview*. Retrieved September 15, 2020, from https://www.who.int/health-topics/sexual-health#tab=tab_1

World Health Organization, & UNFPA. (2010). *Measuring sexual health: Conceptual and practical considerations and related indicators* [PDF]. https://www.who.int/reproductivehealth/publications/monitoring/who_rhr_10.12/en/

Wright, J. J., & O'Connor, K. M. (2015). Female sexual dysfunction. *The Medical Clinics of North America, 99*(3), 607–628. https://doi.org/10.1016/j.mcna.2015.01.011

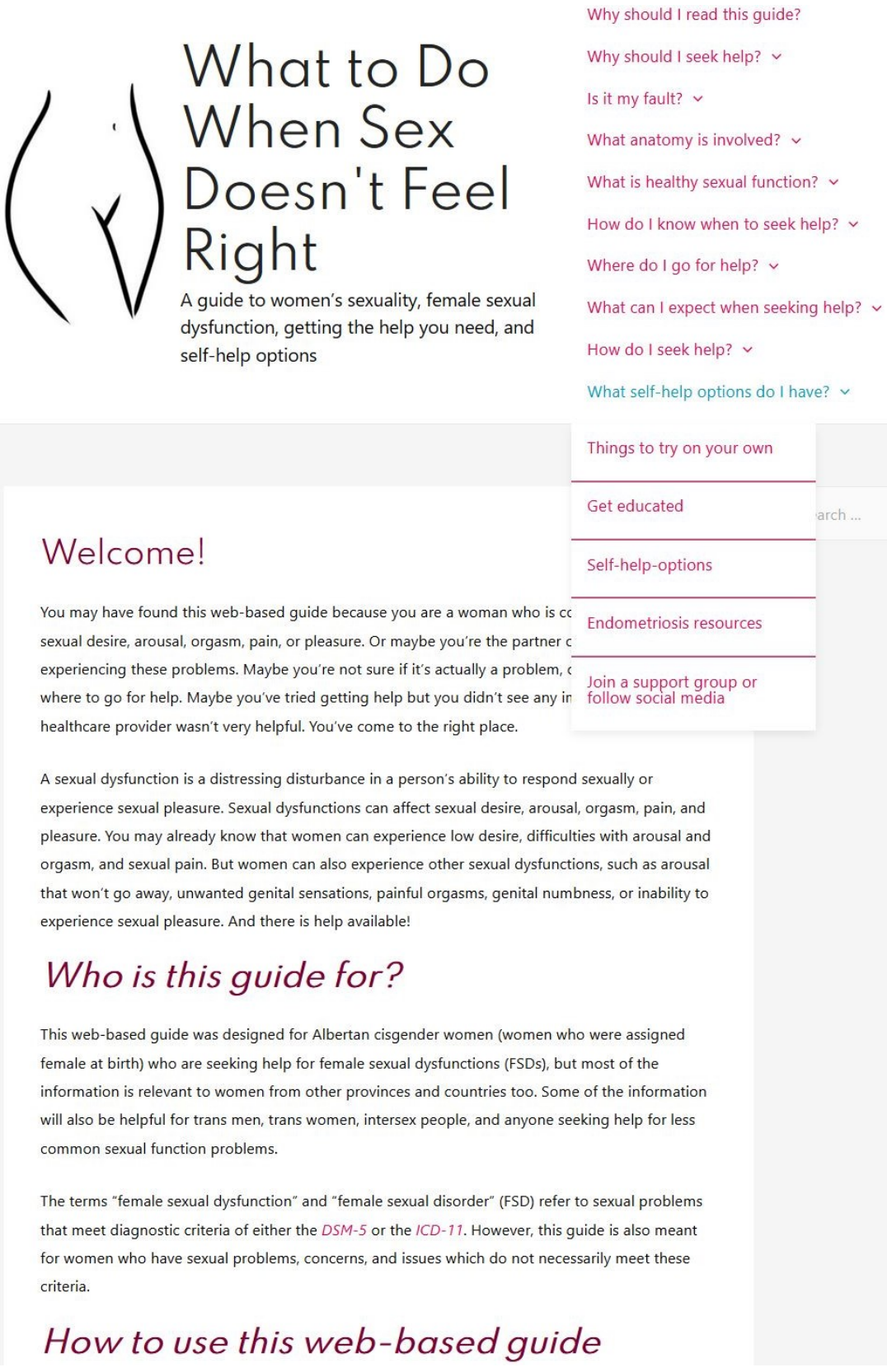
Xie, Y., Shi, L., Xiong, X., Wu, E., Veasley, C., & Dade, C. (2012). Economic burden and quality of life of vulvodynia in the United States. *Current Medical Research & Opinion, 28*(4), 601–608. https://doi.org/10.1185/03007995.2012.666963

Yee, B. Y. (2019). Time to stop labeling physicians as providers. *Forbes*. https://www.forbes.com/sites/brucelee/2019/05/05/time-to-stop-labeling-physicians-as-providers/

Yule, M. A., Brotto, L. A., & Gorzalka, B. B. (2017). Sexual fantasy and masturbation among asexual individuals: An in-depth exploration. *Archives of Sexual Behavior, 46*(1), 311–328. https://doi.org/10.1007/s10508-016-0870-8

Zippan, N., Stephenson, K. R., & Brotto, L. A. (2020). Feasibility of a brief online psychoeducational intervention for women with sexual interest/arousal disorder. *The Journal of Sexual Medicine, 17*(11), 2208–2219. https://doi.org/10.1016/j.jsxm.2020.07.086

Appendix A: Screen Capture of the Web-Based Guide's Welcome Page



Appendix B: What to Do When Sex Doesn't Feel Right

Table of Contents

Welcome!

You may have found this web-based guide because you are a woman who is concerned about your sexual desire, arousal, orgasm, pain, or pleasure. Or maybe you're the partner of a woman who is experiencing these problems. Maybe you're not sure if it's actually a problem, or you're not sure where to go for help. Maybe you've tried getting help but you didn't see any improvement or your healthcare provider wasn't very helpful. You've come to the right place.

A sexual dysfunction is a distressing disturbance in a person's ability to respond sexually or experience sexual pleasure. Sexual dysfunctions can affect sexual desire, arousal, orgasm, pain, and pleasure. You may already know that women can experience low desire, difficulties with arousal and orgasm, and sexual pain. But women can also experience other sexual dysfunctions, such as arousal that won't go away, unwanted genital sensations, painful orgasms, genital numbness, or inability to experience sexual pleasure. And there is help available!

Who is this guide for?

This web-based guide was designed for Albertan cisgender women (women who were assigned female at birth) who are seeking help for female sexual dysfunctions (FSDs) or problems, but most of the information is relevant to women from other provinces and countries too. Some of the information will also be helpful for trans men, trans women, intersex people, and anyone seeking help for less common sexual function problems.

The terms "female sexual dysfunction" and "female sexual disorder" (FSD) refer to sexual problems that meet diagnostic criteria of either the *DSM-5* or the *ICD-11*. However, this guide is also meant for women who have sexual problems, concerns, and issues which do not necessarily meet these criteria.

How to use this web-based guide

You don't have to read this entire web-based guide from beginning to end. In a perfect world, you would, but let's face it, you probably have other priorities, even if your sexual function problems are really important too. That's why I've organized the information in this web-based guide under menu questions (at the top of the page), so that you can read the information that seems important or relevant to you.

I have included many hyperlinks (in red) within this web-based guide. Sometimes they link to content within this guide and sometimes they link to external webpages. To avoid you losing your place in this guide, I have made it so all of these links open in a new tab.

Warning: While this web-based guide does not contain any pornography, it does contain diagrams of female genitals (on the anatomy webpage) and links to resources that have diagrams or images of female genitals for educational purposes.

Why should I read this guide?

As I've been studying sex therapy and women's sexuality before and during graduate school, I've noticed that there is a lack of support for women experiencing sexual dysfunctions. Sexuality is an important part of most women's lives, through both partnered sex and solo sex. Female sexual dysfunction (FSD) can have a massive and widespread impact, negatively affecting women's mental health, physical health, general wellbeing, self-esteem, sexual self-esteem, quality of life, and relationships. FSD can also have further impacts on a woman's sexual function, decreasing sexual desire, the ability to get aroused, and sexual satisfaction. FSD can also negatively affect the emotions and mental health of women's sexual partners and even the partners' sexual function. Without knowledge of FSD and resources available for it, women run the risk of not receiving the help they need and thus experiencing some or even all of these negative impacts.

Unfortunately, many women experience sexual function problems and sexual dysfunctions. 55% of non-European Western women (including Canada and the USA) experience at least one sexual function problem. If we look strictly at sexual dysfunctions, 28% of Canadian women experience at least one. That's more than one in four women! How many Canadian women experience each sexual dysfunction? Periodically or frequently, 11% experience low sexual desire, 12% experience lubrication difficulties, 10% experience an inability to reach orgasm, 7% experience pain during sex, and 8% experience unpleasurable sex. It is likely that Albertan women experience these problems at similar rates. There are also other sexual dysfunctions that have only been recognized recently, and so we have limited information on them. It is estimated that approximately 1% to 4% of North Americans experience persistent genital arousal disorder/genito-pelvic dysesthesia (PGAD/GPD) unwanted and persistent abnormal genital sensations). There does not appear to be any information on how many people experience lasting sexual dysfunctions (e.g., low desire, genital numbness) after stopping drugs (e.g., antidepressants, acne drugs).

To make matters worse, there are many barriers preventing women from seeking help for their sexual function problems, and when women do seek help, negative experiences are common. To adequately support women in navigating the healthcare system and other resources available, women need accurate information about female sexual function and dysfunction, but they also need direction about where and how to seek help. This information will also help women to prepare for and prevent negative help-seeking experiences and to identify sexual problems as soon as they arise. Due to the wide range of sexual health needs that exist among women, this web-based guide is only designed to support women with FSD, though some of the information may still be helpful for women with other related conditions, such as endometriosis, overactive bladder, and sexually transmitted infections. This web-based guide will help educate women about sexual function and the resources available to them, enabling women to know why, when, where, and how to seek help effectively and efficiently.

Why should I seek help?

Sexual health, sexual pleasure, and sexual satisfaction are human rights according to the World Health Organization and the Sex Information & Education Council of Canada. Your sexual satisfaction is important to your sexual wellness, sexual health, and general well-being, as well as your social life, relationship, and your partner's mental health and sexual function. Sexual satisfaction within a relationship can also predict future relationship satisfaction and stability.

However, whether you seek help or not is completely up to you (even if your partner really wants you to). You may have very important reasons for not seeking help or delaying help. But if you want to know why I think you should seek help if you think you have a sexual dysfunction, we'll dive into the negative impacts of female sexual dysfunction (FSD). Most of this information pertains specifically to the impacts of sexual pain, but I believe it applies to all sexual dysfunctions to varying degrees.

Can my sexual dysfunction affect my mental health?

FSD, especially sexual pain, can have a negative impact on women's mental health, including self-esteem and body image. Women with sexual pain experience a negative impact on their quality of life and often experience depression and anxiety. Many women with sexual pain feel guilt and internalized pressure to be sexual with their male partners—they feel obligated to have sex, as though they do not have a choice. A woman like this cares about and wants to please her partner, views her partner's needs as more important than her own, and assumes responsibility for her partners' reactions (e.g., frustration, disappointment, anger) if she turns him down. She also fears negative consequences if she refuses sex, feels social pressure to engage in sexual interactions, and views sexual interactions as part of her role as a wife or woman.

Women may experience negative thoughts, feelings, and behaviours as a result of sexual pain. Mental distress and a range of negative feelings are common, including shame, embarrassment, frustration, worsened mood, anger, fear, grief, and confusion. Many women with sexual pain feel inadequate as women and sexual partners because of the Western belief that vaginal intercourse is the only "real sex" and that all other sexual behaviours are foreplay. They may begin to view themselves as broken, damaged, abnormal, and incomplete. Their self-esteem may suffer and they may feel a loss of femininity, loss of self, and diminished confidence.

Body image is often impacted by the experience of sexual pain as well. Women with vulvodynia view their bodies as "not normal," "worthless," "useless," "broken," and "dysfunctional" for not being able to satisfy their partners' sexual needs and they describe their bodies with the words "garbage," "trash," "useless," "mutant," and "gimp." Some women with sexual pain view their genitalia as a useless and dead part of their body and may

begin to resent their body for being "faulty." Women with sexual pain are not only suffering from physical pain but intense emotional pain as well.

People with lasting sexual dysfunctions, especially those involving abnormal genital sensations (PGAD/GPD) or lasting genital numbness (e.g., PSSD), appear to experience mental health impacts of a different magnitude. People with PSSD and PGAD/GPD experience severe depression and loss of quality of life, sometimes leading to suicide, due not only to the devastating effects of these sexual dysfunctions, but also likely to the experiences of not being believed by healthcare providers and the absence of a cure.

Can my sexual dysfunction affect other aspects of sexual function?

It is no surprise that women with sexual pain experience a negative impact on their sexuality, including decreased sexual interest, arousal ability, sexual satisfaction, and sexual self-esteem. Sexual satisfaction is an important component of sexual health. Decreased sexual desire, sexual arousal, and orgasm ability can also lead to a woman's decreased sexual satisfaction.

Some women with sexual pain avoid sexual interactions and refuse their partners' advances to avoid or reduce pain. These women may fantasize about circumstances in which they could avoid vaginal penetration, such as being single or being a lesbian.

Many women engage in painful and unwanted vaginal intercourse for their partners' benefits, to prevent their partners from cheating or leaving, and in hopes of experiencing pleasure themselves. Some women feel detached from the experience and their partner. They focus on their partners' sexual arousal and tell themselves things like "Grin and bear it" to get through the encounter. They may experience physical pain, ranging from "annoying" to "very excruciating" during sexual interactions. They may be entirely motionless during the sexual act or mentally detach from the experience and think about other things. When the sexual interaction is over, these women are relieved, but the experience may also leave them feeling frustrated, guilty, sad, depressed, lonely, insecure, uncertain, anxious, and fearful. Meeting others' needs while not having their own needs met may lead them to feel exhausted, hurt, and angry. It is unlikely these women experience much sexual satisfaction.

Can my sexual dysfunction affect my partner or my relationship?

Research findings are mixed on whether sexual pain causes relationship problems, but points more to "yes" than "no." These negative impacts are reported by both the women with sexual pain and their male partners. (There's no research on female partners.) As PSSD can impact all aspects of sexual function, particular erotic sensation, people with PSSD may experience failed relationships.

Beyond the negative views of herself, a woman with sexual pain may have negative views toward sexual activity, viewing sex as a chore or a duty or even as "disgusting" and "dirty." She may have negative thoughts about her male partner, such as thinking he is abnormal and needy, believing that he resents her, or questioning her choice of partner. She may also wonder why her partner is with her while also believing that other men would be less understanding than he is.

A woman may not speak up about painful intercourse because she fears her partner's rejection or infidelity or views herself as an inadequate woman. Some women cope with their sexual dysfunction and its impacts through alcohol use, compulsive eating, and overworking themselves.

Lubrication difficulties may not have much impact on a woman's partner because synthetic lube is such an easy solution, though some men feel this solution is "unnatural." A woman's orgasm difficulties may not prevent intercourse or other sexual activities, but men do view women's orgasms as "masculinity achievements" and men are more sexually satisfied with women who orgasm more intensely and more frequently. However, low desire and sexual pain are factors that could interfere with the frequency or occurrence of intercourse or other sexual activity at all. Given that Western society places such an emphasis on vaginal intercourse, women's sexual pain and low desire could impact their male partners by inhibiting women from desiring or consenting to some or all partnered sexual activities.

Male partners of women with sexual pain may experience negative emotions, such as anger, disappointment, frustration, guilt, and depression. They are likely to experience sexual distress, either through decreased sexual experiences (e.g., decreased quality and quantity of intercourse) or reduced intimacy (e.g., decreased physical intimacy, disconnection). A man may experience relationship strain (e.g., fighting or questioning the relationship) and communication challenges, such as difficulty discussing his partner's sexual pain with her or anyone else. Erectile function, sexual satisfaction, and sexual communication may all suffer as a result of his female partner's sexual pain.

Can my sexual dysfunction be a sign of other health issues?

FSDs have implications for a woman's physical health. They are often associated with other health problems, though it is not always clear if the FSD is the cause or the effect of other conditions. For example, women's sexual desire can be impacted by testosterone levels, and testosterone levels can impact bone density, body fat, lean muscle mass, risk of coronary heart disease, insulin sensitivity, and mood. Low testosterone (which causes low desire in some women) can also be a result of other conditions, including hypopituitarism, premature ovarian failure, or adrenal insufficiency. So it's possible that low desire is a sign of another problem, especially if low desire is not normal for you. Similarly, a variety of health conditions are associated with vaginal dryness, sexual pain, and other FSDs. Thus, seeking help for your sexual function problem may be important in caring for your overall physical health.

What if I'm still not sure about seeking help?

There may be a number of reasons you're reluctant to seeking help. Let's take a look at these barriers, and how this web-based guide can help.

I don't think I have a problem

Women may not recognize their own sexual experiences as a problem for a variety of reasons and, as a result, do not necessarily seek help. Poor or inaccurate sex education (at home, at school, or through socialization) rarely, if ever, mentions sexual pleasure—especially women's sexual pleasure—and may include false and damaging beliefs about women, such as the idea that sexual desire is unfeminine, that women's enjoyment of sex is unfeminine and interferes with reproduction, or that the female body is inherently dysfunctional. Women may believe that having sexual problems (e.g., low desire, limited pleasure, orgasm difficulties) is normal, that this is just how women experience sex (e.g., "I don't care for sex but neither do most women" or "sex should hurt"), or that sexual problems are a normal part of aging, motherhood, first-time vaginal intercourse, or even all intercourse.

If any of these barriers apply to you, you may want to check out the webpages on healthy sexual function, anatomy, and when to seek help.

Many Canadian women do not seek help because they are comfortable the way they are, they do not think the problem is very serious, or they are waiting to see if the problem goes away. Additionally, women may never even have considered seeking help and may be less likely to seek help if they are not bothered by their sexual function problem. Not seeking help should not be taken as an indication of contentment, however, as many women who have not sought help would like to do so. Women may also not wish to have any treatment.

If any of these barriers apply to you, check out the webpages on healthy sexual function and when to seek help.

I'm uncomfortable discussing the problem

Older age, poor health, not knowing what services are available, and self-stigma may be barriers to help-seeking. Some women believe that their healthcare provider cannot help them or that the healthcare provider will be dismissive of their concerns. Women may be too embarrassed to bring up sexual function problems or believe that their doctors will be embarrassed. Similarly, women may expect or prefer that doctors initiate discussions about sexual function.

A healthcare provider's personal characteristics, including age and gender, may contribute to women's discomfort with seeking help. Specifically, women may be reluctant to seek help if their provider is too young, too old, significantly younger or older than them, or a different gender than them. Many women (but not all women) prefer seeing female physicians. Finally, women may be reluctant to seek help from a provider who does not seem approachable or seems uncomfortable discussing sex.

If you have concerns about your healthcare provider's ability or willingness to provide help, or you're not sure how to bring up the topic yourself, check out the webpage on how to seek help. That webpage will give you information on how to interview healthcare providers so that you can pick the best one for you.

I don't have enough time or money

Limited time with physicians is a common barrier for women who wish to discuss sexual function problems. People may also assume that health services cost more than they really do. A fifth of Canadian women reported that they had not consulted a doctor because they did not have a regular physician or that going to the doctor is expensive. Insurance policies can be another barrier, as they may not cover the treatments recommended by doctors.

If time and money are barriers for you, the best thing you can do is find a way to maximize your time when you do seek help. That means educating yourself (check out healthy sexual function and when to seek help), considering free and cheap options first (check out the self-help resources), maximizing the time in your appointment (check out how to seek help), and doing your best to avoid spending time and money on unnecessary services (check out where to go for help and how to seek help).

Is it my fault that I have sexual problems?

Short answer: no. There are so many reasons women experience sexual problems: biological reasons, psychological reasons, social/cultural reasons, interpersonal reasons, etc. Let's take a quick look at the broad range of factors that can impact female sexual function, and then we'll dive into some of the social and cultural impacts.

Many factors impact women's sexual function

Even though sexual dysfunctions used to be blamed on psychological factors, we now know that they can be caused by all kinds of things, only some of which are psychological. Below is a table showing some possible risk factors for female sexual dysfunction (FSD). Note that each risk factor is not necessarily a risk factor for *every* FSD and notice how many factors are not "in your head."

Risk Factors for Sexual Dysfunction	
Physiological Factors Pregnancy, childbirth, menopause, age, medications (e.g., birth control pills, Accutane, antidepressants), nerve damage, neuropathy, surgery in the genital area, hormonal imbalances, diabetes, thyroid problems, hypertension, hyperlipidemia, heart disease, atherosclerosis, cancer, dermatological conditions, clitoral adhesions, endometriosis, infections, muscular factors, poor overall health.	**Psychological Factors** Poor mental health (e.g., emotional distress, stress, depression, anxiety), sexual abuse, self-image, body image, unrealistic expectations, lack of knowledge and skills.
Sociocultural Factors Religious or cultural beliefs (especially in strict or patriarchal cultures or religions), upbringing, societal pressures, cultural norms and expectations, deterioration of socioeconomic status, low educational attainment, ethnicity (due to cultural influences, *not biology*).	**Interpersonal Factors** Relationship factors, being unmarried (premarital, divorced, widowed, separated), being married, partner's sexual dysfunction.

The fact that there are so many factors that can impact female sexuality makes it really hard for women to know what's causing their problem, which means it's hard to know where to seek help! Having so many possible contributing factors can also make it hard for healthcare providers to figure out the problem. None of this is your fault.

Nobody talks about women's sexual pleasure

Teaching people of all genders about women's sexual function can both prevent FSD and treat FSD. Comprehensive sexual health education enhances a person's physical, emotional, mental, and social well-being in relation to sexuality. Sexual health education should teach people what normal and healthy sexual functioning is, when and where to ask for help, and that sexual health and pleasure are their rights. Albertan resources (e.g., Alberta Health's TeachingSexualHealth.ca) do not mention pleasure or the clitoris (but they do mention the vagina and penis), while Canada's resources (e.g., SIECCAN's Question & Answers or Canadian Guidelines for Sexual Health Education) do at least mention pleasure.

Unfortunately, Alberta Education's requirements for sexual health education also fail to mention pleasure or sexual function, instead focusing on prevention of negative outcomes (e.g., STIs, unplanned pregnancy), mostly by abstinence. It's likely that neither your schooling nor your parents taught you about sexual pleasure or the clitoris, and you may not have learned much more as an adult. You may have learned to feel shame and embarrassment about your genitals as a child and carried much of this shame into adulthood. Do you relate to this person's experience of sexual health education?

> My sex-ed was a failure. I didn't learn about body parts and their proper names…. I never learned that sex shouldn't or doesn't have to hurt. I never heard about reproductive control, like birth control and abortion. I was left to my own devices, many of which were unreliable, biased, and inaccurate, in learning about these topics. (Action Canada for Sexual Health & Rights)

Lots of women haven't learned about their bodies through masturbation

Masturbation is the stimulation of the genitals with a hand or another object by yourself or someone else. I'm going to refer to solo masturbation simply as "masturbation."

There is no correct method of masturbation—it is simply what works best for each person. Women may touch their bodies (usually their clitorises) using their fingers, vibrators or dildos, though almost all women who masturbate with a dildo add clitoral stimulation, and few women masturbate only through vaginal penetration. Women may enhance their masturbation through fantasies, pornography, erotica, music, or thinking about previous sexual experiences. On average, it takes women about four minutes to orgasm from masturbation—the same amount of time it takes a man to orgasm from masturbation. So don't let anyone tell you women take too long to orgasm!

How many women masturbate?

In a 2017 study of 1046 American women, 41% had masturbated in the last month and 22% had never masturbated. Another 2017 study found that over 70% of asexual women and over 90% of sexual women masturbate at least monthly. Women tend to underreport masturbation, so it is safe to assume that many women are masturbating.

85% of women aged 25 to 29 have ever masturbated while only 58% of women aged 70 or more have ever masturbated! Masturbation seems to be becoming more popular with women.

Is masturbation harmful?

Masturbation was referred to as "self-love" in ancient Ireland, but Christianity misinterpreted the Biblical story of Onan as referring to masturbation, and the name changed to "self-abuse." Masturbation is considered a sin by some religions, including Orthodox Jews (though it is not a sin for women), Latter-day Saints, and Catholics. The demonization of masturbation has led to personal shame, fear, and misinformation. There are many myths about masturbation, such as the myth that it causes physical deterioration and deformity. These myths were intended to prevent masturbation and lead to a bunch of unproven prevention techniques, including cutting off the clitoral glans. This shame about masturbation has resulted in some women being unwilling to masturbate, many people being reluctant to discuss or admit to masturbation, and the myth that women simply do not masturbate. But is masturbation harmful? No, it is not.

Is masturbation beneficial?

Yes! Masturbation has many benefits. It allows for sexual exploration, sexual expression, and sexual gratification without the risks (e.g., STIs, pregnancy) and stressors of partnered sex (e.g., partner judgment, worrying about partner enjoyment). Women are more likely to experience orgasms and multiple orgasms during masturbation than during sexual intercourse or other partnered sexual activity—specifically, masturbation leads to orgasm for 94% of women. Masturbation is beneficial for partnered sex too, as it helps women to learn about their sexual response, and this knowledge can be transferred to partnered sex. Masturbation is also beneficial for women with sexual dysfunctions. Because some sexual dysfunctions are often treated with "directed masturbation," learning about their own sexual response through masturbation would probably prevent some women from experiencing sexual dysfunctions.

Women masturbate for a variety of reasons, including for sexual pleasure, to relieve tension, for fun, for self-care, or to avoid being sexual with another person. And four out of five women continue to engage in masturbation when they are in a relationship!

What if I don't masturbate?

Some women do not masturbate at all, and there are a variety of reasons for this, including being asexual, not knowing how, shame, fear of being caught, low sex drive, a partner's insecurity, lack of interest, being in a relationship, and religious prohibition, though many religious people masturbate despite their prohibitive religious beliefs. If a woman is seeking help for FSD, however, refusing to masturbate may be a treatment barrier, as masturbation is a standard recommendation for some sexual dysfunctions, particularly orgasm dysfunctions. I highly recommend masturbation, but it is entirely up to you whether you do it!

Asexuality is a sexual orientation describing people who do not experience sexual attraction to other people. While significantly fewer asexual women masturbate than sexual women, many asexual women do masturbate and they masturbate for somewhat different reasons than sexual women (e.g., "I feel that I have to").

Female sexuality is not complex, just misunderstood

Another reason it's not your fault that you have a sexual function problem is that female sexuality is misunderstood, especially by the average person. You may believe that women's sexuality is complicated. Have you seen this sculpture before? Does it resonate with you?

Man, Woman by Miller Levy, photographed by Barend Jan de Jong.
Permission granted by photographer.

This sculpture represents Western views of female sexuality. Desire, arousal, and orgasm are very straightforward for men but very complicated for women—so complicated, in fact, that it's probably not even worth trying to figure it out. However, this is because we are judging women's sexuality by the standard of men's sexuality. Vaginal intercourse easily stimulates a man's primary pleasure organ (his penis), and that is why his desire, arousal, and orgasm are so straightforward. Vaginal intercourse does not easily stimulate a woman's primary pleasure organ (her clitoris), but many other behaviours do—such as cunnilingus (oral sex on a vulva), masturbation, and even vaginal intercourse with added clitoral stimulation. And women tend to experience arousal and orgasm just as easily and quickly as men do when their clitorises are stimulated. The takeaway: women's sexuality isn't complicated. The clitoris just needs to be stimulated. (I cannot emphasize this enough.)

I would also argue that women do not have significantly lower sexual desire than men do. Women simply experience more barriers to sexual desire than men do, such as being responsible for a greater proportion of the gendered division of labour and significantly fewer sexual encounters that take women's needs into account. If men were expected to endure painful or boring sex and if men's penises were ignored during sex, I think men would have lower sexual desire too.

So why don't women ask for pleasure?

By now, you may have a burning question in your mind: If women are not receiving pleasure, why don't they just ask for it or demand it? Great question! There are many factors at play here. Young women are generally quite motivated to have sex, but they do not necessarily feel entitled to experience pleasure. Asking for pleasure assumes that one deserves pleasure, but female sexual pleasure has been shamed by Western society. Further, some women don't ask out of habit, fear of losing their partner's love, or fear of losing economic stability. Some women have partners who seem reluctant to fulfill their female partners' sexual needs, and some people follow the sexual script that says sex is over when the man orgasms.

We know that most women know how to orgasm from masturbation, but for some reason this information is not translated over to partnered sex. Why? One factor is men's egos. To protect men's egos, some women fake orgasms or avoid asking for the clitoral stimulation they need. This concern isn't without a basis: most men view vibrators with either indifference or negativity, so women don't exactly feel empowered to use them with male partners. This is unfortunate, given that vibrators are so successful at producing women's orgasms and the lack of evidence that women become dependent on vibrators. Most men do, however, view clitoral stimulation with the hand positively. Regardless of how your partner feels about clitoral stimulation with a hand or vibrator, you should feel free to ask and receive the stimulation you need.

Despite the fact that women tend to really enjoy cunnilingus (and it is the most reliable partnered path to orgasm), women may not necessarily want it. However, this may be due a number of factors, such as the belief that they should orgasm from vaginal intercourse, being self-conscious about their genitals, or having an untalented sexual partner, or it maybe a way to avoid feeling obligated to perform fellatio (oral sex on a penis). That may seem like a fair trade for people who think that vaginal intercourse to be as pleasurable for women as it is for men, but it simply is not. In heterosexual sex, vaginal penetration and clitoral stimulation should be considered equal. However the clitoris gets stimulated is up to the couple!

Another reason that women are less likely to ask for or demand pleasure because they have less power than men do. This is a big topic and you can read more about it elsewhere, but let's look at women's power in Alberta. In a 2019 report on the best and worst places to be a woman in Canada, the two Albertan cities included (Calgary and Edmonton) scored 21st and 25th out of 26 cities, and women occupied only five of the 28 city council seats between Calgary and Edmonton. Sally Hunter put it best: "We like to think women are empowered in

[the West] and yet we are underrepresented in board rooms and in parliament…. Is it any wonder, then, that women find it hard to negotiate their own sexual satisfaction?"

You may not even realize that your body has the ability to experience sexual pleasure—or how much pleasure or how easily. This isn't your fault either! (Remember, sex education is inadequate in most countries, and Alberta is no exception.) Many older women have had a life of vaginal intercourse with no orgasm because they didn't know any better. Many younger women report high sexual satisfaction simply because sex didn't hurt, they felt close to their partner, and their partner had an orgasm. This injustice is demonstrated especially well when we look at the differences between how women and men describe the low and high ends of a sexual satisfaction scale. Check it out:

Women's and men's descriptions of the high and low ends of a sexual satisfaction scale, based on their experiences. Adapted from Sara McClelland's 2009 doctoral dissertation, *Intimate justice: Sexual satisfaction in young adults*.

You may notice that women and men seem to be measuring sexual satisfaction with completely different scales. And you may notice how the high end of this scale is skewed in favour of women's partners' sexual satisfaction. Well, that's the next thing we're going to discuss!

Straight women and men prioritize men's sexual pleasure

Alright, this is a big topic, so buckle in. You may have been trained to prioritize men's sexual pleasure at the expense of your own. You may have experienced sexual interactions that end when the man ejaculates, and if you didn't orgasm before he did, you might not have orgasmed at all. You may have given a lot more oral sex than you received in return or you may have learned that being sexy is more important than receiving sexual pleasure. All of these things teach women that their pleasure does not matter and that their partners' pleasure is more important.

There are several important ideas intertwined with this phenomenon (prioritizing men's sexual pleasure), including the coital imperative, the difference between sexual behaviours that pleasure women and those that women actually engage in, and the orgasm gap. Let's dive in!

The coital imperative

Western culture overvalues vaginal intercourse. And even though few women orgasm from vaginal intercourse alone, Western society still expects them to do so (and makes them feel like something is wrong with them if they don't). Why does Western society expect women to orgasm from vaginal intercourse? Three reasons:

1. The belief that sexual pleasure ensures reproduction (even though women's orgasms are not required for reproduction).
2. The "coital imperative," a Western belief that vaginal intercourse is "real sex" and all other behaviours (cunnilingus [oral sex on a vulva], hand jobs) are foreplay or adolescent sexual behaviours. And because of the coital imperative, Western society expects women to orgasm from vaginal intercourse (despite the fact that about one third of women rarely or never orgasm with vaginal intercourse).
3. Freud's teachings that clitoral orgasms are immature and that the mature orgasm must transfer to the vagina. This is nonsense, and is akin to teaching that men must learn to transfer their orgasm from their penis to their testicles (or their "prostatic utricles" if we want to compare the vagina to the male organ that developed from the same reproductive tissues in fetuses). However, even women who orgasm from vaginal intercourse alone have easier or better orgasms when clitoral stimulation is added, so Freud's teachings are damaging to all women.

This emphasis on vaginal intercourse, which is very effective at producing men's orgasms but not women's, inevitably leads to a difference between the sexual behaviours that straight couples engage in and those that lead to women's orgasms.

Many women aren't having the kinds of sex that give them the most pleasure

The coital imperative and the prioritization of men's pleasure leads to women having more sex that pleasures men and less sex that pleasures themselves. It's common for Western society to believe that the best or healthiest way to experience sexual pleasure is with a partner, and that the best way to be sexual with a partner is vaginal intercourse. This faulty belief comes from many sources, including the early Christian prohibition on all sexual behaviours that weren't attempts at making babies and the myth that masturbation causes disease.

So what kinds of sex do women enjoy the most?

Women have sex for different reasons at different times (e.g., pleasure, their partner's desire, intended pregnancy), so just because a woman has a lot of a certain type of sex does not necessarily mean it's her favourite type of sex. Let's look at behaviours that women find appealing or satisfying and that reliably lead to women's orgasms.

You may not be surprised to find that 70% of women find vaginal intercourse "very appealing"—the highest rated of any partnered sexual behaviour. Somewhat surprisingly (at least to me), only 43% of women rate cunnilingus as "very appealing," (though I will address why this may be). It's interesting that women view vaginal intercourse so positively, as vaginal intercourse alone does not reliably lead to women's orgasms, especially in casual sex. However, many women say that vaginal intercourse is sexually satisfying. This may be due to a number of factors, such as orgasm not necessarily being correlated with sexual satisfaction, women's low expectations of pleasure, or women's limited knowledge about their capacity for pleasure. Women may also prefer vaginal intercourse because they prioritize men's sexual pleasure and base their own satisfaction on how satisfied their partner is. (We'll dive more into these reasons later in this section.)

While women rate vaginal intercourse as very appealing, women experience sexual satisfaction when they receive more cunnilingus, reach orgasm more consistently, and experience sexual variety (which can *include* vaginal intercourse but should not be *exclusively* vaginal intercourse). The most reliable path to female orgasm is clitoral stimulation, such as of cunnilingus or other "foreplay." In fact, cunnilingus is the most reliable partnered path to orgasm.

Okay, so what sexual behaviours are most common for women?

Vaginal intercourse, cunnilingus, masturbation, and vibrator use are common Western sexual behaviours for women. Over three quarters of adult women have ever had vaginal intercourse or received cunnilingus, but frequency of these behaviours varies greatly with age. Research suggests that women are having significantly more vaginal intercourse than they are receiving cunnilingus. (Women also perform somewhat more oral sex than they receive, though this research included women who have sex with women, so the gap is likely larger for straight women.) This is disappointing for women, given that clitoral stimulation is necessary for most women's orgasms, but it does provide a very concrete explanation for the orgasm gap.

While you might think older women would be more sexually experienced because they have been alive longer, this is not necessarily true. Having ever had vaginal intercourse increases with age, but having ever received cunnilingus peaks with women in their 30s. For all sexual behaviours included in one study (e.g., vaginal intercourse, giving and receiving oral sex, receiving anal sex, wearing lingerie), women aged 25 to 49 are the age group most likely to have done them in the last month, in the last year, or ever. Regarding intercourse and cunnilingus specifically, women in their 30s are the age group most likely to have done these behaviours in the last month. It seems that that middle-aged women and younger women are increasing their sexual repertoires to include more orgasmic activities, which is great!

Are some women enduring unwanted sex for their male partners?

Unfortunately, yes. Many women endure unwanted sex to prevent their partners from straying or to maintain their relationships, even when sex hurts. More than half of women who experience sexual pain do not tell their partners about the pain. Worse, women are even less likely to speak up about pain if they are experiencing little to no pleasure. So why don't they speak up? The main reasons are that painful sex has been normalized for women, some women view pain as unimportant, some women (or even their partners) prioritize their partner's enjoyment, and women may try to avoid awkwardness or manage their partner's emotions. Some doctors may also reinforce the idea that painful sex is normal or that women do not need to enjoy sex. You may have been told to expect pain with vaginal intercourse (especially first penetration) and some men may even use the Bible to justify the expectation that women endure painful sex for their male partners' enjoyment. Women also endure unwanted sex with men to avoid seeming rude or to avoid men's negative reactions, including hurt, disappointment, anger, and violence.

Why are you blaming men for so much?

I'm actually blaming a system that supports an unequal balance of power between women and men (the patriarchy), which many men and women uphold. Whether or not you agree with that isn't important. We can look at research on women who have sex with women (WSW) for concrete answers!

Compared to heterosexual women, lesbians are at less risk of sexual dysfunction, have better orgasmic function and less sexual pain. 88% percent of lesbian women orgasm with a partner frequently or always, while only 66% of heterosexual women orgasm with a partner frequently or always. Additionally, few lesbians (2%) never experience orgasm, compared to 13% of heterosexual women. Among lesbian, bisexual, and heterosexual women, lesbians report having the most orgasms. Lesbians are also just as sexually satisfied as heterosexual women, if not more satisfied.

The difference between sexual problems in WSW and heterosexual women may be due to WSWs' understanding of pleasuring a female partner and the fact that WSW sexual interactions do not prioritize vaginal penetration (a possible source of pain and a limited source of pleasure). These studies suggest that the introduction of men (or, more likely, penises) into women's sexuality is inhibiting women's orgasms. As one sex educator explains, "When women are put in a situation where the penis is not involved—as in the situations I described before [masturbation or sex with other women]—then sex differences disappear." You'll find more information about this in the next section on the orgasm gap.

The orgasm gap

The orgasm gap is the inevitable result of the coital imperative and the difference between the sexual behaviours that women practice and those that lead to their orgasms. What's the orgasm gap? Essentially, the orgasm gap is the phenomenon where men have significantly more orgasms than women do during partnered sex, especially during vaginal intercourse.

About 95% of straight men usually/always orgasm but only 65% of straight women usually/always orgasm! That's a big gap, and it's even bigger with casual sex because women *and* men prioritize men's orgasms and undervalue women's orgasms. Women aren't happy about it either. When their male partners orgasm and women do not, women feel angry, resentful, frustrated, and cheated.

While the orgasm gap is often blamed on women's supposedly "complicated" sexuality or psychological issues (e.g., body image, anxiety), it's actually a social issue, not a biological issue. That is to say, women's orgasmic capacity is the same as men's, but Western society expects women's bodies to function like men, which generally means orgasming from vaginal intercourse.

There is almost no orgasm gap for masturbation—94% of women orgasm with masturbation compared to 98% of men. Women and men also take about the same amount of time to orgasm during masturbation. Most (95%!) of women report that clitoral stimulation is their most reliable route to orgasm. What is notable is that straight women orgasm more during masturbation than during vaginal intercourse and heterosexual sex and that about one third of women rarely or *never* have orgasm with vaginal intercourse.

Among those women who can orgasm during vaginal intercourse (about one third), additional clitoral stimulation improves their orgasm or makes it easier to achieve for most of them. In fact, in research on thousands of women, 95% said that clitoral stimulation is their most reliable route to orgasm. This is normal sexual function for women. Vaginal intercourse stimulates the vagina but tends to neglect the external clitoris, so it inherently provides inadequate clitoral stimulation for most women. The clitoris and the penis both developed from the same tissues in utero, which means they are essentially different versions of the same organ, so they both require adequate stimulation for orgasm to occur. (Imagine if men were expected to orgasm with minimal touch to their penises!) So there's no need to feel inferior, broken, or guilty if you aren't having an orgasm from vaginal intercourse—that's normal! The vagina isn't the primary pleasure organ for most women. (But if you want to have an orgasm *with* vaginal intercourse, we'll address that later.)

Sexual scripts (socially expected sexual behaviours) are another important contributor to the orgasm gap. For example, many people follow sexual scripts that place the responsibility of women's orgasms on men's penises. Many people also follow sexual scripts that believe that "foreplay" is only needed to prepare for vaginal penetration, followed by vaginal intercourse (the main event), which leads to a woman's orgasm and ends when the man orgasms. Following these scripts—which do not promote clitoral stimulation—decreases a woman's ability to orgasm with her male partner, especially if he orgasms before she does. Again, not orgasming from vaginal intercourse alone is normal sexual function for women because their clitorises are not adequately stimulated.

You may now be wondering whether women actually have lower sexual desire than men do, or if straight women would have equal sexual desire to men if their clitorises were getting as much attention as men's penises do—and if this would reduce or eliminate the orgasm gap. I believe it would.

Lack of research, training, treatments, and insurance coverage for FSD

You may have sought help and given up because it was too difficult, pointless, or expensive. This isn't your fault either.

Doctors receive little to no education in sexual health during medical school or residency training, and when they do, it tends to have a heavy emphasis on contraception and STIs (though sexual violence and FSD may be the next most common topics). Many doctors are unaware of FSD treatment options and don't know where to refer patients for FSDs. Sexual medicine specialists exist, but they are less common.

Mental healthcare providers don't usually have any training in sexual health either, and those programs that do include sexuality training also tend to have a heavy emphasis on infection and disease. Neither the College of Alberta Psychologists nor the Canadian Counselling and Psychotherapy Association requires any training in sexuality beyond sex role development, sex role differences, and sexual orientation. However, AASECT-certified sex therapists are required to undergo extensive sexuality training and supervision.

Quick! Can you name some possible treatments for male sexual dysfunction? If you did, I bet you came up with Viagra, maybe Cialis, and maybe even a penis pump or testosterone supplementation. Now quickly try naming some treatments for FSD. If you can't think of any, I'm not surprised. In the USA in 2020, there were 26 FDA-approved drugs for male sexual dysfunction and zero for women. As of March 2021, there were 30 for men and three or four for women.

Another problem is that treatments for sexual dysfunction are more often covered for males than for females (though neither are covered very often in Canada). This meme depicts the problem in a humorous way.

A meme on gendered allocation of research funds for sexual dysfunction.
Created by Instagram user Vulvar Healing (@healingvulva). Permission granted by creator.

I know the situation seems bleak, but there *are* healthcare providers out there who can help. You just have to find them. (We'll get to that.)

What anatomy is involved in female sexual pleasure?

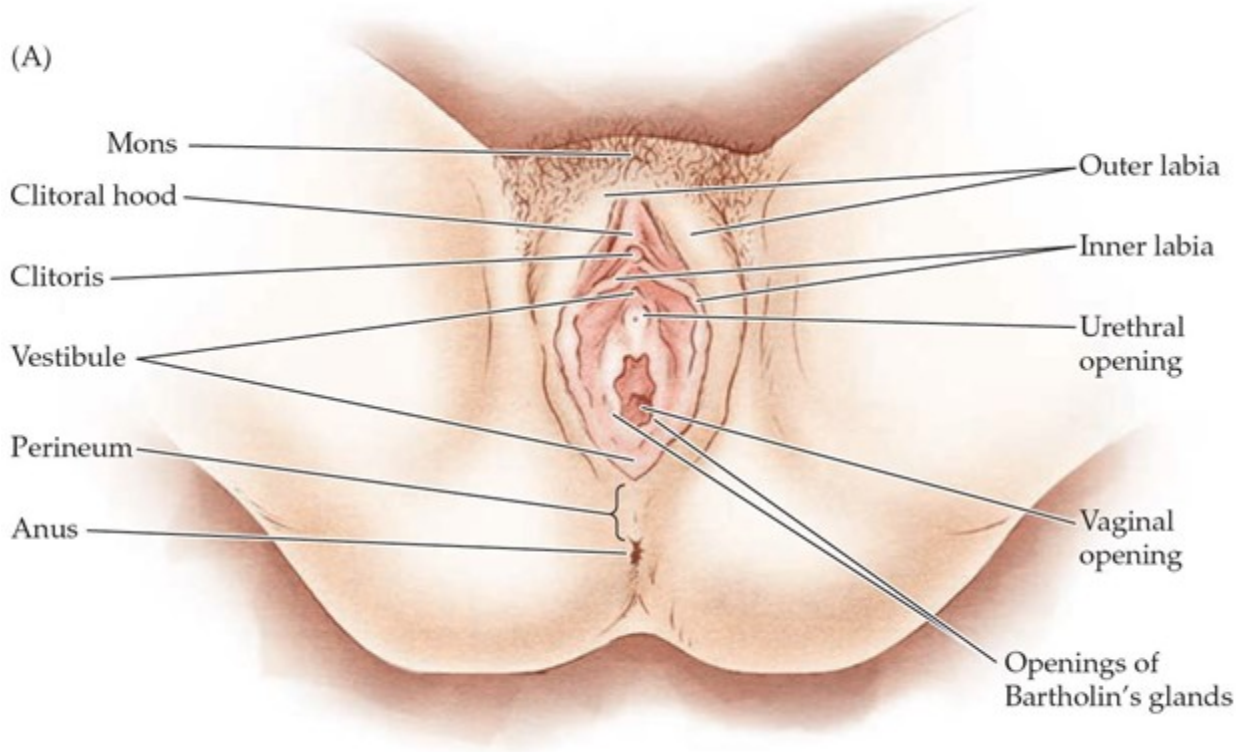
An understanding of female bodies is important for your own sexual function, and accurate terminology is imperative for effective communication between you and your healthcare providers.

Female genitals contain the same type and almost as much erectile tissue as male genitals, but it is laid out differently, as most female erectile tissue is inside the body. Erectile tissue has many nerves, which allow for movement and the perception of sensation.

Note: The diagrams I have included in this section were chosen because they were the most comprehensive high-quality images I could access. However, I prefer the diagrams in *A New View of a Woman's Body: A Fully Illustrated Guide* by the Federation of Feminist Women's Health Centers, which you can purchase at ComeAsYouAre.com, a sex shop in Toronto. Those images include more organs (and the book is an amazing resource).

What genital anatomy is on the outside?

The term vulva refers to all female external genitalia or all the visible parts of female genitalia. You may have grown up referring to the entire genital area as the "vagina" but this is inaccurate. The vulva includes the mons pubis, outer labia, inner labia, external clitoris, urethral opening, vestibule, and vaginal opening. The parts of the vulva vary in shape, size, and colour from female to female.



The vulva, or female external genitalia.
From page 25 of *Discovering human sexuality* (4th ed.) by LeVay, Baldwin, & Baldwin.

Mons pubis

The mons pubis, or mons (see diagram above) is a mound of fatty tissue over the pubic bones and it is covered in pubic hair. Its purpose is to provide cushioning during vaginal intercourse and attract sexual partners by secreting pheromones.

Outer and inner labia

The mons connects directly to the outer labia or outer lips (see diagram above). The outer labia are a fleshy pair of skin folds that cover and protect the inner parts of the vulva. The outer labia are also known as the labia majora ("big lips"), but outer labia is a more inclusive name because some inner lips protrude out from between the outer lips. The outer sides of the outer labia are covered in pubic hair while the inner sides are smooth and contain oil glands and sweat glands. These lips can be a source of sexual stimulation, though they are not as sensitive as the inner labia or clitoris. During sexual arousal, the outer labia engorge with blood and appear swollen.

The outer labia surround the hairless inner labia, which are a pair of thinner skin folds with oil glands that look and feel like tiny bumps. The inner labia surround the head (glans) of the clitoris to form the clitoral hood and the frenulum and they also extend around the vagina. The inner labia surround and end at the vestibule. Diversity in the appearance (e.g., colour, size, shape, symmetry) of the inner labia is normal—both between females and within one

vulva. Because they are dense with nerves, the inner labia are extremely sensitive and best touched with lubrication, either natural or synthetic. During sexual arousal, the inner labia will become engorged with blood, causing their colour to darken.

External clitoris

The clitoris is the primary pleasure organ in females (just like the penis is the primary pleasure organ in males). In fact, the clitoris serves no other purpose but pleasure for its owner. It consists of both external and internal parts. The external clitoris (see diagram below) consists of the glans (head), hood (also known as the prepuce or foreskin), and the frenulum. As the clitoris body (shaft) can be felt through the hood, it may also be considered part of the external clitoris.

The clitoral hood is formed by the joining of two inner labia over the glans. The hood protects the sensitive glans from overstimulation, though the degree that the hood covers the glans varies between women. Pleasure can be created through the friction of rubbing the hood against the glans.

The glans is the visible part of the clitoris (though sometimes the hood needs to be pulled back to see it), at the end of the clitoral body. Both the clitoral body and the glans are very sensitive to stimulation. Glans size varies between females and is unrelated to clitoral sensitivity. On the underside of the glans, the inner labia connect to form a small area of sensitive skin called the frenulum, which is also rich in nerve endings. During sexual stimulation and sexual arousal, the glans will become erect as it becomes engorged with blood. Arousal and impending orgasm will cause the glans to retract under the hood in order to protect itself from overstimulation.

The glans of the clitoris connects to the clitoris body (or shaft), which is a soft, tubular pipe of erectile tissue running just beneath the hood. It is about the width of a chopstick or a pencil, about half an inch to one inch long, and can be easily felt with the fingers, especially when it is engorged. The clitoral body is extremely sensitive receptive to sensation, and the hood allows for the shaft to be rubbed without friction. The clitoris body is about two to four centimetres long and extends toward the mons for about ¾ inch before splitting into two thin crura (legs) under the inner lips.

Vestibule

Just below the clitoris is the top of the vestibule (see diagram above), a smooth surface just inside the inner lips that surrounds the vaginal opening and the urethral opening. The urethral opening is a small and sensitive hole or slit between the clitoris and the vaginal opening which opens into the urethra, a tube that extends from the bladder to the outside of the body in order to allow for the excretion of urine.

The vaginal opening (see diagram above) is also within the vestibule. Its opening is partially covered by the hymen (not depicted in the diagrams), a membrane which can vary in shape, thickness, and how much it covers the vaginal opening. We aren’t sure of the hymen’s

purpose, but it is probably simply to protect young females' vaginas from infection. While you may have been taught that an intact hymen (and subsequent bleeding with first vaginal intercourse) is proof of no previous vaginal intercourse, the state of the hymen is not a reliable indicator of prior vaginal penetration. The hymen may be torn or stretched by accident, tampons, intentional stretching, physical activity, or first vaginal intercourse. Painful tearing and bleeding can occur during first vaginal intercourse, but it is the exception and is usually due to inadequate arousal, feeling unsafe, or non-consensual experiences—not the hymen itself. If bleeding does occur, it will likely only be a few spots and should only occur the first time. Hormonal changes during puberty may also thin the hymen and cause it to disappear on its own, or the hymen may also remain intact after sexual activity. In rare cases, the hymen can be very thick and obstruct the vaginal opening. Medical intervention is required in this case.

Within the vestibule are also two sets of ducts that expel fluid from glands: the paraurethral glands and the greater vestibular glands. While these ducts open into the vulva, the glands themselves are not visible, and will be discussed with internal anatomy.

Perineum

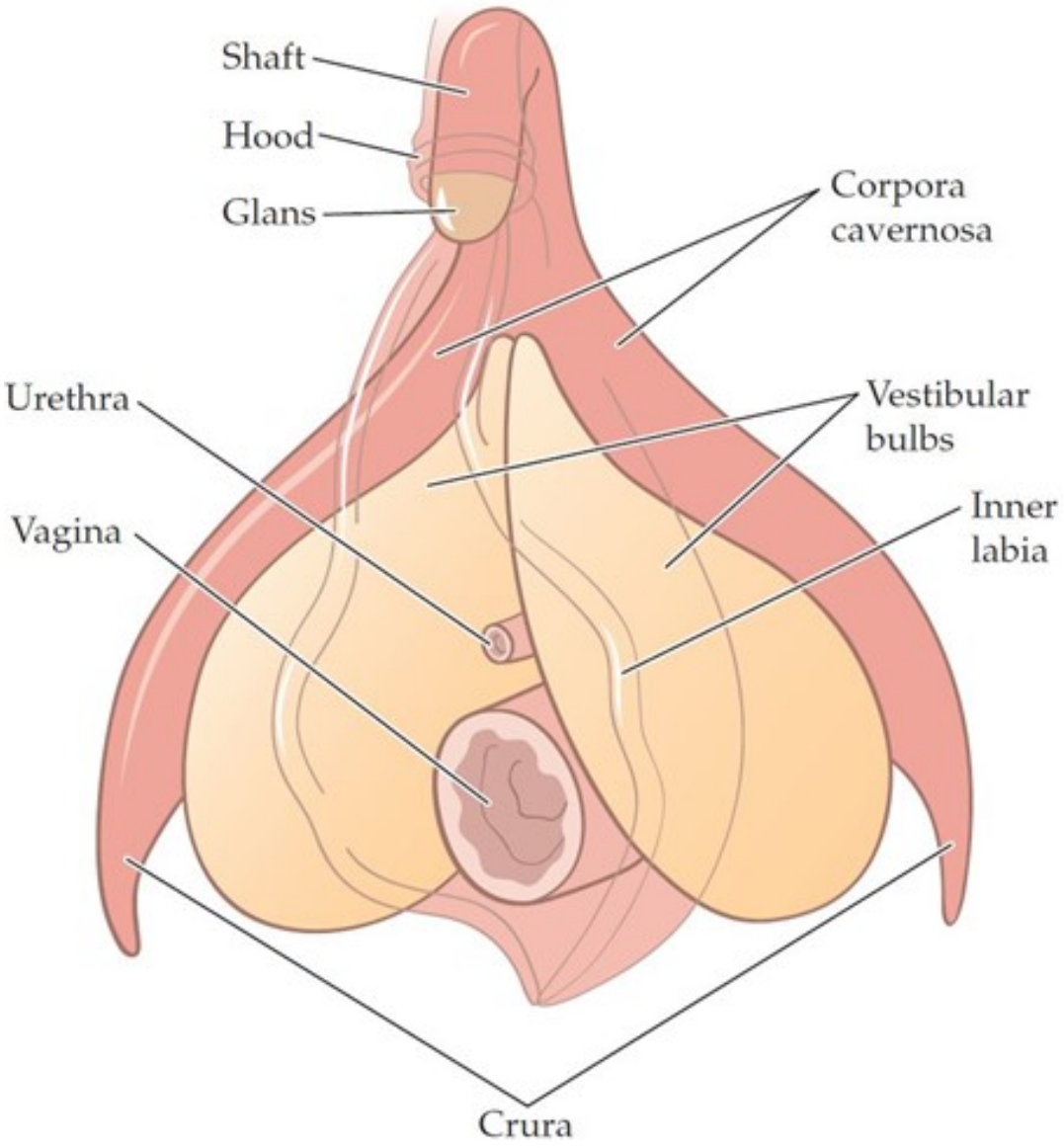
Between the vaginal opening and the anus is a smooth area of skin called the perineum (see diagram above). The surface of the skin is not very sensitive, but underneath the perineum is the perineal sponge, an area of sensitive erectile tissue. This area responds well to firm, rhythmic stimulation and will become firm and spongy and pleasurable to touch when you are highly aroused. Stimulating the anus can also be very pleasurable, as the inner anus is lined with nerve endings.

What genital anatomy is on the inside?

Female internal genital anatomy includes the internal clitoris, vestibular bulbs or clitoral bulbs, the urethral sponge, the paraurethral glands, the greater vestibular glands, the vagina, the uterus, the cervix, and a bunch of muscles.

Internal clitoris

I discussed the external parts of the clitoris (i.e., glans, hood, body), but I have not yet discussed the internal parts of the clitoris. The crura (legs) of the clitoris (see diagram) are about five to nine centimetres long. They follow along the inner pubic bone and anchor the clitoris. If you are not aroused, you probably will not be able to feel the crura with your fingers, but you may be able to feel the top part of the crura during high arousal.



Structure of the clitoris.
From page 26 of *Discovering human sexuality* (4th ed.) by LeVay, Baldwin, & Baldwin.

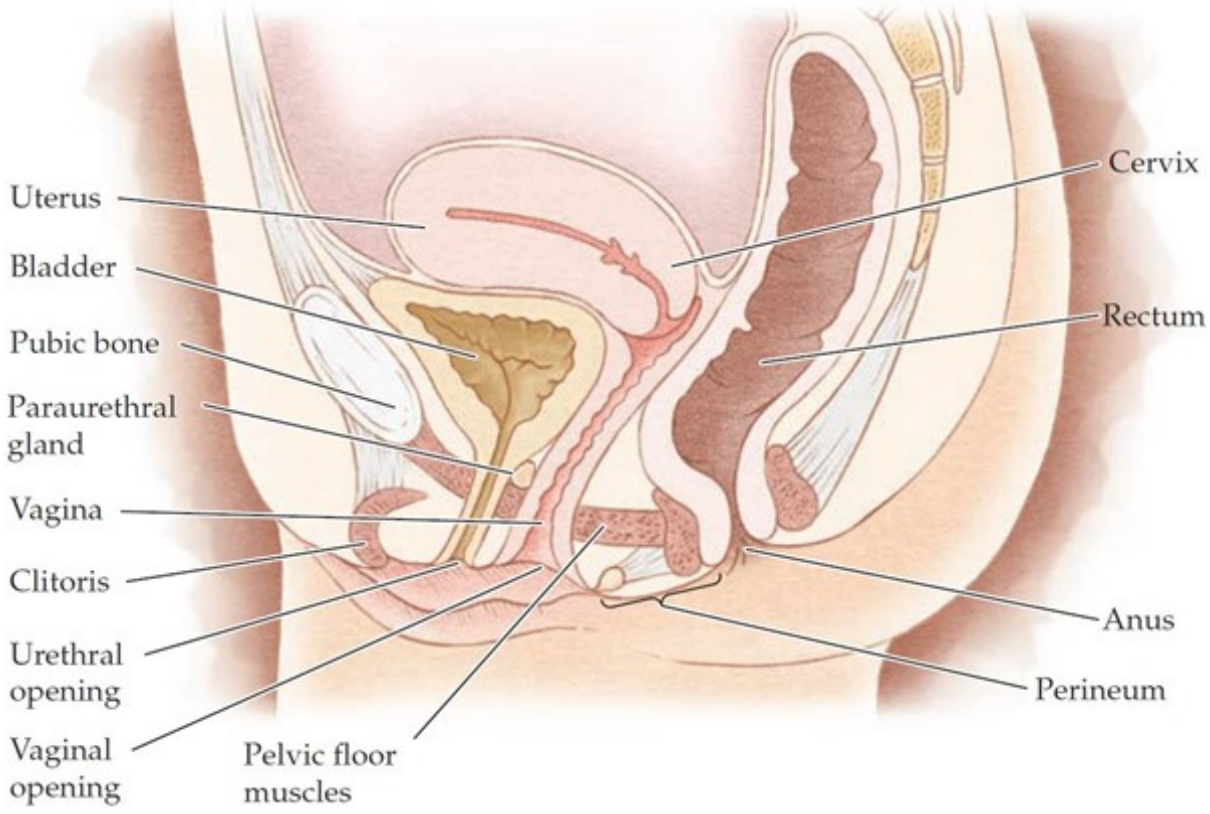
Other organs that are considered by some to be part of a larger clitoral network include the vestibular bulbs and the urethral sponge.

The vestibular bulbs (also known as clitoral bulbs) are masses of erectile tissue that lie under the inner lips and vestibule, are surrounded by the crura, and extend from the clitoris body downward to surround the urethra and vagina (see diagram above). The vestibular bulbs are closely associated with the clitoris and are considered internal parts of the clitoris. In fact, stimulating the clitoris stimulates the vestibular bulbs and vice versa. Stimulation leads to arousal and engorgement, stiffening and lengthening the vagina and creating a snug but flexible vaginal opening, allowing the vagina to accommodate a penis of almost any size. The vestibular bulbs can be stimulated through the outer lips and later through penetration. They are easy to feel with your fingers when they are filled with blood (engorged), and a

high level of engorgement increases the pleasure of vaginal intercourse, possibly because engorgement increases the pressure of the bulbs on the crura of the clitoris.

The urethral sponge (not pictured) is considered by some to be part of the clitoral network. Also known as the G-spot, the urethral sponge is a tube of spongy erectile tissue that surrounds the urethra. It is sensitive (though not as sensitive as the clitoral glans). Pleasure from G-spot stimulation will only occur after arousal and engorgement—prior to arousal and engorgement, stimulation will only produce an urge to urinate. Stimulating this area may be pleasurable simply because the clitoris is indirectly stimulated. Engorgement also protects the urethra from the friction of vaginal intercourse and from microbes entering the urethra.

The urethral sponge houses the paraurethral glands (see diagram below). The paraurethral glands (also known as the Skene's glands) connect to the ducts that open beside the urethral opening. These glands are the source of female ejaculate, an antimicrobial liquid that may help prevent infections in the urethra. Female ejaculation is not common and most females who do ejaculate had to learn how to do it. Some females can ejaculate voluntarily, though they seem to do it for entertainment purposes and it does not enhance arousal or pleasure. Females may ejaculate small or large amounts of liquid, though large ejaculations appear to come from the bladder and not from the paraurethral glands. However, what matters is whether it feels good, not whether the liquid is ejaculate or urine. Also, you should not be made to feel bad if you can't or don't want to ejaculate.



Side view of the internal female sexual organs.
From page 31 of *Discovering human sexuality* (4th ed.) by LeVay, Baldwin, & Baldwin.

Vagina

The vagina (see diagram above) is between the urethral sponge and the rectum. It is a flexible, muscular tube that points down and forward and opens through the vestibule. It is approximately six to eight centimetres in length and it can contract enough to be snug on a penis or expend enough to birth a baby. Despite many diagrams showing otherwise, the vagina is not actually a gaping hole or a spacious canal—it is a collapsed tube that can expand to accommodate whatever pushes its way in or out.

The word vagina comes from the Latin word for sheath, sword repository, or sword scabbard. This unfortunately defines the vagina in terms of its relationship to the penis or its dependency on vaginal intercourse for meaning. Some people prefer to refer to the vagina as a "pussy" or "yoni" or other terms; however, many of these words are ambiguous because they may also refer to the vulva, so I recommend using the word vagina when you want to be clear about anatomy.

The vagina functions as a passageway for menstrual blood, semen, and babies, but it can also provide pleasure when properly stimulated. Arousal causes the uterus to lift out of the way and expose the pelvic nerves, which can then be stimulated by thrusting activity, to which they respond well. That is to say, deep and repetitive thrusting may be pleasurable when highly aroused and the cervix is out of the way. If a female is not aroused enough, the uterus will not lift out of the way and deep thrusts will hit the cervix, which will likely be unpleasant or painful. The urethral sponge can also be stimulated through the front wall of the vagina.

On either side of the vaginal opening are the ducts that connect to the greater vestibular glands (also known as Bartholin's glands—see the vulva diagram above), which secrete a small amount of lubrication into the vagina and labia minora, likely to decrease the friction of vaginal intercourse or maintain a healthy vaginal ecology. Vaginas always have some degree of natural lubrication which is increased by sexual arousal, while breastfeeding or being postpartum or postmenopausal will decrease natural lubrication and make the vagina more fragile. However, increased vaginal lubrication does not necessarily mean a female is ready for penetration, as this is an early sign of arousal. One important consideration about vaginas is that they never need washed—they are self-cleaning. The external vulva can be washed with water only or with a gentle cleanser—not soap—but neither water nor cleanser should be used in the vagina.

Uterus and cervix

At the closed end of the vagina is the cervix (see diagram above), which separates the vagina and the uterus. The uterus is a muscular, pear-shaped organ, with the approximate dimensions of three inches by two inches by one inch in a female who has not given birth. One of the major supports of the uterus is the round ligament, which connects the uterus and the inner lips and connects to muscles that encircle the vaginal opening. This allows the uterus to lift when a female is fertile and also during arousal and orgasm, making room at the back of the vagina for sperm and protecting the cervix from battering during penetration.

Because the uterus is involved in orgasm, females who have had a hysterectomy may report that their orgasms feel different.

Muscles

In female genital anatomy, there are a number of important muscles that either form or support the perineum and the pelvic floor. When these muscles are too tight and/or too weak (note that the muscles can be both tight and weak), a number of negative outcomes may occur, including genital pain and urinary urgency. It is important to remember that tight muscles are not necessarily strong—tight muscles are simply unable to relax—a strong muscle must be able to contract and relax. Kegel exercises (contracting and relaxing the pelvic floor muscles) can create or exacerbate pain if they are performed when they shouldn't be, such as when the pelvic floor muscles are tight. Kegels should only be done after a qualified pelvic floor physiotherapist recommends them and teaches her patient how to do them correctly. While these muscles are relevant to female sexual function and dysfunction, a thorough overview is beyond the scope of this web-based guide. For a brief review, check out:

- *Heal Pelvic Pain: The Proven Stretching, Strengthening, and Nutrition Program for Relieving Pain, Incontinence,& I.B.S, and Other Symptoms Without Surgery* (Chapter 1) by Amy Stein (Amazon) or
- *Women's Anatomy of Arousal: Secret Maps to Buried Pleasure* (pages 129–133) by Sheri Winston (Amazon).

For a thorough review, check out:

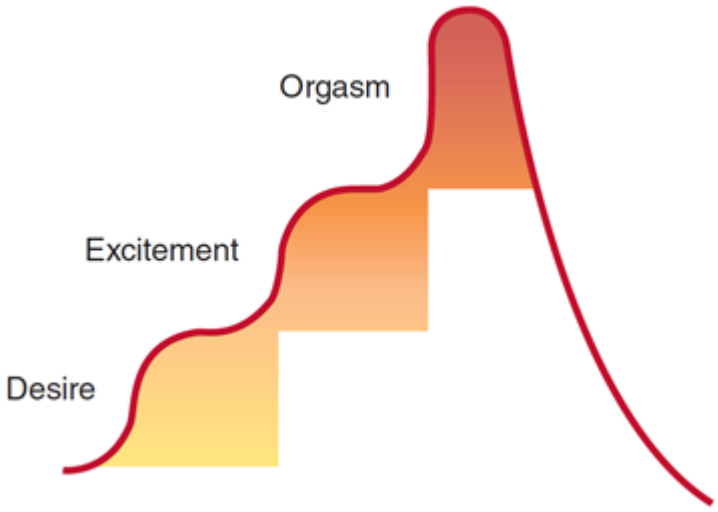
- *Pelvic Pain Explained: What You Need to Know* by Stephanie A. Prendergast & Elizabeth H. Akincilar (Amazon).

What does healthy sexual function look like?

Let's take a look at relevant models of sexual response first, and then we'll look at the stages within those models.

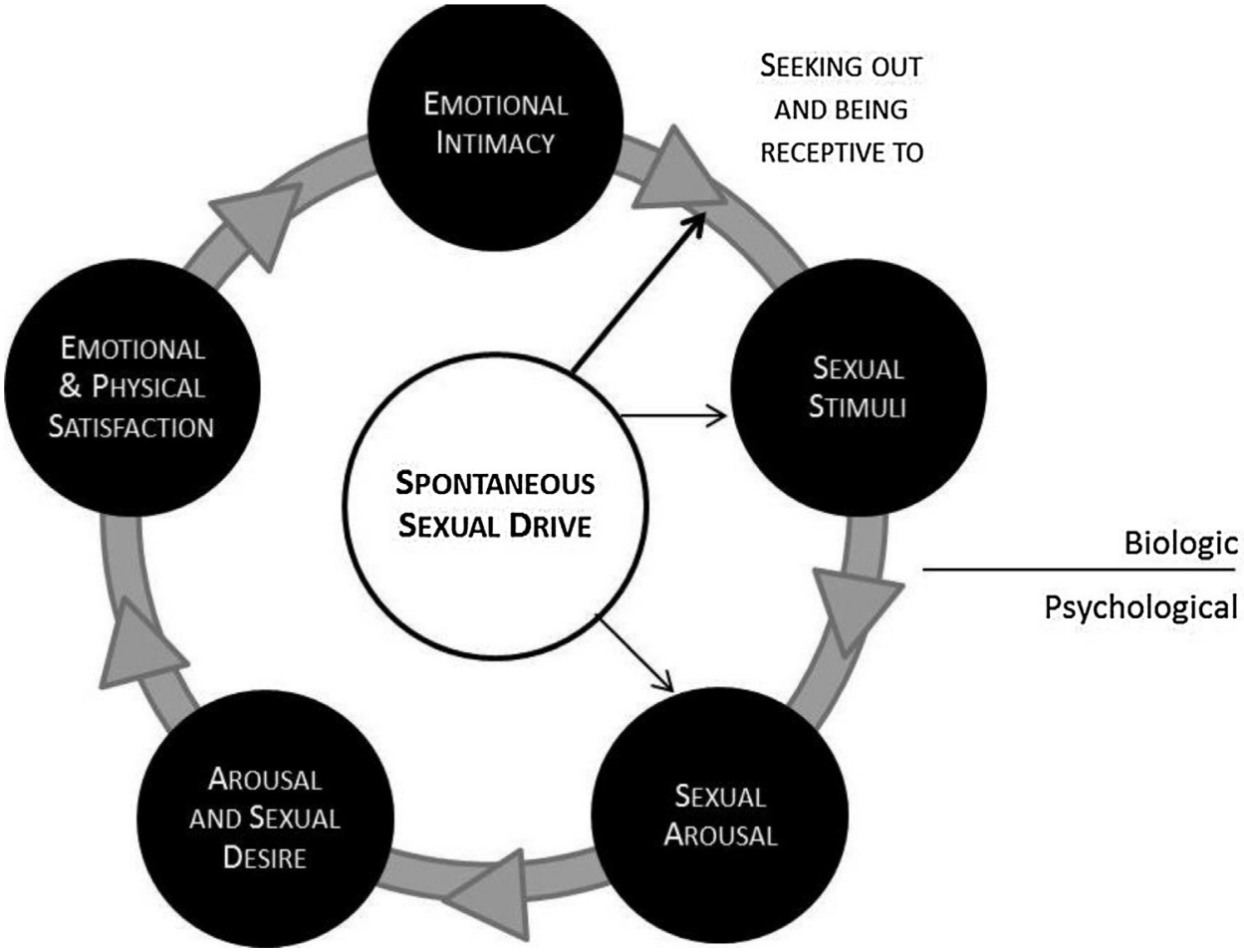
What are the stages of healthy sexual response?

You're probably familiar with the linear model of sexual response, which begins with desire, follows with arousal, and terminates with orgasm:



Kaplan's linear model of sexual response.
From page 164 of *Our Sexuality* (11th ed.) by Crooks and Baur.

However, the linear model of sexual response has been criticized for being based on a small subset of women (who could orgasm from vaginal intercourse while being observed in a laboratory setting) and failing to reflect women's real sexual experiences. That is to say, women are more likely to agree with this model when they are in newer relationships, making this model less representative of women in long-term relationships. There are two other models that may be more relevant: Basson's circular model (below) and Perelman's Dual Control model (further below).



Basson's circular model of sexual response. From page 51 of "A biopsychosocial approach to women's sexual function and dysfunction at midlife: A narrative review" in *Maturitas*.

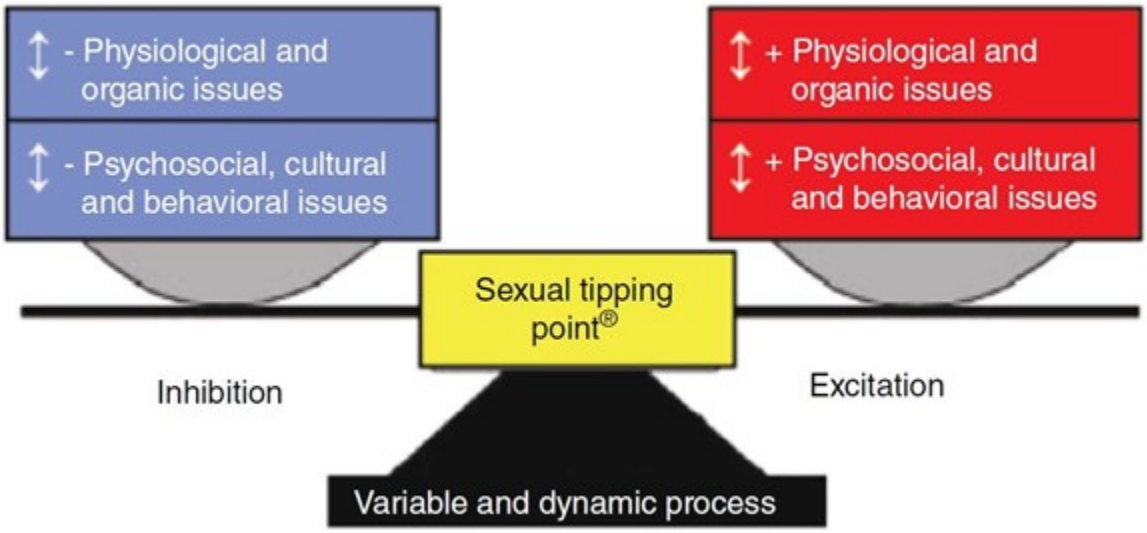
Basson's circular model of sexual response looks a bit complicated, but the important takeaways are:

1. Desire isn't the only motivation for engaging in sexual activity. Women may have sex to express love to their partners, share physical pleasure, experience emotional closeness, make their partners happy, or increase their own well-being.
2. Desire can come before arousal *or after* sexual arousal. This means that you may not have any sexual desire until *after* sexual stimulation begins or after your genitals are physically aroused. This is called responsive desire and it is totally normal, especially in long-term relationships! However, to any partners reading this, please take note: this does not give you permission to tell your partner that she will desire the sex once it gets going. Consent requires that a person is either seeking out or receptive to sexual stimuli.
3. Orgasm is not necessarily a requirement for sexual satisfaction. It may be a requirement for *your* sexual satisfaction (and you should advocate for your orgasm if

it is!), or it may not. You should not feel obligated to have an orgasm, and you certainly should not feel guilty if you do not have one.

4. If you are in a long-term relationship or you have a sexual dysfunction, you are more likely to agree with Basson's model of sexual response than the traditional linear model.

The other relevant model of sexual response is the Sexual Tipping Point or Dual Control model (see diagram below). This model is neither linear nor circular—it's actually a balance scale! Our sexual response is controlled by a balance between excitatory and inhibitory influences unique to each of us. These influences can be biological, psychological, social, cultural, and behavioural. Some of these factors enhance (excite) sexual response, and some of these factors inhibit it. The sum of these factors determines the strength of your sexual response. Low excitation (e.g., insufficient stimulation) or high inhibition (e.g., limited privacy) are relevant to female sexual dysfunction (FSD). Some people have used a driving analogy to explain it: high inhibition is like sticky or sensitive brakes (it doesn't take much to turn them off) while low excitation is like having an insensitive gas pedal (it takes a lot to get them turned on).



Adaptation of the Dual Control model. From page 27 of "Central nervous system anatomy and neurochemistry" by Pfaus and Jones in *Textbook of female sexual function and dysfunction: Diagnosis and treatment* (2018), edited by Kim, Goldstein, Clayton, Kingsberg, and Goldstein.

For example, several strong inhibitors and only one weak excitor will produce overall inhibition of sexual response. (Note that, in this model, "inhibition" does not mean "shyness" or "frigidity"—it means "restricted.") The chart below shows some examples of inhibitors and excitors. Keep in mind that these are possible factors, not definitive factors—you may experience some of these factors without noticing any impact on your sexual function.

Inhibitors	Excitors
Physical problems (e.g., low free testosterone) Negative psychological, social, or cultural factors (e.g., belief that women's sexual role is for men's fulfillment) Stress (e.g., giant to-do list) Being touched in ways that you do not like to be touched Relationship problems (e.g., resentment, lack of trust) Performance anxiety (e.g., worries about lubrication, orgasm) Worrying about consequences (e.g., pregnancy, STIs) Body image issues Mental health issues (e.g., depression, anxiety) Medications with sexual side effects (e.g., antidepressants) Orgasm (i.e., desire, arousal, and orgasm ability generally dissipate after orgasm)	Physical health Being in love with your partner New relationship energy ("NRE") Seeing something sexy (e.g., a romantic movie, pornography). Thinking about sexy things (e.g., fantasizing, reading erotica) Genital stimulation Being touched in the way you prefer to be touched Doing new sexy things (e.g., outdoor sex, role playing) Seeing your partner in an attractive way (e.g., in clothes you really like, doing something they are good at) Medications (e.g., FSD medications) Feeling confident in your body Watching your partner be a good parent Massage

How is consent part of healthy sexual function?

Next, we move on to the stages of sexual response. In Basson's circular model, willingness is the first stage, and it means either seeking out or being receptive to sexual stimuli. You may be initially interested in sexual activity for reasons other than desire, such as expressing love, sharing in physical pleasure, increasing your well-being, or pleasing your partner. This willingness is related to sexual consent, which is the freely given agreement to sexual activity. Willingness is openness to sexual activity, while consent is agreement activity, and they are foundational to healthy sexuality. Whether or not you initially have sexual desire, sexual activity should not begin unless you (and your partner) are willing and consenting. If you're confused, don't worry—you'll understand the importance of willingness more when we look at desire (specifically, *responsive* sexual desire). You can learn more about consent from Dr. Lindsey Doe, Planned Parenthood, RAINN, or Sex and U.

Note: While some women have experienced arousal and orgasm during rape and sexual assault, this is because the body was designed to respond this way to sexual stimulation and not because they secretly desired rape. Consent is crucial to sexual health and healthy sexual functioning, even in consensual non-consent ("rape roleplay").

What does healthy sexual desire look like?

Sexual desire can be described in many ways, leading to difficulty distinguishing between normal and abnormal sexual desire. Many people (and the *DSM-5*!) think of desire and arousal as the same thing, but they are distinct processes that do not always occur together. Sexual desire is simply an "anticipatory motivational state" and may be a desire for the rewards of sexual activity (e.g., physical pleasure, emotional intimacy, partner satisfaction). However, if these rewards decrease, then sexual desire may also decrease. Many women have concerns about low sexual desire, but these concerns are actually quite common the longer women's sexual relationships last. What you need to know is the difference between *spontaneous desire* and *responsive desire.*

Spontaneous desire is pretty self-explanatory—it occurs spontaneously. Most people think of desire this way, expecting desire to precede arousal. In the beginning stages of sexual relationships (and in teens and young adults), spontaneous desire is common.

Have you ever consented to sex that you weren't interested in at the time, but you got interested after the sex got going? Maybe you ended up having really good sex at the end. This is called responsive sexual desire. Responsive desire occurs after a woman has started seeking out (or is receptive to) sexual stimuli (e.g., sexual images or touch) or after a woman's body is sexually aroused. This type of desire is more common in long-term relationships. If this is the only type of desire you experience, nothing is wrong with you. However, Lori Brotto's book might be of help if you wish to cultivate more desire.

What does healthy sexual arousal look like?

Healthy arousal occurs after paying attention to erotic cues (e.g., sexual images, your partner's naked body) or sexual stimulation. There are actually two types of arousal: subjective and genital. Subjective sexual arousal refers to mental engagement and focus on sexual stimuli while genital arousal refers to the body's physical changes in response to sexual stimulation. These two types of arousal do not necessarily occur at the same time. Genital arousal in females involves genital swelling, vaginal lubrication, and clitoral engorgement (like a little erection), though females are not necessarily always subjectively aware of their body's physiological arousal. You may not notice your genital arousal because most of the engorgement happens to structures inside your body (covered in internal genital anatomy).

Arousal should dissipate if you stop paying attention to erotic cues, if you stop sexual stimulation, or if you orgasm. (If arousal does not go away, you may want to check out the information on PGAD/GPD in When should I seek help? and self-help resources.)

What does healthy orgasm look like?

Orgasm is the sensation of intense pleasure after adequate sexual stimulation. Different people require and prefer different kinds of stimulation for orgasm to occur. Most females require direct or indirect clitoral stimulation. Some experience multiple orgasms while others can't, don't want to, or haven't been properly stimulated to experience them. Some are sexually satisfied without orgasm, though most women prefer to have an orgasm.

With enough of the right stimulation (usually direct or indirect clitoral stimulation), you should be able to reach orgasm. Masturbation is the easiest way to orgasm, though you may still need to practice. Cunnilingus (oral sex on a vulva) is the easiest way to orgasm with a partner.

If you cannot orgasm from vaginal intercourse alone, but you can orgasm with masturbation, nothing is wrong. The clitoris is not usually stimulated very well with just vaginal intercourse. You just need to find a way to translate your masturbation knowledge to vaginal intercourse—either by pursuing partnered orgasm in different ways (e.g., mutual masturbation, cunnilingus) or by adding clitoral stimulation to intercourse.

If you feel like you're taking too long to orgasm, consider these ideas:

- Men are praised for how long they last before orgasm.
- Most women do not orgasm from intercourse alone.
- Women that can orgasm from intercourse alone have better or faster orgasms if clitoral stimulation is added.
- Orgasm problems are often caused by social and cultural factors, not by biological or psychological factors.

Is sexual pain ever normal?

Partnered sex (e.g., intercourse, cunnilingus) and masturbation should not ever hurt. If it does hurt, one of two things is probably happening:

- Someone is doing something that they should not be doing (e.g., trying to penetrate a vagina that is either not ready or wet enough, thrusting too hard/deep), or
- Something is physically wrong and needs attention (e.g., your pelvic floor muscles are tight, infection/dermatitis, vulvodynia).

No matter how good your sex education was, it's unlikely that you will ever learn this: you need to pull back your clitoral hood and clean the glans under it (with water or with a gentle cleanser—not soap!). Every female develops some smegma on the vulva, and smegma can also develop under the clitoral hood. If this smegma is not washed away (with water only!), it can cause the clitoral hood and the clitoral glans to stick together, resulting in clitoral adhesions, which *can* (but do not always) cause pain. To check if you have clitoral adhesions,

try pulling back the foreskin of your clitoris. You should be able to pull it back to reveal the glans (the head), which is about the size of a pea (though it varies between women) and looks like a tiny penis head. Check out HealthLine for more information on clitoral adhesions.

Is sex supposed to feel good?

Sexual stimulation from yourself or from another person (by whom you wish to be touched) should produce pleasure. Some stimulation may not feel good, such as deep thrusting, fast rubbing, or high vibrations—or you may not be aroused enough to enjoy these yet. Avoid anything that doesn't feel good and experiment to find the stimulation that feels best. This may involve giving feedback to your partner about their techniques.

Sexual satisfaction is considered a sexual right by the World Health Organization. It's unclear whether orgasm is necessary for sexual satisfaction, but you can decide that for yourself—if you want an orgasm, you should get an orgasm, and if you do not want one or do not care if you have one, you can still be sexually satisfied.

What if I'm not sexually attracted to anyone?

Asexuality is a sexual orientation describing people who do not experience sexual attraction to other people. It is different from celibacy, which is the choice not to act on sexual impulses, and it is different from low sexual desire (though a person can be asexual and have low desire). About one percent of the population is asexual.

A number of groups of girls and women are incorrectly assumed to be asexual, including older women, women who have cancer, mammies, children, mothers, women with disabilities, people with mental illnesses, women during the Victorian era, and even lesbians. These women *can* be asexual, but should not be *assumed* to be asexual (or heterosexual—we just shouldn't assume).

Most asexual women are single and most asexual people have not had intercourse, though some asexual people engage in sexual activity for their partners' benefits. While fewer asexual women masturbate than sexual women, many asexual women do masturbate. If any of this describes you, don't worry—nothing is wrong with you. To learn more about asexuality, check out The Asexual Visibility & Education Network.

How do I know when it's time to seek help?

A sexual dysfunction is a distressing disturbance in a person's ability to respond sexually or experience sexual pleasure, though definitions of specific sexual dysfunctions vary depending on the organization doing the defining. The *Diagnostic and Statistical Manual of Mental Disorders* (*DSM*) and the *International Statistical Classification of Diseases and Related Health Problems* (*ICD*) are the two internationally accepted classification systems, but the *DSM*'s focus is psychiatric while the *ICD*'s focus is medical. The *DSM*'s psychiatric focus limits is relevance to female sexual dysfunction (FSD), and it has also been criticized for failing to adequately reflect the diversity of women's actual experiences of sexual dysfunction, and the most recent edition (the *DSM-5*) has been criticized further for combining different disorders together because some healthcare providers struggled to differentiate between them. Because many healthcare providers will only be familiar with the definitions from the *DSM*, I will mention these definitions briefly, but I will be using the most up-to-date and evidence-based FSD definitions from experts in female sexual medicine—the International Society for the Study of Women's Sexual Health (ISSWSH), the International Society for Sexual Medicine (ISSM), International Society for the Study of Vulvovaginal Disease (ISSVD), and the International Pelvic Pain Society (IPPS).

If you don't want to read everything below, you can just skip to the information under the headings that seem relevant to you.

I have a sexual desire problem

If you experience low or absent desire even after paying attention to sexual cues (e.g., sexual images or erotica) or experiencing adequate sexual stimulation (e.g., cunnilingus, masturbation), you may want to seek help. However, if you *do* experience responsive sexual desire but want to experience more *spontaneous* sexual desire, you can still seek help to enhance your sexuality—just know that there is nothing wrong with you!

Hyposexual desire disorder (HSDD) is defined as any of the following for a minimum of six months:

- Lack of motivation for sexual activity as manifested by:
    - Decreased or absent spontaneous desire (sexual thoughts or fantasies); or
    - Decreased or absent responsive desire to erotic cues and physical stimulation or inability to maintain desire or interest through sexual activity;
- Loss of desire to initiate or participate in sexual activity, including behavioural responses such as avoidance of situations that could lead to sexual activity, that is not secondary to sexual pain disorders;

- And is combined with clinically significant personal distress that includes frustration, grief, guilt, incompetence, loss, sadness, sorrow, or worry.

HSDD symptoms should be rated as *mild*, *moderate*, or *severe*, and can be classified as *acquired* (e.g., first occurring after an event, such as surgery) versus *lifelong* (i.e., the woman has always had the condition). HSDD symptoms should also be classified as *generalized* (i.e., occurring in all sexual situations) versus *situational* (e.g., only with a partner, a specific partner, or a certain activity).

You'll notice that this definition requires symptoms for a minimum of six months. This does not mean you cannot seek help before then, but it does mean that you may end up waiting six months before your healthcare provider is willing or able to diagnose you. (This is usually only important for getting healthcare plans to cover the treatment.) You'll also notice that significant distress is a requirement—if you have low desire and are not bothered by it, there is no problem. If your partner is bothered by your low desire, then that may require a different response—you may wish to seek treatment alone, you may go to couples therapy, or you may pursue another route.

Note: Your healthcare provider may only be familiar with the *DSM-5*, in which HSDD is combined with arousal disorders under "female sexual interest/arousal disorder." You can still use the HSDD definition above to explain your symptoms more specifically.

I have a sexual arousal problem

There are two types of female sexual arousal disorders (FSADs): female genital arousal disorder (FGAD) and female cognitive arousal disorder (FCAD). I have included persistent genital arousal disorder/genito-pelvic dysesthesia (PGAD/GPD) in this section, though it could also fit under pain disorders or orgasm disorders, depending on the individual's specific symptoms.

My genitals aren't responding

While you should feel free to supplement your own lubrication with synthetic lubricants, you can seek help if you are concerned about producing too little lubrication. You should consider seeking help if you notice that your genitals are not swelling and darkening with sexual stimulation.

Female genital arousal disorder (FGAD) is defined as the difficulty or inability to achieve or sustain sufficient genital response (e.g., lubrication, engorgement) and sensitivity of the genitalia while engaged in sexual activity. Like the desire disorders, diagnosis requires that the symptoms cause significant distress and last for at least six months. FGAD is usually *acquired* (women are not born with it) and *generalized* (occurring in all situations).

FGAD is diagnosed mainly by history and physical examination and should not be diagnosed in those whose lack of genital arousal is due to inadequate stimulation. It is tough to define what "inadequate" stimulation is, but note that vaginal intercourse without additional clitoral

stimulation is inadequate for most. Adequate stimulation usually includes direct or indirect clitoral stimulation, such as masturbation by touching the clitoris directly or indirectly, putting a vibrator on or near the clitoris, or receiving cunnilingus (oral sex on a vulva) with attention to the clitoris.

Note that your healthcare provider should rule out other conditions (e.g., vulvovaginal atrophy, vulvovaginal infection or inflammation, inflammatory disorders of the vulva or vagina, vestibulodynia, and clitorodynia) before making a diagnosis of FGAD.

Note: Your healthcare provider may only be familiar with the *DSM-5*, which combines the two female sexual arousal disorders (FGAD and FCAD) with desire disorders (HSDD) under "female sexual interest/arousal disorder." You can still use this FGAD definition to explain your symptoms more specifically.

My brain can't get/stay interested in sex

You may want to seek help if you find that you're having problems with mental arousal or staying present with sexual activity. This could mean that you can't get mentally aroused at all, or that you struggle to stay mentally aroused.

Female cognitive arousal disorder (FCAD) is the mental version of FGAD. It is defined as difficulty or inability to achieve or sustain adequate mental arousal or engagement with sexual activity. These symptoms must cause distress and last for at least six months. The symptoms should be rated as *mild*, *moderate*, or *severe*, and can be classified as *acquired* versus *lifelong* and *generalized* versus *situational*. While FGAD and FCAD are distinct sexual dysfunctions, women can also experience both.

As with the previous sexual dysfunctions, diagnosis requires that symptoms cause distress and last for at least six months.

Note: Your healthcare provider may only be familiar with the *DSM-5*, which combines the two female sexual arousal disorders (FGAD and FCAD) with desire disorders (HSDD) under "female sexual interest/arousal disorder." You can still use this FCAD definition to explain your symptoms more specifically.

I have abnormal genital sensations

You should seek help if you experience unwanted arousal or abnormal genital sensations, particularly if these sensations occur without any sexual interest.

Persistent genital arousal disorder/genito-pelvic dysesthesia (PGAD/GPD) is completely different from the other two sexual arousal disorders. PGAD/GPD is defined as unwanted or intrusive, distressing, and recurring or persistent sensations of genital arousal or abnormal genital sensations, without any sexual interest or thoughts, for a minimum of three months. It can be characterized as *lifelong* versus *acquired* and *generalized* versus *situational*. Sexual activity and/or orgasm help symptoms only a little or not at all, or may even increase symptoms. Orgasm quality, frequency, intensity, timing, and pleasure may all be impaired.

Those with PGAD/GPD may experience mental distress, such as despair or suicidality. Certain circumstances (e.g., sitting, stress, nervousness) may increase genital sensations. However, genital sensations do not necessarily correspond to physical signs of genital arousal (e.g., lubrication, swelling).

Note: Your healthcare provider may only be familiar with the *DSM-5*, which does not include PGAD/GPD or anything like it, but some healthcare providers will have heard of it. Healthcare providers may be able to diagnose these symptoms under *DSM-5* Code 302.79: "Other specified sexual dysfunction."

I have an orgasm problem

There are two female orgasm disorders: female orgasm disorder (FOD) and female orgasmic illness syndrome (FOIS).

My orgasm is too weak/delayed/difficult

If you struggle to orgasm from masturbation and you've spent considerable time practicing, then you may want to seek help. If you struggle to orgasm with a partner but not by yourself, you may want to seek help from a sex therapist or a self-help resource. You may also want to seek help if you experience little to no pleasure with/from orgasm.

Female orgasm disorder (FOD) describes several problems with female orgasm. Orgasm may occur less frequently, not at all (anorgasmia), less intensely, later or earlier than you desire, or with absent or decreased pleasure (*pleasure dissociative orgasm disorder [PDOD]).* Female orgasm disorder is classified as either *lifelong* versus *acquired* and *generalized* versus *situational.* A woman who can achieve orgasm with clitoral stimulation but not through vaginal penetration alone should not be diagnosed with female orgasm disorder.

Note: Your healthcare provider may only be familiar with the *DSM-5*, which includes only one orgasm disorder (female orgasm disorder) and does not account for other orgasm problems such as decreased or absent pleasure (PDOD), unwanted orgasms (PGAD/GPD), or unpleasant symptoms around orgasm (FOIS).

I feel physically terrible before/during/after orgasm

If you experience unpleasant symptoms (e.g., pain, headache) during or after orgasm, you should seek help from a pelvic floor physiotherapist and/or a sexual medicine specialist.

Female orgasmic illness syndrome (FOIS) is defined as negative symptoms that occur before, during, or after orgasm. These symptoms are not necessarily related to altered quality of orgasm. These negative symptoms could include disorientation, seizures (orgasmic epilepsy), chills, genital pain, or other symptoms. Symptoms may vary between people, and these symptoms may last for minutes, hours, or days after orgasm.

Note: Your healthcare provider may only be familiar with the *DSM-5*, which does not include FOIS or anything like it, and you may have trouble finding healthcare providers who have heard of it unless you seek out a sexual medicine specialist.

I experience pain with sexual activity

Female sexual pain disorders can be divided into vulvar pain caused by a specific disorder, vulvodynia, painful orgasm, and female genital-pelvic pain dysfunction. If you have pain, it may be a bit confusing to figure out which definition fits you best.

I have pain on the outside of my genitals

You should seek some sort of help if you experience pain on the external genitals—with or without any stimulation. If you cannot pull back the hood of your clitoris to reveal your glans but you do not have any pain, you do not necessarily need to seek help, but I personally would recommend it.

Vulvar pain caused by a specific disorder is a bit of a mouthful to say, but it describes one of the sexual pain classifications well. Disorders that can cause vulvar pain include infections (e.g., herpes), inflammation (e.g., lichen sclerosis), neurologic factors (e.g., nerve compression), trauma (e.g., female genital cutting), treatments for other conditions (e.g., chemotherapy), and hormonal deficiencies (e.g., menopause). (It's also possible to have these conditions and experience no vulvar pain.)

Vulvodynia is defined as vulvar pain that lasts more than three months and has no apparent cause.

For both conditions (vulvar pain with a specific cause or with no apparent cause), you should note the following:

- Location of the pain: localized to one area (e.g., the clitoris, the vestibule) or generalized to the whole vulva, or both,
- Whether the pain only happens the vulva is touched or if it happens spontaneously,
- Whether you've had the pain your whole life, if it began at some point, and
- Whether the symptoms are intermittent, persistent, constant, immediate (e.g., upon touching), or delayed (e.g., after touching).

Note: Your healthcare provider may only be familiar with the *DSM-5*, which only includes the broad definition of "genito-pelvic pain/penetration disorder" (GPPPD), which does not have room for vulvodynia in its definition. You can still use this these two definitions of vulvar pain to explain your symptoms more specifically.

I have pain during/after orgasm

If you have genital pain during or shortly after orgasm, you should seek help.

Painful orgasm is simply defined as genital and/or pelvic pain during or shortly after orgasm. Diagnosis of painful orgasm should note whether the symptoms are *lifelong* or *acquired*, have occurred for at least three months, cause distress, and occur in 75% to 100% of sexual experiences.

You may look at that definition and say, "I need to have painful orgasms 75% to 100% of the time in order to get a diagnosis? That seems ridiculous." I agree. If you are having painful orgasms more than occasionally, I would seek help.

Note: Your healthcare provider may only be familiar with the *DSM-5*, which does not include painful orgasm, and the sexual pain disorder in the *DSM-5* (genito-pelvic penetration/pain disorder) does not have room for painful orgasm in its definition.

Genital touching and penetration scare me or cause me pain

If you are experiencing difficulties (e.g., fear, anxiety, pain) before, during, or after genital touching (internal or external), you should seek help. You should also seek help if you have noticed that your pelvic floor muscles seem very tight or crampy, if you experience pain when inserting a tampon or your own finger into your vagina, or if you experience pain when touching your vagina or anywhere on your vulva

There are some self-help options that you may want to try first, such as using a personal lubricant (and trying out different lubricants in case one is irritating) and receiving gentle and shallow vaginal penetration after you are very aroused. However, if you have tried those options and you are still experiencing pain, you should seek help.

Female genital-pelvic pain dysfunction (FGPPD) is defined as persistent or recurrent difficulties with at least one of the following:

- vaginal penetration during intercourse;
- marked vulvovaginal or pelvic pain during genital contact;
- marked fear or anxiety about vulvovaginal or pelvic pain in anticipation of, during, or as a result of, genital contact;
- marked hypertonicity (tightness) or overactivity (spasms) of pelvic floor muscles with or without genital contact.

Diagnosis of painful orgasm or FGPPD should note whether the dysfunction is *lifelong* or *acquired*, has been in place for at least three months, leads to individual distress, and occurs in 75% to 100% of sexual experiences.

You'll notice that this definition is quite broad and encompasses a lot of possibilities. You could have difficulty with penetration, pain with genital contact, anxiety about pain before/during/after genital contact, or pelvic floor muscle tightness or spasms. This definition covers a lot of different conditions. While there is some overlap between FGPPD and vulvar pain with/without cause, only the definition of FGPPD includes fear of pain.

Note: Your healthcare provider may only be familiar with the *DSM-5*, which includes one female sexual pain disorder: genito-pelvic pain/penetration disorder (GPPPD). It is quite similar to FGPPD.

I'm not experiencing enough pleasure

Your partner's sexual knowledge and sexual skills are an important factor in your experience of pleasure, as are the sexual activities you participate in. For example, if you are not experiencing pleasure but you're only engaging in vaginal intercourse, you probably don't need to seek help—you need to try out some other ideas, such as cunnilingus, touching yourself during intercourse, masturbating, or using a vibrator (alone or with a partner). You should give your partner feedback about what you like and what you don't like. If you can experience pleasure by yourself but struggle to experience it with another person even though your clitoris is definitely getting stimulated, you may wish to seek help from an AASECT-certified sex therapist or another therapist with competency in sex therapy.

I already mentioned pleasure dissociative orgasm disorder (PDOD) under orgasm disorders, though it could also fit here under pleasure disorders. People with PDOD experience pleasure leading up to orgasm but not during orgasm. However, there is another sexual dysfunction that refers to decreased or absent sexual pleasure during the whole sexual response cycle.

My genitals feel numb

If you do not experience pleasure through any sexual activity (partnered or solo), you should seek help, especially if you've already tried using erotica, pornography, and/or a vibrator (especially any vibrator that provides clitoral suction).

As research on *post-SSRI sexual dysfunction (PSSD)* is new, we only have a working definition: distressing issues with sexual function/pleasure that emerge with SSRI initiation/termination and persist after termination (not due to depression or other contributors). There are many possible symptoms of PSSD, including low desire, decreased vaginal lubrication, decreased orgasm frequency and intensity, loss of pleasure with orgasm, and genital/nipple numbness. Other drugs may also cause lasting sexual dysfunctions, including SNRIs, finasteride ("Propecia"), and isotretinoin ("Accutane"). Starting or stopping these drugs may lead to symptoms similar to those of PSSD. These conditions are known as *post-finasteride syndrome (PFS)*, *post-retinoid sexual dysfunction (PRSD)*, and *post-Accutane syndrome (PAS)*.

Note that other causes must be ruled out in order to be diagnosed with PSSD. This is because other conditions, such as depression, can cause some sexual dysfunctions, such as low desire or orgasm difficulties. However, if you did not have any sexual dysfunction until you started or stopped a drug, and the sexual dysfunction continued after stopping the drug, then it strongly suggests that the drug is the cause of your sexual dysfunction. Further, some symptoms (e.g., lack of sexual pleasure) are not a symptom of depression (or acne or hair loss) and therefore can't be blamed on depression (or acne or hair loss).

Note: Your healthcare provider may only be familiar with the definitions from the *DSM-5*, which include substance/medication-induced sexual dysfunction. However, some people have had a hard time getting their healthcare providers to believe that their persisting sexual dysfunctions are caused by medication, even though this definition exists.

Where do I go for help?

There are so many options for seeking help, and they all have benefits and risks. For example, if you have some sex positive friends or family, these may be a good starting point for discussing sexual concerns, as you will be more comfortable with them and they may be able to provide you with accurate information, helpful resources, or even recommendations about sex positive healthcare providers. While your local sexual health clinic is unlikely to be able to provide you with direct help, they may also be able to recommend some resources or healthcare providers to you. (Look for the links that say "Sexual Health Services" or "Sexual and Reproductive Health" on this page.)

Family doctors, general practitioners, and primary care physicians may be personally able to help you with your sexual function complaints. They can provide you with referrals to the right places but only if these places exist and your doctor knows about them. It may also be important to go to your doctor first because you may need a referral to see certain specialists. For example, you may need a referral from your family doctor in order to go to a specific pelvic floor clinic (e.g., Calgary Pelvic Floor Clinic), to get your health insurance or Alberta Health Care to cover a test or treatment (e.g., MRI, pelvic floor physiotherapy), or even to go to an out-of-province provider (e.g., BC Centre for Sexual Medicine).

Alberta Health's website has a page with general information about sexual problems in women. It recommends that a woman seek out a family doctor, gynecologist, sex therapist, psychologist, or urologist if she has a sexual function problem. It is difficult for me to tell you where to go for help without knowing all of your symptoms (and without being a doctor), but I can give you an idea of how to choose a professional and where to seek help for some issues.

How do I choose a professional?

Dr. Lindsey Doe of the YouTube channel Sexplanations has a great video on How to Choose a Professional. Here's my take on Dr. Doe's recommendations on how to choose a professional:

1. Identify the kind of professional help you need.

Is it a physical problem or a mental problem? Or do you need help figuring out which? Below is a list of possible professions from whom you could seek help. You can click the links below to find out more about what these professionals do.

- Sex coach
- Relationship therapist
- Psychiatrist
- Counsellor
- Psychologist
- Psychotherapist
- Sex therapist
- Sex surrogate

- Consultant
- Physical therapist
- Pelvic floor physiotherapist
- Doctor
- Sexologist
- Clinical sexologist
- Prevention specialist
- Medical provider
- Gynecologist
- Physician's assistant
- Nurse practitioner
- Obstetrician
- Sex educator
- Health teacher
- Human sexuality professor
- Adjunct professor
- Family physician
- Pharmacist
- Neurologist
- Endocrinologist
- Religious advisor
- Urologist

This list isn't exhaustive, but it should help you consider the possibilities. If you're not sure, a family doctor is a good place to start. They should be able to direct you to a professional who can help you. Otherwise, the list below will give you a general idea of where to seek help.

Desire and arousal disorders

- Counselling and therapy
    - Seek out someone who does sex therapy, cognitive-behavioural therapy, or mindfulness-based approaches.
- Sexual medicine specialists

For orgasm disorders

- Counselling and therapy
    - Seek out someone who does sex therapy, cognitive-behavioural therapy, or systemic desensitization.
- Sexual health education
    - Seek out people who teach sexual health education (check out the self-help resources).
- Yourself
    - There are things you can try on your own. (Check out the self-help resources… but masturbation and vibrators are the main ideas.)
- Sexual medicine specialist
    - Especially if your problem is about pleasureless or painful orgasms.

For pain and penetration problems

- Counselling and therapy
    - Seek out someone who uses mindfulness-based approaches, cognitive-behavioural therapy, or biofeedback.
- Sexual medicine specialists
- Pelvic floor physiotherapists

2. Make a list of specific professionals you could see in that field.

At least three! Don't just make an appointment with the only person you know. Check out Alberta Referral Directory to see what referrals are available. You can search by keywords (e.g., female genital pain, orgasm disorder, painful orgasm) or profession. Be sure to use "keyword match" if you include words that could apply to other conditions (e.g., "orgasm disorder" will include results for "disorder" if you don't use keyword match).

Below are some recommendations for some of the professions listed above or how to find more professionals.

Pelvic floor physiotherapy

Be aware that not all pelvic floor physiotherapists are trained in sexual dysfunction, so you should investigate the qualifications and training of the physiotherapist before you make an appointment—some of them may only be trained in dealing with other issues, such as urinary incontinence and prolapse. Below are some of the locations that may offer pelvic floor physiotherapy in Alberta that you could see for female sexual dysfunction (FSD). As this guide is considered to be a fluid document, I have only included specific recommendations on the website, which will be updated as new healthcare providers become available.

- Calgary
    - Foothills Medical Centre - Pelvic Floor Clinic. They do not provide pelvic floor physiotherapy here, but they do deal with the pelvic floor. You'll probably need a referral from your family doctor to see her, but it should be covered by Alberta Health Care.
- Edmonton
    - Cura Physical Therapy
- Lethbridge
    - East Meets West (becoming SIX08 Health)
    - LifeMark
    - Peak Physical Therapy

- Okotoks
    - Momentum Physical Therapy & Sports Rehab.

Sex therapy and mental health

The title "sex therapist" is not regulated anywhere in North America except for Florida. As a result, anyone can call themselves a "sex therapist." However, the American Association of Sexuality Educators, Counselors, and Therapists (AASECT) provides certification for sex therapists, sexuality counselors, and sex educators. If possible, I recommend finding someone who is affiliated with AASECT and has the title "Certified Sex Therapist" (CST). As this guide is considered to be a fluid document, I have only included specific recommendations on the website, which will be updated as new healthcare providers become available.

You can also check out which psychologists in your area list "sex therapy" as an issue they treat on Psychology Today. This does not mean they are a certified sex therapist, but they do have some sex therapy experience and sexual health training. If you are pursuing sex therapy, please check out Dr. Joe Kort's article on How to Pick the Right Sex Therapist to help with this decision—his recommendations are specific to choosing a sex therapist.

One final note on sex therapists: Some people mistakenly believe that clients will be asked to have sex in front of a sex therapist or even have sex *with* a sex therapist. This will never be asked of you, as it goes against all mental health codes of ethics and it would cause a therapist to lose their license to practice. There are other professionals called sex *surrogates* who may either help a couple have sex (e.g., if one partner has mobility issues) or who may have sex with a person for a specific reason (e.g., the client wants to explore their sexuality with an experienced partner), but these are completely different from sex therapists. A sex therapist might suggest that you see a sex surrogate (and you can choose whether or not to do so), but sex therapists will only ever *talk* to you. In sex therapy, everyone keeps their clothes on, and the only touching that might occur is a handshake, a hug, or a pat on the arm.

Gynecologists

- Foothills Medical Centre - Pelvic Floor Clinic. You'll probably need a referral from your family doctor to see her, but it should be covered by Alberta Health Care.

As gynecologists often help people with vaginal infections, pelvic exams, pelvic pain, and fertility issues, they are not necessarily able to help with problems with desire, arousal, orgasm, and pleasure. However, if you wish to see a gynecologist, check out the Alberta Referral Directory.

Urologists

- Foothills Medical Centre - Pelvic Floor Clinic. You'll probably need a referral from your family doctor to see her, but it should be covered by Alberta Health Care.

I am reluctant to recommend urologists because of urologists' heavier focus on male bodies and because there are few female urologists in Alberta. You can find urology services through the Alberta Referral Directory. You can also find urologists by checking out the surgeons at the Alberta Urology Institute and the physicians at the Southern Alberta Institute of Urology.

Sexual medicine specialists

- Foothills Sexual Function Clinic in Okotoks helps people with many sexual function problems, including menopause, low desire, genital pain, arousal problems, orgasm problems, and more. To go here, you will need a referral from your family doctor, but they do accept self-referrals when referrals aren't possible.
- Jablonski Health at Peak Specialty and Pinnacle Medical Centre in Calgary helps people with sexual function problems such as orgasm problems, desire problems, arousal problems, sexual pain, and more.

There are limited sexual medicine services in Alberta, so it's possible you won't be able to find the help you need in Alberta, but that does not mean hope is lost. If you feel you're not getting the help you need in Alberta, here are some options within Canada and the United States.

- BC Centre for Sexual Medicine may accept patients from outside British Columbia. You will need to be referred by your doctor using the referral form on the website.
- BC Centre for Vulvar Pain only accepts referrals from BC physicians for residents of BC but you may want to keep this place in mind, should you ever move to BC!
- San Diego Sexual Medicine allows you to schedule a 10-minute courtesy call to discuss your symptoms and possible treatments with Dr. Irwin Goldstein, one of the world's experts in FSD.
- IntimMedicine is a medical care team that helps women, men, and couples with sexual health and sexual function problems. They are located in Washington, DC.
- You can also check out the Find a Provider webpage for the International Society for the Study of Women's Sexual Health (ISSWSH). Unfortunately, most of the providers listed live in the United States, but that may change in the future.

3. Read reviews

Be sure to read the reviews on professionals' business webpages *and* the webpages they don't control (like RateMDs.com). Read the best and worst reviews and see how they responded to the worst reviews.

4. Interview the professionals

If at all possible, interview anyone you're considering seeing, and take notes. Mental health providers often provide consultations at no charge, as do some other professionals (e.g., pelvic floor physiotherapists). Here's Dr. Doe's step-by-step recommendations:

i. Don't give your last name yet and make sure they respect that. You could say, "Hi, my name is _____. I'm calling to ask some questions about your services."

ii. Ask them if they are taking new patients or clients. If they are quite booked, ask if they will call you when they have a cancellation.

iii. Do the Vagina Test before you make an appointment: Ask some questions related to your concerns using words like vulva, clitoris, vagina, anus, or sex. This gives you an idea of how they respond to discussions about these topics, and whether they are sex positive. Being sex positive simply means that a person is nonjudgmental about people's sexuality. Ideally, every person you seek help from will be sex positive.

iv. Choose someone who will tell you when your thinking is flawed (e.g., "It's unfair to expect yourself to orgasm from vaginal intercourse alone") and whom you feel comfortable correcting (e.g., "Please touch me very gently" or "I use she/her pronouns").

v. Does the professional think they can help you, even if they haven't treated someone with your problem before?

vi. Are they aware of other local services they could refer you to or collaborate with? Are they willing to collaborate or make referrals? Will they make referrals if they can't help you or if someone else could help you better?

vii. Find out about cost. Do they take insurance? Do they have payment plans? Do they have a sliding scale? Many mental health professionals have sliding scales, which means that you pay less if you have a lower income.

Where should I be careful seeking help?

Be careful seeking help for sexual concerns from anyone whose specialty is not sexual concerns. For example, you may have a church counsellor who is eager to help you, but these counsellors (like most counsellors) are frequently uneducated about sex therapy or even rely on misinformation.

While Alberta Health has a fair number of sexual and reproductive health services, but few, if any, of these services are likely to deal with FSD and none are exclusively for FSD (most of them are for pregnancy and STI prevention and response). For example, Lethbridge has an excellent sexual health clinic, but none of its services relate to FSD. As I mentioned earlier, you can ask them for information or referrals, but they are likely unable to help you directly with sexual function complaints.

Pelvic floor physiotherapists are specially trained to work with the pelvic floor muscles. It is unclear whether all pelvic floor physiotherapists are trained in treating sexual dysfunctions, so I would check out their website and search for words like "vulva," "vagina," "sex," "pain," "intercourse," or other words that describe your symptoms.

A meme depicting one barrier women face when seeking help for sexual dysfunctions from gynecologists. Created by Twitter User @TightLippedPod. Permission granted by creator.

Gynecologists deal with female sexual organs, but more so for reproduction than for issues with desire, arousal, orgasm, pain, and pleasure. The memes above and below explain the problem: female sexual dysfunctions are often outside the scope of gynecologists. You can try seeking help from a gynecologist, but do not get discouraged if they are unable to help you. Ask where they might refer you for help.

Which healthcare provider cares for the clitoris? Apparently, none of them. This image is my recreation of a slide from a research podium presentation by Dr. Rachel Rubin at the 2017 ISSWSH Meeting, recreated based on a photograph from this tweet, using a screen capture of this video by The Try Guys.

The above meme also addresses the problem with seeking help from many urologists. While urologists may deal with women and FSD, they are more likely to deal with male sexual dysfunction than FSD (e.g., Calgary's Southern Alberta Institute of Urology or Edmonton's Alberta Urology Institute). If you're interested in seeing a urologist, or if your doctor wants to refer you to a urologist, check out their website first and search for terms like "women," "vulva," and "vagina" (as opposed to "men," "penis," and "prostate") to see if they treat women.

While your sex positive friends and family are good starting points, be careful about taking any direct advice from them about how to treat yourself. Basically, don't take treatment advice from anyone who is not a medical professional or mental healthcare professional and be careful taking advice from anyone whose specialty is not sexual medicine.

What if I want help from within my culture?

Glad you asked! While it can be more challenging to find FSD help that is within your culture or religion, I have tried to find some appropriate practitioners and self-help resources for some of the larger cultural groups within Alberta.

Christian

Because Christianity is one of the dominant religions in Alberta, most healthcare providers are familiar with its general beliefs. However, I am happy to share resources that will help you find specific Christian healthcare providers.

- ChristianDoctors.net allows you to submit a request to see a pre-screened Christian doctor in Alberta who matches your search criteria.
- For mental healthcare, you can probably just Google "Alberta Christian mental health" or "[your city] Christian mental health." Some options that come up are:
    - Faithful Counseling (serving worldwide)
    - Search Theravive by city and then click "Christian counselling" on the left.
    - Browse Christian psychologists on Psychology Today.
- *Sex, God, and the Conservative Church: Erasing Shame from Sexual Intimacy* by Tina Schermer Sellers - Amazon
- *Good Christian Sex: Why Chastity Isn't the Only Option-And Other Things the Bible Says About Sex* by pastor Bromleigh McCleneghan - Publisher | Amazon
    - She is a liberal Christian minister who advocates that sex before marriage is okay and is to be enjoyed guilt-free.
- *The Great Sex Rescue: The Lies You've Been Taught and How to Recover What God Intended* by Sheila Wray Gregoire - Publisher | Amazon
- *Advancing Sexual Health for the Christian Client: Data and Dogma* by Beverly Dale and Rachel Keller - Amazon
    - For any healthcare providers reading this web-based guide: this is for you! It is written by an ordained Christian clergy member and a certified sexologist.

Post-Christian

- Purity Culture Dropout - "an eight-week intensive sexuality education and coaching program for folks who were raised in purity culture"

First Nations, Métis, and Inuit

- As this guide is considered to be a fluid document, I have only included specific recommendations on the website, which will be updated as new healthcare providers become available.
- Alberta Indigenous Virtual Care Clinic allows any First Nations, Métis, or Inuit person in Alberta to see a doctor through their phone or computer, and they

specifically list "sexual health" as a reason you can make an appointment. All their family physicians have some competency in FSD and are able to and required to make appropriate referrals when the patient's concern is outside of their scope. You can also specifically request to be seen by either a First Nations or Métis doctor when you call.

- Indigenous Physicians Association of Canada is a group of Indigenous doctors, residents, and medical students whose goal is to support Indigenous pursuit of medical training. They recommended the doctors below when I asked if they could provide me with the names of Indigenous physicians who have some competency in FSD. (Check out the website to see specific recommendations.)
- You can check out "First Nations Therapists in Alberta" on Psychology Today.
- Alberta Health Services has a webpage dedicated to Indigenous Health with services and resources. There is a brief webpage dedicated to Indigenous mental health, and you can also check out the Indigenous health services by zone.
- Aboriginal Psychological Services & Indigenous Psychological Services is a group of culturally-informed psychologists, counsellors, and knowledge keepers.

Jewish

- You can check out "Jewish Therapists in Alberta" or "Hebrew Therapists in Alberta" on Psychology Today.
- JewishPhysicians.com allows you to submit a request to see a pre-screened Jewish doctor in Alberta who matches your search criteria.
- *Kosher Sex: A Recipe for Passion and Intimacy* by Shmuley Boteach - Amazon

Latter-day Saint (LDS)

Alberta has the highest percentage of LDS people in Canada, and Southern Alberta has the highest percentage of LDS people in Alberta. There are many talented healthcare providers who are familiar with the LDS faith in Utah, but those practitioners are only able to see people who live in Utah. Here are some options that are accessible to you in Alberta:

- As this guide is considered to be a fluid document, I have only included specific recommendations on the website, which will be updated as new healthcare providers become available.
- Facebook group: Improving Intimacy in Latter-day Saint Relationships, run by Daniel Burgess, an LDS sex therapist. It is a very open-minded, co-ed group, open to discussions of masturbation and pornography use.

- Happy, Healthy Sexuality: LDS Women's Discussion Group is a little more conservative and does not allow the promotion of pornography or erotica.
- The Mormon Mental Health Association is a professional association for mental health providers, educators, and researchers who offer ethical and culturally competent services and information to people in any stage of involvement (pre-baptism, active member, post-LDS) with the LDS church. While the providers are mostly from the United States, there are a few who serve Albertans/Canadians (though their sexual health expertise may be limited).
- You can check out "LDS Therapists in Alberta" on Psychology Today.

Muslim

- You can check out "Islam Therapists in Alberta" on Psychology Today
- MuslimDoctors.net allows you to submit a request to see a pre-screened Muslim doctor in Alberta who matches your search criteria.
- *The Muslimah Sex Manual: A Halal Guide to Mind Blowing Sex* by Umm Muladhat - Amazon

What can I expect when seeking help?

How might my healthcare provider respond?

Negative experiences when seeking help for female sexual dysfunction (FSD) are unfortunately common. Remember, however, that these negative experiences are often the result of the discomfort, lack of knowledge, and systemic barriers faced by both women and their healthcare providers, and that this web-based guide provides you many tools to combat these barriers. I will let you know a range of responses you could experience and how you can respond.

There are few studies investigating women's experiences seeking help for sexual dysfunction. In one study, many help-seeking women experienced frustration, anxiety, disgust, shame, and devaluation, while significantly fewer women experienced validation, hope, relief, assurance, optimism, confidence, and satisfaction. About half said that that their doctor was willing to hear their concerns, that their doctor listened carefully to them, and that their doctor was not reluctant to address and treat their issues, while few women felt that their doctor appreciated the importance of their concern, tried to reduce their nervousness, or asked if they had ever received mental health care. Some women have been told that these problems are to be expected with aging, parenting, and/or marriage. This study found that many doctors did not adequately assess women's psychological history or relationship quality, perform a thorough physical examination and appropriate medical tests, make a diagnosis, develop a treatment plan, or follow up with them.

In another study, many women had doctors who seemed disinterested, rushed, impersonal, and embarrassed; however, most women said that their doctor seemed concerned, cared about them, and treated them professionally. Other sources have confirmed that it is common for women to be told that their problems are all in their heads, that they just need to relax, that they should have a glass of wine, that desire/arousal/orgasms are not necessary for women, or that they do not need treatment because they do not have a sexual partner. Some healthcare providers have rejected the materials that women brought in to help them learn about their conditions.

Recent research on healthcare experiences of people with PGAD/GPD and PSSD has shone light on other experiences of help-seeking for FSD. People with PGAD/GPD, PVD (provoked vestibulodynia), or PSSD have approached several healthcare providers, sometimes six or more. Two thirds of PGAD/GPD patients received a formal diagnosis, it took over a year for 20% to receive their diagnosis, and one third of women with PVD waited three or more years for a diagnosis. Many women had healthcare providers who weren't knowledgeable or understanding about PGAD/GPD or PSSD, who responded uncomfortably (e.g., avoiding eye contact) or inappropriately (e.g., laughing), and who didn't acknowledge the distress and harm that these conditions can cause.

Given that women's negative experiences seeking help for PGAD/GPD seem to be associated with a lack of research on the condition, it is expected that women will have

similar or worse help-seeking experiences when seeking help for conditions for which there is a similar lack of research. Indeed, the Queens Sex Lab, which has done significant research on PGAD/GPD, hosts a blog which shared an anecdote about healthcare provider's dismissiveness when a woman sought help for PSSD.

It is unacceptable for healthcare providers to be dismissive of women's sexual health concerns. As some women who were seeking help for PGAD/GPD believed that asking for referrals or reading about the condition on their own was a useful help-seeking strategy, I recommend doing this. Ask for a referral (to one of the healthcare providers you've read about) or consider changing healthcare providers if you don't feel that your healthcare provider is invested in helping you.

If your provider lacks knowledge but appears to take your concerns seriously and appears interested in reading the material(s) you brought to inform them, consider staying with them for now (and accept their referrals if they seem reasonable). Because some conditions are less common (e.g., PGAD/GPD, PSSD, FOIS), healthcare providers may not be familiar with the condition, but they can learn.

Why aren't some healthcare providers good at helping?

You may be surprised to find that healthcare providers face barriers to help-providing that are similar to the barriers women face when seeking help.

They may avoid the topic

Healthcare professionals may not bring up the topic of sexual functioning with patients for several reasons, including that they may expect patients to be assertive and bring up complaints, they are embarrassed, or they do not want to be intrusive. Physicians are less likely to have these discussions about sexual health when patients differ from them in gender, age, marital status, education, race, or ethnicity. Biases such as ageism may also prevent healthcare providers from discussing sexuality and screening older women for sexual dysfunctions. Doctors may also simply be dismissive of women's concerns or believe that sexual function problems are not serious. A healthcare provider's communication skills can also be a barrier.

The main way to combat these barriers is to be proactive by bringing up your concerns instead of waiting for your healthcare provider to ask. You may be uncomfortable, but you can prepare yourself by reading the webpage on How do I seek help?.

They probably had inadequate training

Not only did your healthcare providers probably have the same poor sex ed that you did throughout primary and secondary school, they also usually had poor or absent sexual health education in their healthcare training programs. Both medical professionals and mental healthcare professionals face this barrier. It's also likely that many medical professionals are unaware of what treatment options are available for FSD. Further, healthcare providers may

not know where to refer you for your concerns or there may be limited referral options in your area.

Because of the lack of sexual health training, mental healthcare professionals rely on consultation and referral when faced with clients with sexual concerns. Sex positivity is also missing in counsellor training, inhibiting counsellors' willingness to bring up sexual topics, their willingness to treat sexual problems, and their clients' comfort with disclosing sexual concerns. These problems, caused by a lack of sex positivity training, are likely faced by medical professionals as well.

To combat these barriers, you can educate yourself on healthy sexual function, read to understand how your symptoms match sexual dysfunction definitions (When should I seek help?), and read (and ask your provider) about possible treatment options.

They face systemic barriers

Like patients, physicians and OB/GYNs often state that limited time with patients prevents discussions on sexual health. A shortage of sex therapists and psychologists can cause long waiting times, and medical providers may be unsure of therapy options. A lack of research on women's sexual dysfunctions and treatments means that healthcare providers cannot even recommend many evidence-based treatments. One consequence of this lack of research is the fact that, in the United States, significantly fewer drugs have been approved for premenopausal FSDs than for male sexual dysfunctions. Postmenopausal women face a different issue: misinformation claiming that hormone therapy is dangerous for menopausal women (i.e., causes cancer) has prevented many doctors from prescribing treatments that would benefit these women.

To combat these barriers, you can be proactive by educating yourself about healthy sexual function, maximize your time with your provider by preparing for the appointment (check out How do I seek help?, and read (and ask your provider) about possible treatment options.

What are possible referral options?

Your family doctor is likely not a sexual medicine specialist (and that's a good thing). Unless you specifically seek out someone with expertise in sexual health, you are unlikely to see someone with that expertise. Sometimes, the sexual health expert you seek out still needs to refer you to someone else. You may also need referrals for diagnostic tests. Hopefully, I can give you some idea of what to expect with referrals.

Your healthcare provider may refer you for diagnostic tests, such as MRI scans and CT scans. If you are referred for an MRI scan or CT scan through Alberta Health Care, expect to wait (and make sure to keep your appointment because you don't want to wait even longer). Wait times for MRI scans can be long (39 to 53 weeks), as can those for CT scans (14 to 34 weeks). You may be able to get these services earlier if you are willing to pay for an MRI or CT scan at a private facility (e.g., the University of Lethbridge has the most powerful MRI in the region for a fee). Referrals for other services (e.g., vaginal interventions, pelvic

interventions) can also take a long time (14 to 53 weeks), though it is not clear what these interventions are or how relevant they are to FSD diagnosis and treatment.

You may be referred for pelvic floor physiotherapy—either to rule out pelvic floor problems or to treat them. Pelvic floor physiotherapy is unlikely to be covered by Alberta Health Care, but it may be covered by your personal health insurance. It's a good idea to look up pelvic floor physiotherapists before your appointment so you can request the best one for you.

You could be referred to counselling (e.g., couples counselling, psychotherapy, sex therapy). Outside of Alberta Health Care, you are free to choose whichever provider you prefer, at your own cost (potentially covered by your personal health insurance). Some clinics (e.g., the Haig Clinic in Lethbridge) have free short-term counselling available, but you will not get to pick your counsellor's specialty. Alberta Health Care does offer some mental health services for free, and you can call them yourself or have your medical practitioner refer you.

You may also be expected to travel for your referral, especially if you live in a rural area. For example, Lethbridge has a pelvic floor clinic, but women can only be referred there for incontinence or pelvic organ prolapse, not for sexual pain, which is a common symptom of pelvic floor dysfunction. However, the pelvic floor clinic in Calgary may accept women with a more broad range of symptoms.

You may not qualify for services that are available. A friend of mine was refused referral to Lethbridge's aforementioned pelvic floor clinic for sexual pain because they only accept referrals for incontinence or pelvic organ prolapse. Another friend was refused a referral to a gynecologist for sexual pain because she was not pregnant. You may also struggle to find a urologist who can help you. Members of Calgary's Southern Alberta Institute of Urology or Edmonton's Alberta Urology Institute appear to primarily treat male sexual problems and all of their doctors appear to be men. However, if you think you may be referred to a urologist, I would recommend contacting an individual doctor (just click Our Surgeons or Our Physicians and then click any doctor's name) and asking if anyone has any training or expertise with FSDs or your specific symptoms. You can then ask your doctor for the best urology referral or ask for a different type of referral.

What are possible treatment options?

As FSDs are so varied and each one has many different possible causes, the treatment options that are relevant to you depend on your presenting concern, what is available to you in your area, what you can afford, and what you are willing to do. Your healthcare provider may recommend treatment of physical causes, education, couples counselling, psychotherapy, and/or sex therapy.

A variety of treatment options exist for FSD (though women may not necessarily receive the treatments that are available). The most common medical treatments for women's sexual function problems are prescription hormone injections, topical creams, or gels; changing birth control method or medication; and starting, changing, or ending hormone replacement therapy. Healthcare providers may recommend sildenafil/Viagra (despite a lack of evidence),

antidepressants (despite the fact that they can cause sexual dysfunctions), and herbal supplements infrequently. OB/GYNs commonly recommend education and practical tips, the use of dilators and/or dildos, and self-help resources such as literature, videos, and sex shops. OB/GYNs use other approaches less frequently, including physical therapy, hypnosis, exercise, homeopathic medicine, and permission-giving for self-exploration. Doctors can recommend the Eros Therapy Device to help increase blood flow to the female genitals, though this device may also be purchasable without a prescription. Women are infrequently referred to other professionals or treated by the OB/GYN from whom they initially sought help. Few women receive nondrug therapy such as marriage therapy, sex therapy, counselling, or behaviour therapy, and many women do not receive any treatment for their problems. Research has also demonstrated that some natural products and treatments may be effective in treating FSD (particularly in postmenopausal women), including L-arginine, ginseng, maca, DHEA and DHEAS, black cohosh (*cimicifuga racemosa*), chasteberry fruit (*vitex agnus-castus*), acupuncture, and yoga. See Table 2 below for a list of possible treatment options and important considerations for specific *DSM-5* FSD diagnoses.

You might be prescribed ineffective treatments (e.g., antibiotics or antifungal medications for pain). Sometimes this is because a healthcare provider wants to try safer, cheaper, or more common treatments first; sometimes it is because they do not know what else to do; and sometimes it is because they do not believe their patients. It may be difficult for you to tell the difference. I recommend that you trust your instincts, and lean toward trying their treatments. We are experts on ourselves, but medical providers have much more knowledge about bodies than we have. As long as the treatment they are recommending does not cause harm, it may be a useful diagnostic tool (i.e., some conditions can now be ruled out, as your symptoms did not respond to the treatment).

Treatment Options for Female Sexual Dysfunctions		
	Treatment Options	**Considerations**
Female sexual interest/ arousal disorder (FSIAD)	Psychological and behavioral interventions	There is evidence for modified Masters and Johnson treatment, behavioural sex therapy, cognitive-behavioural therapy, and mindfulness-based approaches.
	Flibanserin (Addyi) Testosterone, buspirone, bremelanotide	Flibanserin is only approved by the Food and Drug Administration (FDA) for the treatment of hypoactive sexual desire disorder in premenopausal women. The clinical effects are somewhat limited, there are notable side effects and medication interactions, and women taking the medication cannot use alcohol.
Female orgasmic disorder (FOD)	Psychological and behavioral interventions	There is evidence for directed masturbation and sensate focus. Anxiety reduction techniques (systematic desensitization, cognitive-behavioural therapy) if anxiety is co-occurring.
	Sexual aids, such as vibrators	These may be refused by some women (e.g., women who belong to conservative religions or cultures); their partners may be threatened by these devices
Genito-pelvic pain/ penetration disorder (GPPPD)	Psychological and behavioral interventions	There is evidence for mindfulness-based approaches and cognitive-behavioural therapy/biofeedback.
	Treatment of genitourinary syndrome of menopause, if present (i.e., vaginal estrogen, ospemifene)	
	Pelvic floor physical therapy	It must be conducted by a specially trained physical therapist.
	Topical lidocaine	It often causes burning when first applied.
	Tricyclic antidepressants	These can interact with other medications and cause sleepiness, dry mouth, or urinary retention (the latter more common in older patients).
	Vestibulectomy (surgical removal of the vestibule)	There are high reported success rates, but it is usually not performed until less invasive treatments have failed.

Adapted from Thomas & Thurston (2016) and Dording & Sangermano (2018)

Note that this list is by no means complete. It does not include possible treatments for all kinds of less common causes of sexual dysfunctions (e.g., Tarlov cysts), but it does include many common treatments.

How do I seek help?

Even though your family physician or general practitioner is not a specialist, they can refer you to specialists. Getting the right treatment or referral depends on what your doctor knows about your symptoms, female sexual dysfunctions (FSDs), and the treatments/referrals available. Let's take a look at how you can maximize your time and improve communication with your providers.

How do I prepare for my appointment?

Ideally, you will have read all of this web-based guide before seeking help. However, if you are crunched for time (or energy), make sure to read the following (listed in order of importance):

- What is healthy sexual function? and When should I seek help? so that you know exactly why you are seeking help and you can communicate it clearly and efficiently to your healthcare provider.
- What anatomy is involved in female sexual pleasure? so that you can identify the physical locations of your problems and communicate clearly with your healthcare provider. This will also help you be taken seriously.
- Where do I go for help? and What are possible referral options? to help you identify which healthcare providers might be right for you
- Treatment options so you have some idea of what the possible treatments are and you can ask about these treatments or referrals if your healthcare provider does not offer one that seems appropriate to you.
- Consider trying some of the self-help activities in advance (e.g., masturbation, vibrators, and adding clitoral stimulation to vaginal intercourse), as they may be suggested by more than one healthcare provider, and this will give you and your healthcare provider important information right away.

In Dr. Jen Gunter's book *The Vagina Bible*, there is a chapter called "Communicating with Your Provider" with a section called "How to Think About Your Symptoms." In this section, Dr. Gunter shares excellent information from a gynecologist's perspective about how to seek help for female genital concerns. I will summarize Dr. Gunter's advice and combine it with my own recommendations for FSD.

1. Figure out what symptom(s) are bothering you the most, such as:

- irritation
- sandpaper-like feeling
- dryness
- burning
- itch
- tingling
- pain
- pain with sex
- tightness
- pressure
- low desire
- can't orgasm
- limited pleasure

2. Identify where you are experiencing symptoms: in the vagina, on the vestibule, on the vulva, in your brain. Get more specific if you can by looking at What anatomy is involved in female sexual pleasure? (e.g., deep vagina, clitoris, left vestibule). You can also print a diagram of a vulva (from What genital anatomy is on the outside?) and mark the image where you feel your symptoms.

3. Be precise about how long you have been bothered by these symptoms, how often they occur, and how long they last. "A while" is vague, but "six months" is clear. Take note of whether your symptoms started after a specific event (e.g., hitting your groin on a bicycle bar, stopping a medication) or if you have always had these symptoms (e.g., has sex ever been pleasurable?).

4. Consider whether these symptoms happen in certain situations and not other situations (e.g., only with a partner, only with a certain partner, only with vaginal intercourse but not with cunnilingus).

5. Write all of this down or say it out loud so it sounds correct. Writing it down is a good idea because (a) you will clarify your thoughts, (b) you can hand your provider your writing if you do not feel comfortable saying it out loud, and (c) you won't forget important details.

Example: “Vaginal intercourse has become painful and I am very bothered by it. The pain started about six years ago but I just assumed it would go away. I only experience the pain with vaginal intercourse, not with any other type of sex, and it is worse when my partner is penetrating me from behind. It hurts in my vagina but I am not sure where—possibly deeper.”

What should I bring to my appointment?

If you are concerned that your healthcare provider may not be very familiar with FSDs or with your particular concerns, feel free to bring some resources along with you to help explain your concern or support your request for a specific test, treatment, or referral. In addition to the information in this guide, below are some of the resources that may be helpful. Unless I have noted otherwise, you probably won’t be able to access the articles directly. If you can’t access an article, you can access it via a university (or a friend who has university access) or you can just bring the webpage on When should I seek help?

If you are seeking help for a lesser-known condition (such as PGAD/GPD, PSSD, or FOIS), you should read about the condition a bit and bring in some peer-reviewed journal articles on the condition. Some doctors will be happy to read these resources and others may be dismissive. If you get a dismissive doctor, find a new one.

What are possible treatment options? and specific professionals you could see are also a great resource to bring along in case your healthcare provider is not familiar with FSD diagnosis or treatment.

Resources on desire disorders

Hyposexual desire disorder (HSDD)

- “Toward a more evidence-based nosology and nomenclature for female sexual dysfunctions—Part II” by Parish et al. (2016) in *The Journal of Sexual Medicine*. https://doi.org/10.1016/j.jsxm.2016.09.020 (available for free at this link). The HSDD definition is on page 1893.

Resources on arousal disorders

Female genital arousal disorder (FGAD)

- “Toward a more evidence-based nosology and nomenclature for female sexual dysfunctions—Part II” by Parish et al. (2016) in *The Journal of Sexual Medicine.* https://doi.org/10.1016/j.jsxm.2016.09.020 (available for free at this link). The FGAD definition is on page 1895.

Female cognitive arousal disorder (FCAD)

- "Toward a more evidence-based nosology and nomenclature for female sexual dysfunctions—Part III" by Parish et al. (2019) in *The Journal of Sexual Medicine.* https://doi.org/10.1016/j.jsxm.2019.01.010. The FCAD definition is on pages 455–456.

Persistent genital arousal disorder/genito-pelvic dysesthesia (PGAD/GPD)

- "Persistent genital arousal disorder" by Jackowich et al. in the book *Female Sexual Pain Disorders: Evaluation and Management* (2nd ed.) by Andrew Goldstein.
- "Persistent genital arousal disorder: A review of its conceptualizations, potential origins, impact, and treatment" by Jackowich et al. (2016) in *Sexual Medicine Reviews.* https://doi.org/10.1016/j.sxmr.2016.06.003
- "Symptom characteristics and medical history of an online sample of women who experience symptoms of persistent genital arousal" by Jackowich et al. (2018) in *Journal of Sex & Marital Therapy*. https://doi.org/10.1080/0092623X.2017.1321598
- "Persistent genital arousal disorder: A special sense neuropathy" by Oaklander et al. (2020) in *Pain Reports.* https://doi.org/10.1097/PR9.0000000000000801 (Available for free at this link)
    - This is a good resource if you are seeing a neurologist.

Note: The PGAD/GPD articles can be also accessed in the Files section of the PGAD Support group on Facebook.

Resources on orgasm disorders

Female orgasm disorder (FOD)

- "Toward a more evidence-based nosology and nomenclature for female sexual dysfunctions—Part II" by Parish et al. in *The Journal of Sexual Medicine.* https://doi.org/10.1016/j.jsxm.2016.09.020 (available for free at this link). The definition of FOD is on page 1899.

Female orgasmic illness syndrome (FOIS)

- "Toward a more evidence-based nosology and nomenclature for female sexual dysfunctions—Part II" by Parish et al. in *The Journal of Sexual Medicine.* https://doi.org/10.1016/j.jsxm.2016.09.020 (available for free at this link). The definition of FOIS is on pages 1899–1900.

Resources on pain disorders

Vulvar pain caused by a specific disorder

- "2015 ISSVD, ISSWSH and IPPS consensus terminology and classification of persistent vulvar pain and vulvodynia" by Bornstein et al. (2016) in *Obstetrics and Gynecology*. https://doi.org/10.1097/AOG.0000000000001359 (available for free here). The newest definition of vulvar pain caused by a specific disorder is on page 747 in Table 3.

Vulvodynia

- "2015 ISSVD, ISSWSH and IPPS consensus terminology and classification of persistent vulvar pain and vulvodynia" by Bornstein et al. (2016) in *Obstetrics and Gynecology*. https://doi.org/10.1097/AOG.0000000000001359 (available for free here). The newest definition of vulvodynia is on page 747 in Table 3.

Painful orgasm

- "Definitions of sexual dysfunctions in women and men: A consensus statement from the Fourth International Consultation on Sexual Medicine 2015" by McCabe et al. (2016) in *The Journal of Sexual Medicine*. https://doi.org/10.1016/j.jsxm.2015.12.019 (available for free here). The definition of painful orgasm is on page 141.

Female genital-pelvic pain disorder (FGPPD)

- "Definitions of sexual dysfunctions in women and men: A consensus statement from the Fourth International Consultation on Sexual Medicine 2015" by McCabe et al. (2016) in *The Journal of Sexual Medicine*. https://doi.org/10.1016/j.jsxm.2015.12.019 (available for free here). The definition of FGPPD is on page 141.

It is important to note that pain with sexual activity may also be related to endometriosis, which can be difficult to get a diagnosis for. If you suspect you have endometriosis, educate yourself on this topic as well and check out the resources on endometriosis in this web-based guide.

Resources on medication-induced sexual dysfunctions

Post-SSRI/SNRI sexual dysfunction (PSSD), Post-Accutane syndrome (PAS), Post-finasteride syndrome (PFS), and Post-retinoid sexual dysfunction (PFSD)

- "Enduring sexual dysfunction after treatment with antidepressants, 5α-reductase inhibitors and isotretinoin: 300 cases" by Healy et al. (2018) in *The International Journal of Risk & Safety in Medicine*. https://doi.org/10.3233/JRS-180744 (available for free at this link)

- "Post-SSRI sexual dysfunction & other enduring sexual dysfunctions" by Healy (2018) in *Epidemiology and Psychiatric Sciences*. https://doi.org/10.1017/S2045796019000519 (available for free at this link)

- "Citizen petition: Sexual side effects of SSRIs and SNRIs" by Healy (2018) in *The International Journal of Risk & Safety in Medicine.* https://doi.org/10.3233/JRS-180745 (available for free at this link)

- "When antidepressants leave lasting damage: Living with post-SSRI/SNRI sexual dysfunction" by Grey (2020) in *A Blog About Sex, Relationships, and Health.* Available for free at https://www.sexlab.ca/blog/2020/10/17/when-antidepressants-leave-lasting-damage-living-with-post-ssrisnri-sexual-dysfunction

There is also a list of healthcare providers who are familiar with PSSD and a very thorough list of PSDD medical literature.

What do I do at the appointment?

Because your healthcare provider is human too (and faces barriers to providing you help), you may perceive their discomfort or hesitation with discussing sexual topics. As uncomfortable as it may be to start this discussion, many providers actually hope that patients will bring these concerns up themselves! That is why we are empowering you with information about how to do this.

1. Ask your healthcare provider if you can make an audio recording of the appointment and explain why. You may receive a lot of information in the appointment and it is easy to forget or misremember the information. If you do not wish to record the meeting or if your healthcare provider does not give you permission, take written notes.

2. Share the information you've prepared about your symptoms. You can read it, summarize it, or hand the written document to your healthcare provider. They should ask you some follow-up questions, even if you've prepared thoroughly.

3. Don't tell them what you think your diagnosis is until after you have shared and discussed your symptoms with them.

4. Ask about treatment options and referrals. If your healthcare provider doesn't have any suggestions, or if you are very keen on a specific referral or treatment option, you

can ask about some of the treatment options and referrals you've read about in Where do I go for help?

5. If your healthcare provider seems unfamiliar with FSDs or the specific sexual dysfunction you are wondering about, ask them if you can share information that you have selected from the materials recommended in What should I bring to my appointment? If you can, print out the articles yourself. Otherwise, you can share the website URLs and article titles.

6. After sharing and discussing your symptoms with your healthcare provider, you should ask whichever follow-up questions are important to you. Keep in mind that not every question is relevant to everyone, that you will not have time to ask every question, that your healthcare provider may not know all of the answers, and that many of these questions may be more appropriate for later appointments or the specialists to whom you are referred. I have included some examples of follow-up questions that you may wish to ask below:

General questions

- Am I normal? Is this common?
- What do I do if I have more questions after my appointment?
- What do I do if things get worse/different between appointments?
- Can you recommend other resources, such as books, websites, support groups, or blogs?
- What can I do on my own to help?
- What can I do while waiting for diagnosis/treatment/recovery to regain a normal sex life?

Tests and diagnosis questions

- What else do you need to know?
- Do I have to show my genitals to anyone or let anyone touch my genitals?
- Will these tests be scary or painful?
- Are these tests covered by Alberta Health Care? If not, how much do these tests cost?
- Which test is the most effective, affordable, quick, or safe?
- What if I can't afford this test? Are there less expensive options?
- What happens to test results? Who receives them? How do I find out what they are? Who will give me the results?

Referral questions

- Which specialists could I see?
- Do I call someone or will they call me? When will they call?
- What if I am uncomfortable with the healthcare provider I'm referred to? Is there another local specialist in this field?

Treatment questions

- Is this curable?
- Have you treated someone with this condition before?
- How effective are these treatments?
- What are the risks of this treatment?
- Do I have to show my genitals to anyone or let anyone touch my genitals?
- Will these treatments be scary or painful?
- Are these treatments covered by Alberta Health Care? If not, how much do these treatments cost?
- What if I can't afford this treatment? Are there less expensive options?
- What if I don't want to do that particular treatment?
- What if these treatments don't work?
- Which treatment is the most effective, affordable, quick, or safe?
- Will I have to get surgery?
- Can you explain the procedure to me?
- What should I or my partner watch out for with treatment?
- How long will treatment take? When will I feel better?

Medication-specific treatment questions

- Will I have to take medication?
- Will this treatment interact with other medications? Is it safe if I am pregnant, breastfeeding, or trying to conceive?
- What are the side effects of this medication?
- What are the risks of this medication?

What self-help options do I have?

There are many things you can try on your own before you seek help. Trying these things out beforehand may help you with your problem, or it may give you useful information to share with your healthcare provider when you do seek help. You can also try these if you're not ready to seek help yet. However, none of these suggestions are a one-size-fits-all solution. You may not be comfortable with them or they may not be helpful for you. I encourage you to *consider* the options, but you don't have to try all (or any) of them.

One important note: masturbation and vibrators are such common and effective treatment options for female sexual dysfunctions (FSDs) that I have dedicated entire sections to them. However, they also fit under self-help for problems with partnered sex or orgasm.

Things to try on your own

Masturbate!

Masturbation is the manual stimulation (with a hand or another object) of the genitals, either by yourself or by a partner. It a safe and healthy sexual outlet for everyone, including women who can't consent to partnered sex (e.g., some women with disabilities) or who don't have access to a consenting partner.

Many women masturbate, though prevalence varies with age. Women aged 25 to 29 have the highest prevalence of masturbation both in the past month and over their lifetime: 85% of these women have ever masturbated, and 52% have masturbated in the past month. The age groups with the lowest prevalence of masturbation are girls aged 14 to 15 (43% have ever masturbated) and women aged 70 or more (12% have masturbated in the last month). Needless to say, women of all ages masturbate!

There is no correct way to masturbate—the best way is simply what feels best for you. Women may touch their clitorises with their fingers or vibrators. Most women who masturbate with a dildo add clitoral stimulation and few women masturbate by stimulating only the vagina.

Women may enhance masturbation through fantasies, watching pornography, reading erotica, listening to music, or thinking about previous sexual experiences. On average, it takes women about four minutes to orgasm from masturbation—but a shorter or longer time is okay too.

There are many benefits to masturbation. Masturbation allows women to explore and express their own sexuality, and it allows for these benefits without the risks and stressors of partnered sex (e.g., unwanted pregnancy, STIs, worrying about taking too long to orgasm). Women are more likely to experience orgasms (and multiple orgasms!) during masturbation than during partnered sex. Masturbation allows women to experience pleasure and fun, relieve tension, engage in self-care, and avoid engaging with other people.

There are many myths about masturbation, such as the belief that it will cause physical deterioration and disfigurement. However, masturbation is healthy as long as you are enjoying it.

Some women do not masturbate, and there are a variety of reasons for this, including being asexual (though some asexual women do masturbate), not knowing how to masturbate, shame, fear of being caught, low sex drive, a partner's insecurity, lack of interest, being in a relationship (though many women still masturbate when they are in relationships), and religious prohibition (though many religious people masturbate anyway). While masturbation is great and I highly recommend it, it's also okay if you *don't* want to try it!

Masturbation is a very commonly recommended treatment option for many women's sexual function concerns, especially issues with orgasm. Women who masturbate already know what gives their body pleasure, so it's significantly easier to communicate this to a partner. I strongly recommend giving masturbation a very thorough effort for any sexual problem, especially because this will likely save you time with your healthcare provider.

Some people are reluctant to masturbate due to prohibitions from their religion, partner, or self. If this is the case for you, consider these ideas:

1. If your partner does not want you to masturbate, try discussing how you both feel about solo masturbation for the purposes of tackling a sexual problem. Masturbation is a lot easier without an audience, and your partner may even want you to masturbate! You can revisit not masturbating later if it helps you achieve your goals.
2. If your partner does not want you to masturbate, discuss how you both feel about masturbating together. While this will likely be more distracting to you, it may be less threatening to your partner, and it has two other potential benefits: (a) it may be sexy to watch and/or be watched, and (b) it allows you to show your partner what you like. You can even try experimenting with different ways to make it less uncomfortable, such as in the dark or over the phone.
3. If your religion prohibits masturbation, I invite you to pray about it. You may get an answer telling you that masturbation is okay, or that it's okay in this circumstance, and you may not. No one else can answer that question for you.

Some books that may be of help with exploring masturbation:

- *Sex for One* by Betty Dodson - Publisher | Amazon
- *For Yourself* by Lonnie Barbach - Publisher | Amazon
- *Tickle Your Fancy: A Woman's Guide to Sexual Self-Pleasure* by Sadie Allison - Publisher | Amazon
- *The Ultimate Guide to Solo Sex* by Jenny Block - Publisher | Chapters | Amazon
- *Pocket Sex Guide* by Anne Hooper - AbeBooks | Amazon

Use a vibrator

Vibrators are very effective at helping women orgasm alone or with a partner.

PinkCherry and LoveHoney are Canadian websites that have enormous collections of vibrators. I recommend starting with a small and affordable one so that you don't feel intimidated or waste money, and then make a more expensive purchase later based on your experience with the first vibrator. Check out Dr. Lindsey Doe's vibrator guide video on YouTube for a good overview or check out my personal recommendations:

- A vibrating cock ring such as the We-Vibe Pivot Vibrating Silicone Ring or the Je Joue Mio Luxury Rechargeable Vibrating Cock Ring. The great thing about these is that they provide hands-free vibration during intercourse!
- Lelo Nea 2 - This vibrator is small and has a variety of low to high settings.
- Any clitoral suction toys, especially the Womanizer and Satisfyer.
- Hitachi Magic Wand - This is a powerful vibrator and it only has two settings and they're both very powerful, so if you're new to vibrators, I recommend putting a folded-up cloth between you and the vibrator to make the vibrations tolerable. This vibrator is also enormous (and great for your shoulders and back too!) so it limits the positions with which you can use it with a partner (here are some suggestions from Cosmo or Shape). However, it's great for masturbation. It also plugs into an outlet, so you never have to worry about batteries dying. Reminder: don't use any powered sex toys (or the wireless version) in water unless they are specifically designed for that!

Get educated

Learn about general female sexual function

- *Women's Anatomy of Arousal* by Sheri Winston - Publisher | Amazon
- Check out Healthy Hooha's website, Twitter, Instagram, or YouTube for more information about healthy sexual function that is both easy to understand and medically accurate!
- *The Vagina Bible* by Dr. Jen Gunter - Publisher | Amazon
- Dr. Heather Howard of Center for Sexual Health and Rehabilitation has a resource page.
- *Tell Me What You Want* by Justin J. Lehmiller - Publisher | Amazon
- *The Ultimate Guide to Anal Sex for Women* by Tristan Taormino - Simon & Schuster | Amazon
- Guide to Self Help Books: Women's Sexual Health and Sexuality and Sex Education

Learn about new ways to experience pleasure

- *Come As You Are: The Surprising New Science that Will Transform Your Sex Life* by Emily Nagoski - Publisher | Chapters | Amazon
    - Also *The Come As You Are Workbook: A Practical Guide to the Science of Sex* - Chapters | Amazon
    - *Come As You Are* worksheets
- Emjoy app - Google | Apple
- OMGYes - Videos and interactive content for enhancing pleasure during masturbation and/or partnered sex. One-time fee. There are definitely images and diagrams of female genitals on this site.
- Cindy Darnell: The Pleasure Program (free 21-day online course)
- *Becoming Cliterate: Why Orgasm Equality Matters—And How to Get It* by Laurie Mintz - Publisher | Amazon
- *Because It Feels Good: A Woman's Guide to Sexual Pleasure and Satisfaction* by Debby Herbenick - Publisher | Amazon

Learn about other women's sexual experiences

The Vagina Monologues by Eve Ensler

- This is actually a play (which I recommend attending if you get the opportunity), but you can also read the book.

The Hite Report by Shere Hite - Publisher | Amazon

- This book is a compilation of 3000 women's answers to all sorts of questions about their thoughts and experiences with sex.

The Pleasure Plan by Laura Zam - Publisher | Amazon

- This book describes how the author overcame shame, sexual pain, and absent desire, and provides guidance for the reader to do the same.

The Diary of My Broken Vagina | *Comedy Blaps* - YouTube

- This is an 11-minute video with a comedic look at sexual dysfunction.

Three Women by Lisa Taddeo - Simon & Schuster | Chapters | Amazon

- This book studies the sexual desires of three women over eight years.

Check out sexual health education websites

One important consideration: Google is a useful tool, but it can be difficult to tell what's helpful or harmful and what's proven or unproven. Googling can lead you to all kinds of false information and untested or unsafe treatments, or convince you that you have a condition that you do not actually have. As much as possible, stick to the information or resources in this web-based guide, as it has been designed based on the latest peer-reviewed and evidence-based literature on women's sexual health. If you have health questions before, after, or between appointments, you can phone HealthLink (just dial 811) or visit MyHealth.Alberta.ca. HealthLink will connect you with registered nurses (usually) who have access to computer software where they can find answers to all kinds of health questions. MyHealth.Alberta.ca is a similar resource but it allows you to type in keywords yourself to search for accurate information within their site. MyHealth.Alberta.ca also has a specific section on sexual health with some helpful information. You won't find answers to everything with these resources, but they are trustworthy and they are more likely to be able to direct you to Alberta resources than any other resources!

There are also some other great sexual health websites available, including:

- Sex and U is an amazing website by the Society of Obstetricians and Gynaecologists of Canada. It has tons of help and accurate information on sexual topics, including your body, sexual activity, sexual arousal, orgasms, consent, and sexual problems.

- Go Ask Alice is a website for all kinds of health topics: alcohol and drugs, emotional health, general health, nutrition and physical activity, relationships, and sexual & reproductive health (with sub-sections on topics such as erotica and pornography, vulvas, labia, clitorises, vaginas, kissing, masturbation, orgasms, toys, and women's sexual health).

- Teaching Sexual Health is a Canadian resource for parents and teachers, but it can be just as useful for you! I recommend entering through the teacher portal, as it seems to have more comprehensive information. You can also find Teaching Sexual Health Alberta Health Services on YouTube.

- Dr. Lindsey Doe has a YouTube channel called Sexplanations with videos like How to know your body is aroused, What's the cervix? How do you stimulate it?, Orgasmic Sex Positions, and Masturbation Frequency (a partial rant).

Self-help options

Self-help for problems with partnered sex

Many women are having sex that doesn't give them enough stimulation to orgasm. Try things that will enhance your arousal—cunnilingus, vibrators, etc. Vaginal intercourse does not directly stimulate the clitoris glans and most women require some sort of direct clitoral stimulation to orgasm, so if you aren't having an orgasm from vaginal intercourse, there's

nothing wrong with you. While a few men feel threatened by vibrators (a different problem to tackle), many men find it sexy when a woman touches herself with her own hand.

The video Orgasmic Sex Positions by Dr. Lindsey Doe shows 10 great ways to orgasm with a partner. There is no nudity in this video, as the positions are demonstrated by people who are fully clothed.

Thrusting sex techniques by Jacqueline Hellyer is also a great video for men about how to make vaginal intercourse more pleasurable for their partners. This video does not have any nudity either, but she does use a dildo and her hand for demonstration.

Coital Alignment Technique - This technique is similar to missionary position, but the man positions his body a little higher/further forward so that his penis stimulates the woman's clitoris. Just be aware that this website refers to "female coital anorgasmia" (women's inability to orgasm from vaginal intercourse), which should not be thought of as a dysfunction but rather a feature of women's sexuality. The Coital Alignment Technique is #5 in Dr. Lindsey Doe's video, Orgasmic Sex Positions. You can learn more about the Coital Alignment Technique it at CoitalAlignmentTechnique.com.

Woman on top positions are also great for increasing women's pleasure. There is nothing fancy about this. These positions merely allow a woman to control the angle and depth of penetration. If she has a free hand, she can stimulate her clitoris, or her partner can stimulate her clitoris.

There are also lots and lots of books on experiencing sexual pleasure with a partner.

- *Guide to Getting It On* by Paul Joannides - AbeBooks | Amazon
- *Orgasms for Two* by Betty Dodson - Amazon | Publisher
- *She Comes First* by Ian Kerner - Publisher | Amazon
- *The Ultimate Guide to Cunnilingus: How to Go Down on a Woman and Give Her Exquisite Pleasure* by Violet Blue - Simon & Schuster | Amazon
- *Let Me Count the Ways* by Marty Klein - Amazon
    - How to make sexual more enjoyable without vaginal intercourse
- *Why Good Sex Matters: Understanding the Neuroscience of Pleasure for a Smarter, Happier, and More Purpose-Filled Life* by Nan Wise - Publisher | Chapters | Amazon

Self-help for sexual desire problems

Reminder: spontaneous desire is exciting but not necessarily common in long-term relationships. Responsive desire is still normal!

Remember when we learned about the Dual Control Model/Sexual Tipping Point model of sexual response? Our sexual desire, arousal, and orgasm are influenced by a variety of biological, psychological, and social factors. Some of these factors enhance our sexual

response (e.g., being touched how we like to be touched, feeling relaxed), and some of these factors inhibit (e.g., having a giant to-do list, medications).

Many times when people are looking to fix their sexual problems, they think they just need to "spice things up" (enhance) by trying new things like threesomes, sex toys, or outdoor sex. But enhancing only does so much, and enhancing can even be pointless if your inhibitors are too abundant and/or strong!

While enhancers will probably provide some benefit (at least temporarily), a better place to start might be addressing the things that are inhibiting sexual response (e.g., giant to-do list, lack of privacy). Emily Nagoski's exercise Turning Off the Offs will help you identify and alter the things that are inhibiting your sexual response.

Here are some books that might be of use in increasing desire:

- *Better Sex Through Mindfulness: How Women Can Cultivate Desire* by Lori Brotto - Publisher | Chapters | Amazon
- *Come As You Are* by Emily Nagoski - Publisher | Chapters | Amazon
    - *Come As You Are workbook* - Chapters | Amazon
    - Other *Come As You Are* worksheets
- *Mating in Captivity: Unlocking Erotic Intelligence* by Esther Perel - Amazon
    - One of the main tenets of this book is the idea that desire thrives when there is some distance between two people.

Self-help for sexual arousal problems

As many people (women and researchers alike) fail to distinguish between desire and arousal, self-help options for desire and arousal may also overlap. The resources recommended for desire problems are likely helpful for arousal problems as well. There are also some products that may increase arousal (but you should check with your doctor before using any of them):

- Eros clitoral therapy is a small, handheld suction pump that you put on the clitoris to help bring blood to the area.
- Zestra is an oil that can be applied to the clitoris to enhance arousal.
- On arousal gel provides a buzzing, vibration sensation on the clitoris.

Self-help for orgasm problems

It's okay to want to figure out how to orgasm from vaginal intercourse and there are some things you can try!

- Coital Alignment Technique (mentioned above)

- Touch yourself with your hand during intercourse
- Have your partner touch your clitoris during intercourse
- Touch yourself with a small vibrator (check out my recommendations) during intercourse
- Use a vibrating cock ring (again, check out my recommendations)

Here are some resources to help you learn to orgasm:

- *Becoming Orgasmic* by Julia Heiman and Joseph LoPiccolo - Publisher | Amazon
- *The Elusive Orgasm: A Woman's Guide to Why She Can't and How She Can Orgasm* by Vivienne Cass - Publisher | Amazon
- *The Ultimate Guide to Orgasm for Women: How to Become Orgasmic for a Lifetime* by Mikaya Heart - Simon & Schuster | Amazon

The most common and most effective treatment for most orgasm difficulties is masturbation, so you can save yourself some time and money by trying this easy, fun, effective, and affordable treatment on your own. Check out the resources on masturbation if you're not sure where to go.

Self-help for sexual pain or penetration problems

- Kirsten Loop's upcoming book on vaginismus is based on modern pain science and her own 20-year lived experience. Kirsten self-cured her vaginismus in 1998!
- *How to Create A 'Structured' Diary for Vaginismus Dilation At Home* by Kirsten Loop - available as a free digital download
- *When Sex Hurts: A Woman's Guide to Banishing Sexual Pain* by Andrew Goldstein, Caroline Pukall, Irwin Goldstein - Publisher | Amazon
- *Pelvic Pain Explained: What You Need to Know* by Stephanie A. Prendergast, Elizabeth H. Akincilar - Publisher | Amazon
- *A Headache in the Pelvis: The Wise-Anderson Protocol for Healing Pelvic Pain: The Definitive Edition* by David Wise Ph.D., Rodney Anderson M.D. - Publisher | Amazon
- *When a Woman's Body Says No to Sex: Understanding an Overcoming Vaginismus* by Linda Valins - AbeBooks | Amazon
- Reduce Sexual Pain: A New Way to Look at Sex and Reduce Sexual Pain: A Guide for Couples and Reduce Sexual Pain: Pleasurable Activities and Products by Heather Howard. These are short PDFs.
- The SexMed Advocate website: Why does sex hurt?

- AHS Pelvic Floor Clinic - Online Educational Workshops

Self-help for problems stemming from sexual abuse

- *Sexual Healing Journey: A Guide for Survivors of Sexual Abuse* by Wendy Maltz - Publisher | Amazon | AbeBooks
- *Sexual Healing* by Barbara Keesling - AbeBooks | Amazon

Endometriosis resources

While endometriosis itself is not a sexual dysfunction, I have included resources on endometriosis for two reasons: (1) it can cause pain with sexual activity, and (2) women who seek help for endometriosis have had negative experiences with seeking help, taking an average of seven and a half years to get diagnosed.

- Nancy's Nook Endometriosis Education on Facebook and online.
- MyHealth.Alberta's pages on endometriosis and endometriosis: care instructions.
- The Mayo Clinic has information on endometriosis symptoms and causes and diagnosis and treatment.
- HealthLine and Johns Hopkins Medicine and WebMD have information on endometriosis.
- The Endometriosis Network Canada has a page for Alberta doctors with expertise in treating endometriosis.
- The Lois Hole Hospital for Women (Edmonton) has a Chronic Pelvic Pain Program to which you could request referral from your healthcare provider.

Join a support group or follow social media

Persistent genital arousal disorder/genito-pelvic dysesthesia (PGAD/GPD)

- Facebook: PGAD Support (you'll need to go through the PGAD Support Group - Entry Requests first). This group has a ton of resources on coping with PGAD/GPD.
- Facebook: Spinal surgery for GPD/PGAD

There is a page on reddit and there are other Facebook groups for PGAD/GPD support. However, I only recommend the above groups because I know that they carefully screen members to ensure that they only admit people who have PGAD/GPD (or a parent, if the patient is a child). These groups are also well-connected with ISSWSH.

Post-SSRI sexual dysfunction (PSSD)

- Reddit: r/PSSD
- Online Forum: Post-SSRI Sexual Dysfunction Forum
- Online Forum: Post-Accutane Syndrome forum

Pelvic floor dysfunction

- Facebook: Pelvic Floor Dysfunction for Women
- Facebook: Pelvic Floor Dysfunction Support Group
- Facebook: Finding Pelvic Sanity - Pelvic Health Support

Vaginismus

- Facebook: Vaginismus Support
- Tight Lipped Podcast on Twitter, Instagram, Apple Podcasts, and online
- Vaginismus Awareness on Twitter

Female sexual health

- Ashley Winter MD || Urologist on Twitter and Instagram
- Rachel S. Rubin, MD (urologist) on Twitter and Instagram
- Dr. Jennifer Gunter (gynecologist) on Twitter, Facebook, and Instagram
- International Society for the Study of Women's Sexual Health (ISSWSH) on Twitter, Instagram, and Facebook

Sex education

- Sexplanations on Twitter and YouTube
- Sex Ed with Liz on Twitter
- Carlin Ross on Twitter and online

References

Abdo, C. H. N., Oliveira, J. W. M., Moreira, J. E. D., & Fittipaldi, J. A. S. (2004). Prevalence of sexual dysfunctions and correlated conditions in a sample of Brazilian women-results of the Brazilian study on sexual behavior (BSSB). *International Journal of Impotence Research, 16*(2), 160–166. https://doi.org/10.1038/sj.ijir.3901198

Action Canada for Sexual Health & Rights. (2020). *The state of sex-ed in Canada*. https://www.actioncanadashr.org/resources/reports-analysis/2020-04-03-state-sex-ed-report

Aerts, L., Rubin, R. S., Randazzo, M., Goldstein, S. W., & Goldstein, I. (2018). Retrospective study of the prevalence and risk factors of clitoral adhesions: Women's health providers should routinely examine the glans clitoris. *Sexual Medicine, 6*(2), 115–122. https://doi.org/10.1016/j.esxm.2018.01.003

Albaugh, J. (2014). Female sexual dysfunction. *International Journal of Urological Nursing, 8*(1), 38–43. https://doi.org/10.1111/ijun.12027

Alberta Health. (n.d.). *Alberta wait times reporting*. Retrieved October 6, 2020, from http://waittimes.alberta.ca/WaitTimeTrends.jsp

Alberta Health Services. (2019). *Find healthcare*. Retrieved September 23, 2019, from https://www.albertahealthservices.ca/findhealth/results.aspx?type=service&id=30&locationPostalCode=T1J%200T2&radius=all#contentStart

Alberta Health Services. (n.d.-a). *Chinook Regional Hospital: Pelvic floor clinic*. Retrieved August 23, 2020, from https://www.albertahealthservices.ca/findhealth/Service.aspx?id=1076741&serviceAtFacilityID=1119536

Alberta Health Services. (n.d.-b). *Sexual & reproductive health*. Retrieved September 11, 2020, from https://www.albertahealthservices.ca/services/page13737.aspx

Alberta Health Services. (n.d.-c). *Teaching sexual health*. Retrieved from Internet Archive website: https://web.archive.org/web/20170315171105/http://teachingsexualhealth.ca/

Alberta Learning. (2002a). *Career and life management (senior high): Program of studies* [PDF]. https://education.alberta.ca/media/160199/calm.pdf

Alberta Learning. (2002b). *Career and life management for senior high school: Guide to implementation* [PDF]. https://education.alberta.ca/media/1477141/calmgi.pdf

Alberta Learning. (2002c). *Health and life skills for kindergarten to grade 9: Guide to implementation* [PDF]. https://education.alberta.ca/media/1477143/healthgi.pdf

Alberta Learning. (2002d). *Health and life skills kindergarten to grade 9: Program of studies* [PDF]. https://education.alberta.ca/media/160196/health.pdf

Alberta Urology Institute. (n.d.). *General patient information*. Retrieved October 5, 2020, from https://www.aburologyinstitute.com/general/index.asp

Alexander, M. G., & Fisher, T. D. (2003). Truth and consequences: Using the bogus pipeline to examine sex differences in self-reported sexuality. *The Journal of Sex Research: Gender and Sexuality, 40*(1), 27–35. https://doi.org/10.1080/00224490309552164

Althof, S. E., Leiblum, S. R., Chevret-Measson, M., Hartmann, U., Levine, S. B., McCabe, M., Plaut, M., Rodrigues, O., & Wylie, K. (2005). Psychological and interpersonal dimensions of sexual function and dysfunction. *The Journal of Sexual Medicine, 2*(6), 793–800. https://doi.org/10.1111/j.1743-6109.2005.00145.x

American Psychiatric Association. (2013). Sexual dysfunctions. In *Diagnostic and statistical manual of mental disorders* (5th ed.). Author. https://doi.org/10.1176/appi.books.9780890425596.dsm13

American Psychological Association. (2019). *Standards of accreditation for health service psychology and accreditation operating procedures*. Retrieved July 1, 2020, from https://irp-cdn.multiscreensite.com/a14f9462/files/uploaded/APA-Principles-Accreditation-SoA-AOP_200124.pdf

Andrejek, N., & Fetner, T. (2019). The gender gap in orgasms: Survey data from a mid-sized Canadian city. *International Journal of Sexual Health, 31*(1), 26–35. https://doi.org/10.1080/19317611.2018.1563014

Armstrong, E. A., England, P., & Fogarty, A. C. K. (2012). Accounting for women's orgasm and sexual enjoyment in college hookups and relationships. *American Sociological Review, 77*(3), 435–462. https://doi.org/10.1177/0003122412445802

Aslan, E., & Fynes, M. (2008). Female sexual dysfunction. *International Urogynecology Journal, 19*(2), 293–305. https://doi.org/10.1007/s00192-007-0436-3

Aswath, M., Pandit, L. V., Kashyap, K., & Ramnath, R. (2016). Persistent genital arousal disorder. *Indian Journal of Psychological Medicine, 38*(4), 341–343. https://doi.org/10.4103/0253-7176.185942

Atallah, S., Johnson-Agbakwu, C., Rosenbaum, T., Abdo, C., Byers, E. S., Graham, C., Nobre, P., Wylie, K., & Brotto, L. (2016). Ethical and sociocultural aspects of sexual function and dysfunction in both sexes. *The Journal of Sexual Medicine, 13*(4), 591–606. https://doi.org/10.1016/j.jsxm.2016.01.021

Ayling, K., & Ussher, J. M. (2008). "If sex hurts, am I still a woman?" The subjective experience of vulvodynia in hetero-sexual women. *Archives of Sexual Behavior, 37*(2), 294–304. https://doi.org/10.1007/s10508-007-9204-1

Azar, M., Bradbury-Jones, C., & Kroll, T. (2013). Patterns of help-seeking in women when problems arise in their sexual life: A discussion paper. *Journal of Clinical Nursing, 22*(23–24), 3587–3596. https://doi.org/10.1111/jocn.12374

Bailey, J. V., Farquhar, C., Owen, C., & Whittaker, D. (2003). Sexual behaviour of lesbians and bisexual women. *Sexually Transmitted Infections, 79*(2), 147–150. https://doi.org/10.1136/sti.79.2.147

Balon, R. (2017). Burden of sexual dysfunction. *Journal of Sex & Marital Therapy, 43*(1), 49–55. https://doi.org/10.1080/0092623X.2015.1113597

Bancroft, J. (1999). Central inhibition of sexual response in the male: A theoretical perspective. *Neuroscience and Biobehavioral Reviews, 23*(6), 763–784. https://doi.org/10.1016/s0149-7634(99)00019-6

Bancroft, J., Graham, C. A., Janssen, E., & Sanders, S. A. (2009). The Dual Control Model: Current status and future directions. *The Journal of Sex Research, 46*(2–3), 121–142. https://doi.org/10.1080/00224490902747222

Barbach, L. G. (2000). *For yourself: The fulfillment of female sexuality (revised and updated)*. Penguin Publishing Group.

Barmak, S. (2016, October 27). *The uncomplicated truth about women's sexuality* [Video]. TEDxToronto. https://www.ted.com/talks/sarah_barmak_the_uncomplicated_truth_about_women_s_sexuality?language=en

Barrett, M., McKay, A., Dickson, C., Seto, J., Fisher, W., Read, R., Steben, M., Gale-Rowe, M., & Wong, T. (2012). Sexual health curriculum and training in Canadian medical schools: A study of family medicine, obstetrics and gynaecology and undergraduate medicine programs in 2011 with comparisons to 1996. *The Canadian Journal of Human Sexuality, 21*(2), 63–73. https://search.proquest.com/openview/d12989dd856da6669a537685173fdde3/

Basson, R. (2000). The female sexual response: A different model. *Journal of Sex & Marital Therapy, 26*(1), 51–65. https://doi.org/10.1080/009262300278641

Basson, R. (2001). Female sexual response: The role of drugs in the management of sexual dysfunction. *Obstetrics and Gynecology, 98*(2), 350. https://doi.org/10.1016/s0029-7844(01)01452-1

Basson, R. (2005). Women's sexual dysfunction: Revised and expanded definitions. *Canadian Medical Association Journal, 172*(10), 1327–1333. https://doi.org/10.1503/cmaj.1020174

Basson, R. (2006). Sexual desire and arousal disorders in women. *The New England Journal of Medicine, 354*(14), 1497–1506. https://doi.org/10.1056/NEJMcp050154

Basson, R., Berman, J., Burnett, A., Derogatis, L., Ferguson, D., Fourcroy, J., Goldstein, I., Graziottin, A., Heiman, J., & Laan, E. (2000). Report of the international consensus development conference on female sexual dysfunction: Definitions and classifications. *The Journal of Urology, 163*(3), 888–893. https://doi.org/10.1016/S0022-5347(05)67828-7

Beaber, T. E., & Werner, P. D. (2009). The relationship between anxiety and sexual functioning in lesbians and heterosexual women. *Journal of Homosexuality, 56*(5), 639–654. https://doi.org/10.1080/00918360903005303

Behboodi Moghadam, Z., Rezaei, E., Khaleghi Yalegonbadi, F., Montazeri, A., Arzaqi, S. M., Tavakol, Z., & Yari, F. (2015). The effect of sexual health education program on women sexual function in Iran. *Journal of Research in Health Sciences, 15*(2), 124. http://eprints.skums.ac.ir/6051/1/92.pdf

Bell, J. (2018, January 9). Masturbation: Common questions and misconceptions. *Clue*. https://helloclue.com/articles/sex/masturbation-common-questions-misconceptions

Bergvall, L., & Himelein, M. J. (2014). Attitudes toward seeking help for sexual dysfunctions among US and Swedish college students. *Sexual and Relationship Therapy, 29*(2), 215–228. https://doi.org/10.1080/14681994.2013.860222

Berman, L., Berman, J., Felder, S., Pollets, D., Chhabra, S., Miles, M., & Powell, J. A. (2003). Seeking help for sexual function complaints: What gynecologists need to know about the female patient's experience. *Fertility and Sterility, 79*(3), 572–576. https://doi.org/10.1016/S0015-0282(02)04695-2

Biblical Gender Roles. (2018, December 20). Why a wife should endure painful sex with her husband [Blog post]. *Biblical Gender Roles*.

https://biblicalgenderroles.com/2018/12/20/why-a-wife-should-endure-painful-sex-with-her-husband/

Blair, B., Arnow, B. A., Haas, A., & Millheiser, L. (2013). Improving women's sexual health: A quantitative evaluation of an educational intervention for healthcare professionals. *Sex Education: Sexuality, Society and Learning, 13*(5), 535–547. https://doi.org/10.1080/14681811.2013.771774

Blair, K. L., Cappell, J., & Pukall, C. F. (2017). Not all orgasms were created equal: Differences in frequency and satisfaction of orgasm experiences by sexual activity in same-sex versus mixed-sex relationships. *The Journal of Sex Research, 55*(6), 719–733. https://doi.org/10.1080/00224499.2017.1303437

Boatman, B. [@txsensualhealth]. (2020, June 18). *ditto. As a sex therapist I'm also constantly enraged by the things I hear from my clients that docs said.* [Tweet]. Twitter. Retrieved June 18, 2020, from https://twitter.com/txsensualhealth/status/1273702742968750081

Bornstein, J., Goldstein, A., & Coady, D. (2015). *2015 Consensus terminology and classification of persistent vulvar pain* [PDF]. https://www.isswsh.org/images/PDF/Consensus_Terminology_of_Vulvar_Pain.pdf

Bornstein, J., Goldstein, A. T., Stockdale, C. K., Bergeron, S., Pukall, C., Zolnoun, D., & Coady, D. (2016). 2015 ISSVD, ISSWSH and IPPS consensus terminology and classification of persistent vulvar pain and vulvodynia. *Obstetrics and Gynecology, 127*(4), 745–751. https://doi.org/10.1097/AOG.0000000000001359

Braun, V., & Kitzinger, C. (2001). "Snatch," "Hole," or "Honey-pot"? Semantic categories and the problem of nonspecificity in female genital slang. *The Journal of Sex Research, 38*(2), 146–158. https://doi.org/10.1080/00224490109552082

Breyer, B. N., Smith, J. F., Eisenberg, M. L., Ando, K. A., Rowen, T. S., & Shindel, A. W. (2010). The impact of sexual orientation on sexuality and sexual practices in North American medical students. *The Journal of Sexual Medicine, 7*(7), 2391–2400. https://doi.org/10.1111/j.1743-6109.2010.01794.x

Brock, G., Moreira Jr., E. D., Glasser, D. B., Gingell, C., & GSSAB Investigators' Group. (2006). Sexual disorders and associated help-seeking behaviors in Canada. *The Canadian Journal of Urology, 13*(1), 2953–2961. https://www.canjurol.com/

Brock, L. J., & Jennings, G. H. (1993). Sexuality education: What daughters in their 30s wish their mothers had told them. *Family Relations, 42*(1), 61–65. https://doi.org/10.2307/584923

Brotto, L. A. (2010). The DSM diagnostic criteria for hypoactive sexual desire disorder in women. *Archives of Sexual Behavior, 39*(2), 221–239. https://doi.org/10.1007/s10508-009-9543-1

Brotto, L. A., Heiman, J. R., & Tolman, D. L. (2009). Narratives of desire in mid-age women with and without arousal difficulties. *The Journal of Sex Research, 46*(5), 387–398. https://doi.org/10.1080/00224490902792624

Brotto, L. A., Knudson, G., Inskip, J., Rhodes, K., & Erskine, Y. (2010). Asexuality: A mixed-methods approach. *Archives of Sexual Behavior, 39*(3), 599–618. https://doi.org/10.1007/s10508-008-9434-x

Brotto, L. A., Yong, P., Smith, K. B., & Sadownik, L. A. (2015). Impact of a multidisciplinary vulvodynia program on sexual functioning and dyspareunia. *The Journal of Sexual Medicine, 12*(1), 238–247. https://doi.org/10.1111/jsm.12718

Burd, I. D., Nevadunsky, N., & Bachmann, G. (2006). Impact of physician gender on sexual history taking in a multispecialty practice. *The Journal of Sexual Medicine, 3*(2), 194–200. https://doi.org/10.1111/j.1743-6109.2005.00168.x

Burnes, T. R., Singh, A. A., & Witherspoon, R. G. (2017). Graduate counseling psychology training in sex and sexuality: An exploratory analysis. *The Counseling Psychologist, 45*(4), 504–527. https://doi.org/10.1177/0011000017714765

Byrd, J. E., Hyde, J. S., DeLamater, J. D., & Plant, E. A. (1998). Sexuality during pregnancy and the year postpartum. *The Journal of Family Practice, 47*(4), 143–151. https://www.jstor.org/stable/3813687

Canadian Counselling and Psychotherapy Association. (2019). *Certification guide*. Retrieved June 30, 2020, from https://www.ccpa-accp.ca/wp-content/uploads/2019/06/CertificationGuide_EN_APRIL2019-1.pdf

Canadian Institutes of Health Research, Natural Sciences and Engineering Research Council of Canada, & Social Sciences and Humanities Research Council of Canada. (2014). *Tri-council policy statement: Ethical conduct for research involving humans* (2nd ed.). http://www.pre.ethics.gc.ca/pdf/eng/tcps2-2014/TCPS_2_FINAL_Web.pdf

Carroll, J. L. (2018). *Sexuality now: Embracing diversity*. Cengage Learning.

Carter, A., Ford, J. V., Luetke, M., Fu, T.-c. J., Townes, A., Hensel, D. J., Dodge, B., & Herbenick, D. (2019). "Fulfilling his needs, not mine": Reasons for not talking about painful sex and associations with lack of pleasure in a nationally representative

sample of women in the United States. *The Journal of Sexual Medicine, 16*(12), 1953–1965. https://doi.org/10.1016/j.jsxm.2019.08.016

Cassano, O. (2018, February 28). Not all women masturbate, and that's fine: 6 women tell us why they don't. *Metro*. https://metro.co.uk/2018/02/28/not-all-women-masturbate-and-thats-fine-6-women-tell-us-why-they-dont-7335394/

Chadwick, S. B., & van Anders, S. M. (2017). Do women's orgasms function as a masculinity achievement for men? *The Journal of Sex Research, 54*(9), 1141–1152. https://doi.org/10.1080/00224499.2017.1283484

Chalker, R. (2018). *The clitoral truth*. Seven Stories Press.

Chew, P. Y., Choy, C. L., Sidi, H. B., Abdullah, N., Che Roos, N. A., Salleh Sahimi, H. M., Abdul Samad, F. D., & Ravindran, A. (2021). The association between female sexual dysfunction and sexual dysfunction in the male partner: A systematic review and meta-analysis. *The Journal of Sexual Medicine, 18*(1), 99–112. https://doi.org/10.1016/j.jsxm.2020.10.001

Chivers, M. L., Seto, M. C., Lalumière, M. L., Laan, E., & Grimbos, T. (2010, 2010/02/01). Agreement of self-reported and genital measures of sexual arousal in men and women: A meta-analysis. *Archives of Sexual Behavior, 39*(1), 5–56. https://doi.org/10.1007/s10508-009-9556-9

Christopher, F. S., & Sprecher, S. (2000). Sexuality in marriage, dating, and other relationships: A decade review. *Journal of Marriage and Family, 62*(4), 999–1017. https://doi.org/10.1111/j.1741-3737.2000.00999.x

Ciarrocchi, J. W. (1993). *A minister's handbook of mental disorders*. Paulist Press.

Coleman, E. M., Hoon, P. W., & Hoon, E. F. (1983). Arousability and sexual satisfaction in lesbian and heterosexual women. *The Journal of Sex Research, 19*(1), 58–73. https://doi.org/10.1080/00224498309551169

College of Alberta Psychologists. (2017). *Criteria for evaluating academic credentials*. Retrieved June 30, 2020, from https://www.cap.ab.ca/LinkClick.aspx?fileticket=_oGXACieTOY%3d&portalid=0

Connor, J. J., Robinson, B., & Wieling, E. (2008). Vulvar pain: A phenomenological study of couples in search of effective diagnosis and treatment. *Family Process, 47*(2), 139–155. https://doi.org/10.1111/j.1545-5300.2008.00245.x

Cordes, C. C., Mona, L. R., Syme, M. L., Cameron, R. P., & Smith, K. (2013). Sexuality and sexual health among women with physical disabilities. In D. Castañeda (Ed.), *The essential handbook of women's sexuality* (Vol. 2, pp. 71–92). Praeger.

Crooks, R., & Baur, K. (2011a). Perspectives on sexuality. In *Our sexuality* (11th ed., pp. 1–27). Wadsworth, Cengage Learning.

Crooks, R., & Baur, K. (2011b). Sexual arousal and response. In *Our sexuality* (11th ed., pp. 144–179). Wadsworth, Cengage Learning.

Davis, S. R., & Braunstein, G. D. (2012). Efficacy and safety of testosterone in the management of hypoactive sexual desire disorder in postmenopausal women. *The Journal of Sexual Medicine, 9*(4), 1134–1148. https://doi.org/10.1111/j.1743-6109.2011.02634.x

Davison, J. (2013). Gaining intimate citizenship: Sexuality and women with enduring mental illness. In D. Castañeda (Ed.), *The essential handbook of women's sexuality* (Vol. 2, pp. 293–309). Praeger.

Dennerstein, L., Dudley, E., & Burger, H. (2001). Are changes in sexual functioning during midlife due to aging or menopause? *Fertility and Sterility, 76*(3), 456–460. https://doi.org/10.1016/S0015-0282(01)01978-1

DeRogatis, L. R., Sand, M., Balon, R., Rosen, R., & Parish, S. J. (2016). Toward a more evidence-based nosology and nomenclature for female sexual dysfunctions—Part I. *The Journal of Sexual Medicine, 13*(12), 1881–1887. https://doi.org/10.1016/j.jsxm.2016.09.014

Dhand, S. (2015, October 10). Why we need to stop calling physicians "providers". *KevinMD*. https://www.kevinmd.com/blog/2015/10/why-we-need-to-stop-calling-physicians-providers.html

Di Marino, V., & Lepidi, H. (2014). *Anatomic study of the clitoris and the bulbo-clitoral organ*. Springer.

Dodson, B. (2002). *Orgasms for two: The joy of partnersex*. Harmony Books.

Dodson, B. (2015). Masturbation. In P. Whelehan & A. Bolin (Eds.), *The international encyclopedia of human sexuality* (1st ed.). Wiley. http://ezproxy.uleth.ca/login?url=https://search.credoreference.com/content/entry/wileyhs/masturbation/0?institutionId=2649

Donaghue, C. (2015). *Sex outside the lines: Authentic sexuality in a sexually dysfunctional culture*. Benbella Books.

Donaldson, R. L., & Meana, M. (2011). Early dyspareunia experience in young women: Confusion, consequences, and help-seeking barriers. *The Journal of Sexual Medicine, 8*(3), 814–823. https://doi.org/10.1111/j.1743-6109.2010.02150.x

Dording, C. M., & Sangermano, L. (2018). Female sexual dysfunction: Natural and complementary treatments. *Focus 16*(1), 19–23. https://doi.org/10.1176/appi.focus.20170049

Ehrenreich, B., & English, D. (2005). The sexual politics of sickness. In *For her own good: Two centuries of the experts' advice to women* (2nd ed., pp. 111–154). Anchor Books.

Elbay, R. Y. (2017). Female patients with sexual dysfunction: An experience in a general psychiatry outpatient clinic. *Klinik Psikofarmakoloji Bulteni, 27*(1), 219–220. https://doi.org/10.4103/0019-5545.148522

Ellsworth, R. M., & Bailey, D. H. (2013). Human female orgasm as evolved signal: A test of two hypotheses. *Archives of Sexual Behavior, 42*(8), 1545–1554. https://doi.org/10.1007/s10508-013-0152-7

Etaugh, C. (2013). Women and sexuality in the middle and later years. In D. Castañeda (Ed.), *The essential handbook of women's sexuality* (Vol. 1, pp. 125–139). Praeger.

Faubion, S. S., & Rullo, J. E. (2015). Sexual dysfunction in women: A practical approach. *American Family Physician, 92*(4), 281–288. http://www.aafp.org/afp/2015/0815/p281.html

Febos, M. (2021, March 31). I spent my life consenting to touch I didn't want. *The New York Times Magazine*. https://www.nytimes.com/2021/03/31/magazine/consent.html

Federation of Feminist Women's Health Centers. (1991). *A new view of a woman's body: A fully illustrated guide*. Feminist Press.

Feldhaus-Dahir, M. (2009). Female sexual dysfunction: Barriers to treatment. *Urologic Nursing, 29*(2), 81–85. http://www.tuleoffice.com/images/editor/File/pdf/book/IMPOTENCY/38714459-web.pdf

Fine, M. (1988). Sexuality, schooling, and adolescent females: The missing discourse of desire. *Harvard Educational Review, 58*(1), 29–53. https://doi.org/10.17763/haer.58.1.u0468k1v2n2n8242

Fine, M., & McClelland, S. I. (2006). Sexuality education and desire: Still missing after all these years. *Harvard Educational Review, 76*(3), 297–338. https://doi.org/10.17763/haer.76.3.w5042g23122n6703

Frederick, D. A., John, H. K. S., Garcia, J. R., & Lloyd, E. A. (2017). Differences in orgasm frequency among gay, lesbian, bisexual, and heterosexual men and women in a U.S. national sample. *Archives of Sexual Behavior, 47*(1), 273–288. https://doi.org/10.1007/s10508-017-0939-z

Frederick, D. A., Lever, J., Gillespie, B. J., & Garcia, J. R. (2017). What keeps passion alive? Sexual satisfaction is associated with sexual communication, mood setting, sexual variety, oral sex, orgasm, and sex frequency in a aational U.S. study. *The Journal of Sex Research, 54*(2), 186–201. https://doi.org/10.1080/00224499.2015.1137854

Freud, S. (1905). *Three essays on the theory of sexuality*. Verso Books.

Freud, S. (1961). Female sexuality. In J. Strachey (Ed.), *The standard edition of the complete psychological works of Sigmund Freud* (Vol. 21, pp. 225–243). Hogarth Press.

Fronek, P., Kendall, M., Booth, S., Eugarde, E., & Geraghty, T. (2010). A longitudinal study of sexuality training for the interdisciplinary rehabilitation team. *Sexuality and Disability, 29*(2), 87–100. https://doi.org/10.1007/s11195-010-9177-1

Fugl-Meyer, A. R., & Fugl-Meyer, K. S. (2005). Prevalence data in Europe. In I. Goldstein, C. M. Meston, S. Davis, & A. Traish (Eds.), *Women's sexual function and dysfunction: Study, diagnosis and treatment* (pp. 34–41). CRC Press.

Garcia, J. R., Lloyd, E. A., Wallen, K., & Fisher, H. E. (2014). Variation in orgasm occurrence by sexual orientation in a sample of U.S. singles. *The Journal of Sexual Medicine, 11*(11), 2645–2652. https://doi.org/10.1111/jsm.12669

Gates, E. A., & Galask, R. P. (2001). Psychological and sexual functioning in women with vulvar vestibulitis. *Journal of Psychosomatic Obstetrics & Gynecology, 22*(4), 221–228. https://doi.org/10.3109/01674820109049977

Gavey, N., McPhillips, K., & Braun, V. (1999). Interruptus coitus: Heterosexuals accounting for intercourse. *Sexualities, 2*(1), 35–68. https://doi.org/10.1177/136346099002001003

Giatti, S., Diviccaro, S., Panzica, G., & Melcangi, R. C. (2018). Post-finasteride syndrome and post-SSRI sexual dysfunction: two sides of the same coin? *Endocrine, 61*(2), 180–193. https://doi.org/10.1007/s12020-018-1593-5

Giles, K. R., & McCabe, M. P. (2009). Conceptualizing women's sexual function: Linear vs. circular models of sexual response. *The Journal of Sexual Medicine, 6*(10), 2761–2771. https://doi.org/10.1111/j.1743-6109.2009.01425.x

Goldmeier, D., Malik, F., Phillips, R., & Green, J. (2004). Cost implications of sexual dysfunction: The female picture. *International Journal of Impotence Research, 16*(2), 130–134. https://doi.org/10.1038/sj.ijir.3901179

Goldstein, I., Clayton, A. H., Goldstein, A. T., Kim, N. N., & Kingsberg, S. A. (2018). *Textbook of female sexual function and dysfunction: Diagnosis and treatment*. John Wiley & Sons.

Goldstein, I., Komisaruk, B. R., Rubin, R. S., Goldstein, S. W., Elliott, S., Kissee, J., & Kim, C. W. (2017). A novel collaborative protocol for successful management of penile pain mediated by radiculitis of sacral spinal nerve roots trom Tarlov cysts. *Sexual Medicine, 5*(3), e203–e211. https://doi.org/10.1016/j.esxm.2017.04.001

Gott, M. (2004). "Opening a can of worms": GP and practice nurse barriers to talking about sexual health in primary care. *Family Practice, 21*(5), 528–536. https://doi.org/10.1093/fampra/cmh509

Gott, M., & Hinchliff, S. (2003). Barriers to seeking treatment for sexual problems in primary care: A qualitative study with older people. *Family Practice, 20*(6), 690–695. https://doi.org/10.1093/fampra/cmg612

Government of Alberta. (n.d., 2021). *Health care services covered in Alberta*. Retrieved May 6, 2021, from https://www.alberta.ca/ahcip-what-is-covered.aspx

Graham, C. A., Sanders, S. A., Milhausen, R. R., & McBride, K. R. (2004). Turning on and turning off: A focus group study of the factors that affect women's sexual arousal. *Archives of Sexual Behavior, 33*(6), 527–538. https://doi.org/10.1023/B:ASEB.0000044737.62561.fd

Graziottin, A. (2008). Dyspareunia and vaginismus: Review of the literature and treatment. *Current Sexual Health Reports, 5*(1), 43–50. https://doi.org/10.1007/s11930-008-0008-7

Grey, E. (2020, October 17). When antidepressants leave lasting damage: Living with post-SSRI/SNRI sexual dysfunction. *A Blot About Sex, Relationships, and Health*. https://www.sexlab.ca/blog/2020/10/17/when-antidepressants-leave-lasting-damage-living-with-post-ssrisnri-sexual-dysfunction

Gunter, J. (2019). *The vagina bible: The vulva and the vagina—separating the myth from the medicine*. Citadel Press.

Haavio-Mannila, E., & Kontula, O. (1997). Correlates of increased sexual satisfaction. *Archives of Sexual Behavior, 26*(4), 399–419. https://doi.org/10.1023/A:1024591318836

Hanzlik, M. P., & Gaubatz, M. (2012). Clinical PsyD trainees' comfort discussing sexual issues with clients. *American Journal of Sexuality Education, 7*(3), 219–236. https://doi.org/10.1080/15546128.2012.707080

Hayes, R. D. (2011). Circular and linear modeling of female sexual desire and arousal. *The Journal of Sex Research, 48*(2–3), 130–141. https://doi.org/10.1080/00224499.2010.548611

Healthwise Staff. (n.d.). *Sexual problems in women*. Retrieved August 21, 2020, from https://myhealth.alberta.ca/health/pages/conditions.aspx?Hwid=uh1854

Healy, D. (2019). Post-SSRI sexual dysfunction & other enduring sexual dysfunctions. *Epidemiology and Psychiatric Sciences, 29*, e55. https://doi.org/10.1017/S2045796019000519

Healy, D. (2020). Antidepressants and sexual dysfunction: A history. *Journal of the Royal Society of Medicine, 113*(4), 133–135. https://doi.org/10.1177/0141076819899299

Healy, D., Le Noury, J., & Mangin, D. (2018). Enduring sexual dysfunction after treatment with antidepressants, 5α-reductase inhibitors and isotretinoin: 300 cases. *The International Journal of Risk & Safety in Medicine, 29*(3–4), 125–134. https://doi.org/10.3233/JRS-180744

Healy, D., Le Noury, J., & Mangin, D. (2019). Post-SSRI sexual dysfunction: Patient experiences of engagement with healthcare professionals. *The International Journal of Risk & Safety in Medicine, 30*(3), 167–178. https://doi.org/10.3233/JRS-191005

Heiman, J. R., & Meston, C. M. (1997). Empirically validated treatment for sexual dysfunction. *Annual Review of Sex Research, 8*(1), 148–195. https://doi.org/10.1007/s11930-016-0088-8

Hengartner, M. P., Schulthess, L., Sorensen, A., & Framer, A. (2020). Protracted withdrawal syndrome after stopping antidepressants: a descriptive quantitative analysis of consumer narratives from a large internet forum. *Therapeutic Advances in Psychopharmacology, 10*, 1–13. https://doi.org/10.1177/2045125320980573

Hensley, P. L., & Nurnberg, H. G. (2002). SSRI sexual dysfunction: A female perspective. *Journal of Sex & Marital Therapy, 28*(sup1), 143–153. https://doi.org/10.1080/00926230252851267

Herbenick, D., Bowling, J., Fu, T. J., Dodge, B., Guerra-Reyes, L., & Sanders, S. (2017). Sexual diversity in the United States: Results from a nationally representative probability sample of adult women and men. *PLoS One, 12*(7), e0181198. https://doi.org/10.1371/journal.pone.0181198

Herbenick, D., Fu, T.-C., Arter, J., Sanders, S. A., & Dodge, B. (2018). Women's experiences with genital touching, sexual pleasure, and orgasm: Results from a U.S. probability sample of women ages 18 to 94. *Journal of Sex & Marital Therapy, 44*(2), 201–212. https://doi.org/10.1080/0092623X.2017.1346530

Herbenick, D., Reece, M., Sanders, S., Dodge, B., Ghassemi, A., & Fortenberry, J. D. (2009). Prevalence and characteristics of vibrator use by women in the United States: Results from a nationally representative study. *The Journal of Sexual Medicine, 6*(7), 1857–1866. https://doi.org/10.1111/j.1743-6109.2009.01318.x

Herbenick, D., Reece, M., Schick, V., Sanders, S. A., Dodge, B., & Fortenberry, J. D. (2010). Sexual behavior in the United States: Results from a national probability sample of men and women ages 14–94. *The Journal of Sexual Medicine, 7*, 255–265. https://doi.org/10.1111/j.1743-6109.2010.02012.x

Higgins, A., Sharek, D., Nolan, M., Sheerin, B., Flanagan, P., Slaicuinaite, S., Mc Donnell, S., & Walsh, H. (2012). Mixed methods evaluation of an interdisciplinary sexuality education programme for staff working with people who have an acquired physical disability. *Journal of Advanced Nursing, 68*(11), 2559–2569. https://doi.org/10.1111/j.1365-2648.2012.05959.x

Higgins, J. A., Mullinax, M., Trussell, J., Davidson, S. J. K., & Moore, N. B. (2011). Sexual satisfaction and sexual health among university students in the United States. *American Journal of Public Health, 101*(9), 1643–1654. https://doi.org/10.2105/AJPH.2011.300154

Hinchliff, S., Gott, M., & Galena, E. (2004). GPs' perceptions of the gender-related barriers to discussing sexual health in consultations: A qualitative study. *European Journal of General Practice, 10*(2), 56–60. https://doi.org/10.3109/13814780409094233

Hite, S. (2004). *The Hite report: A nationwide study of female sexuality*. Seven Stories Press.

Hoare, B. S., & Khan, Y. S. (2020). *Anatomy, abdomen and pelvis, female internal genitalia*. StatPearls Publishing. https://www.ncbi.nlm.nih.gov/books/NBK554601/

Humphreys, T. (2017). The state of Canadian sexuality education. *The Journal of Sexual Medicine, 14*(5), e231. https://doi.org/https://doi.org/10.1016/j.jsxm.2017.04.116

Hunter, S. (2014). Female sexual dysfunction or not konwing how to ask for what feels good? *The Conversation*. https://theconversation.com/female-sexual-dysfunction-or-not-knowing-how-to-ask-for-what-feels-good-34651

Hurlbert, D. F., Apt, C., & Rabehl, S. M. (1993). Key variables to understanding female sexual satisfaction: An examination of women in nondistressed marriages. *Journal of Sex & Marital Therapy, 19*(2), 154–165. https://doi.org/10.1080/00926239308404899

Hurlbert, D. F., White, L. C., Powell, R. D., & Apt, C. (1993). Orgasm consistency training in the treatment of women reporting hypoactive sexual desire: An outcome comparison of women-only groups and couples-only groups. *Journal of Behavior Therapy and Experimental Psychiatry, 24*(1), 3–13. https://doi.org/10.1016/0005-7916(93)90003-F

Ibine, B., Sefakor Ametepe, L., Okere, M., & Anto-Ocrah, M. (2020). "I did not know it was a medical condition": Predictors, severity and help seeking behaviors of women with female sexual dysfunction in the Volta region of Ghana. *PloS One, 15*(1), 1–25. https://doi.org/10.1371/journal.pone.0226404

Jackowich, R. A., Boyer, S. C., Bienias, S., Chamberlain, S., & Pukall, C. F. (2021). Healthcare experiences of individuals with persistent genital arousal disorder/genito-pelvic dysesthesia. *Sexual Medicine, 9*(3), 100335. https://doi.org/https://doi.org/10.1016/j.esxm.2021.100335

Jackowich, R. A., & Pukall, C. F. (2020a). Persistent genital arousal disorder: A biopsychosocial framework. *Current Sexual Health Reports, 12*(3), 127–135. https://doi.org/10.1007/s11930-020-00268-2

Jackowich, R. A., & Pukall, C. F. (2020b). Prevalence of persistent penital arousal disorder in 2 North American samples. *The Journal of Sexual Medicine, 17*(12), 2408–2416. https://doi.org/10.1016/j.jsxm.2020.09.004

Jackowich, R. A., Pukall, C. F., & Goldstein, I. (2021). Persistent genital arousal disorder. In A. T. Goldstein (Ed.), *Female Sexual Pain Disorders: Evaluation and Management* (2nd ed.). John Wiley & Sons Ltd.

Jackson, G. (2019, November 13). The female problem: How male bias in medical trials ruined women's health. *The Guardian*. https://www.theguardian.com/lifeandstyle/2019/nov/13/the-female-problem-male-bias-in-medical-trials

Jackson, M. (1984). Sex research and the construction of sexuality: A tool of male supremacy? *Women's Studies International Forum, 7*(1), 43–51. https://doi.org/10.1016/0277-5395(84)90083-9

Jadan, P. (2016, March). *Tight does not equal strong*. Retrieved March 22, 2021, from https://thrivenowphysio.com/tight-does-not-equal-strong/

Jannini, E. A., Buisson, O., & Rubio-Casillas, A. (2014). Beyond the G-spot: Clitourethrovaginal complex anatomy in female orgasm. *Nature Reviews Urology, 11*(9), 531–538. https://doi.org/10.1038/nrurol.2014.193

Jannini, E. A., Wise, N., Frangos, E., & Komisaruk, B. R. (2018). Peripheral and central neural bases of orgasm. In I. Goldstein, A. H. Clayton, A. T. Goldstein, N. N. Kim, & S. A. Kingsberg (Eds.), *Textbook of female sexual function and dysfunction: Diagnosis and treatment* (pp. 179–198). John Wiley & Sons.

Jantos, M., & White, G. (1997). The vestibulitis syndrome. Medical and psychosexual assessment of a cohort of patients. *The Journal of Reproductive Medicine, 42*(3), 145–152.

Jawed-Wessel, S. (2016, October 8). *The lies we tell pregnant women*. TEDxOmaha. https://www.ted.com/talks/sofia_jawed_wessel_the_lies_we_tell_pregnant_women

Jones, H. W., & Rock, J. A. (2015). *Te Linde's operative gynecology* (11th ed.). Wolters Kluwer.

Kaplan, H. S. (1979). *Disorders of sexual desire and other new concepts and techniques in sex therapy*. Brunner/Mazel.

Karney, B. R., & Bradbury, T. N. (1995). The longitudinal course of marital quality and stability: A review of theory, method, and research. *Psychological Bulletin, 118*(1), 3–34. https://doi.org/10.1037/0033-2909.118.1.3

Katz, S. R. (1995). *The experience of chronic vulvar pain: Psychosocial dimensions and the sense of self* (Publication Number 304260795) [Doctoral dissertation, The Fielding Institute]. ProQuest Dissertations & Theses A&I.

Kaviani, M., Rahnavard, T., Azima, S., Emamghoreishi, M., Asadi, N., & Sayadi, M. (2014). The effect of education on sexual health of women with hypoactive sexual desire disorder: A randomized controlled trial. *International Journal of Community Based Nursing and Midwifery, 2*(2), 94–102.

Kelly, M. P., Strassberg, D. S., & Turner, C. M. (2004). Communication and associated relationship issues in female anorgasmia. *Journal of Sex & Marital Therapy, 30*(4), 263–276. https://doi.org/10.1080/00926230490422403

Kerner, I. (2010). *She comes first: The thinking man's guide to pleasuring a woman*. HarperCollins Publishers.

Khajehei, M., Doherty, M., & Tilley, P. J. M. (2015). An update on sexual function and dysfunction in women [Report]. *Archives of Women's Mental Health, 18*(3), 423–433. https://doi.org/10.1007/s00737-015-0535-y

Kingsberg, S. (2020, March 5-8). *NAMS lecture: Sex, drugs, and rock and roll* [Conference session]. ISSWSH Annual Meeting, Orlando, FL, United States. http://www.isswshmeeting.org

Kingsberg, S. A. (2014). Attitudinal survey of women living with low sexual desire. *Journal of Women's Health, 23*(10), 817–823. https://doi.org/10.1089/jwh.2014.4743

Kingsberg, S. A., & Althof, S. E. (2018). Psychological management of hypoactive sexual desire disorder. In I. Goldstein, A. H. Clayton, A. T. Goldstein, N. N. Kim, & S. A. Kingsberg (Eds.), *Textbook of female sexual function and dysfunction: Diagnosis and treatment* (pp. 53–57). John Wiley & Sons.

Kingsberg, S. A., & Rezaee, R. L. (2013). Hypoactive sexual desire in women. *Menopause, 20*(12), 1284–1300. https://doi.org/10.1097/gme.0000000000000131

Kinsey, A. C., Pomeroy, W. B., Martin, C. E., & Gabhard, P. H. (1953). *Sexual behavior in the human female*. Saunders.

Komisaruk, B. R., & Lee, H. J. (2012). Prevalence of sacral spinal (Tarlov) cysts in persistent genital arousal disorder. *The Journal of Sexual Medicine, 9*(8), 2047–2056. https://doi.org/10.1111/j.1743-6109.2012.02765.x

Kreinin, T. (2002). Pleasure is ultimate secret of sexuality. *SIECUS Report, 30*(4), 5–6.

Laan, E., & Both, S. (2008). What makes women experience desire? *Feminism & Psychology, 18*(4), 505–514. https://doi.org/10.1177/0959353508095533

Laan, E., & Rellini, A. H. (2011). Can we treat anorgasmia in women? The challenge to experiencing pleasure. *Sexual and Relationship Therapy, 26*(4), 329–341. https://doi.org/10.1080/14681994.2011.649691

Laumann, E. O., Gagnon, J. H., Michael, R. T., & Michaels, S. (1994). *The social organization of sexuality: Sexual practices in the United States*. University of Chicago Press.

Laumann, E. O., Glasser, D. B., Neves, R. C. S., Moreira, E. D., Jr., & GSSAB Investigators' Group. (2009). A population-based survey of sexual activity, sexual problems and associated help-seeking behavior patterns in mature adults in the United States of America [Survey]. *International Journal of Impotence Research, 21*(3), 171–178. https://doi.org/10.1038/ijir.2009.7

Laumann, E. O., Paik, A., Glasser, D. B., Kang, J.-H., Wang, T., Levinson, B., Moreira Jr, E. D., Nicolosi, A., & Gingell, C. (2006). A cross-national study of subjective sexual well-being among older women and men: Findings from the Global Study of Sexual Attitudes and Behaviors. *Archives of Sexual Behavior, 35*(2), 143–159. https://doi.org/10.1007/s10508-005-9005-3

Laumann, E. O., Paik, A., & Rosen, R. C. (1999). Sexual dysfunction in the United States: Prevalence and predictors. *Journal of the American Medical Association, 281*(6), 537–544. https://doi.org/10.1001/jama.281.6.537

Lawrance, K.-A., & Byers, E. S. (1995). Sexual satisfaction in long-term heterosexual relationships: The interpersonal exchange model of sexual satisfaction. *Personal Relationships, 2*(4), 267–285. https://doi.org/10.1111/j.1475-6811.1995.tb00092.x

Leiblum, S. R. (2001). An established medical school human sexuality curriculum: Description and evaluation. *Sexual and Relationship Therapy, 16*(1), 59–70. https://doi.org/10.1080/14681990020021566

Lerner, H. E. (1976). Parental mislabeling of female genitals as a determinant of penis envy and learning inhibitions in women. *Journal of the American Psychoanalytic Association, 24*(5 Suppl.), 269–283.

LeVay, S., Baldwin, J. I., & Baldwin, J. D. (2019). *Discovering human sexuality* (4th ed.). Sinauer Associates.

Levesque, R. J. R. (2011). Masturbation. In R. J. R. Levesque (Ed.), *Encyclopedia of Adolescence* (Vol. 3, pp. 1654–1655). Springer. https://doi.org/10.1007/978-1-4419-1695-2_565

Levin, R. J. (2019). The clitoris—An appraisal of its reproductive function during the fertile years: Why was it, and still is, overlooked in accounts of female sexual arousal. *Clinical Anatomy, 33*(1), 136–145. https://doi.org/10.1002/ca.23498

Levin, R. J., & van Berlo, W. (2004). Sexual arousal and orgasm in subjects who experience forced or non-consensual sexual stimulation – a review. *Journal of Clinical Forensic Medicine, 11*(2), 82–88. https://doi.org/10.1016/j.jcfm.2003.10.008

Levy, M. (2010). *Man, Woman* [Sculpture]. http://bjdejong.squarespace.com/blog/tag/miller-levy

Lindau, S. T., Schumm, L. P., Laumann, E. O., Levinson, W., O'Muircheartaigh, C. A., & Waite, L. J. (2007). A study of sexuality and health among older adults in the United States. *The New England Journal of Medicine, 357*(8), 762–774. https://doi.org/10.1056/NEJMoa067423

Lindberg, L. D., Maddow-Zimet, I., & Boonstra, H. (2016). Changes in adolescents' receipt of sex education, 2006–2013. *Journal of Adolescent Health, 58*(6), 621–627. https://doi.org/10.1016/j.jadohealth.2016.02.004

Lips, H. M. (2020). Sexual lives and orientations. In *Sex and gender: An introduction* (pp. 265–320). Waveland Press, Inc.

Lloyd, E. A. (2005). *The case of the female orgasm: Bias in the science of evolution*. Harvard University Press.

Loofbourow, L. (2018, January 25). The female price of male pleasure. *The Week*. https://theweek.com/articles/749978/female-price-male-pleasure

Lou, W.-J., Chen, B., Zhu, L., Han, S.-M., Xu, T., Lang, J.-H., & Zhang, L. (2017). Prevalence and factors associated with female sexual dysfunction in Beijing, China. *中华医学杂志：英文版 (Chinese Medical Journal), 130*(12), 1389–1394. https://doi.org/10.4103/0366-6999.207466

MacNeil, S., & Byers, E. S. (1997). The relationships between sexual problems, communication, and sexual satisfaction. *The Canadian Journal of Human Sexuality, 6*(4), 277–283.

Marcus, B. S. (2011). Changes in a woman's sexual experience and expectations following the introduction of electric vibrator assistance. *The Journal of Sexual Medicine, 8*(12), 3398–3406. https://doi.org/10.1111/j.1743-6109.2010.02132.x

Martz, G. (2004). Masturbation. In S. Loue & M. Sajatovic (Eds.), *Encyclopedia of Women's Health* (pp. 396–397). Kluwer Academic/Plenum Publishers. http://ezproxy.uleth.ca/login?url=https://search.credoreference.com/content/entry/sprwh/masturbation/0?institutionId=2649

Marwick, C. (1999). Survey says patients expect little physician help on sex. *Journal of the American Medical Association, 281*(23), 2173–2174. https://doi.org/10.1001/jama.281.23.2171c

Masheb, R. M., Brondolo, E., & Kerns, R. D. (2002). A multidimensional, case-control study of women with self-identified chronic vulvar pain. *Pain Medicine, 3*(3), 253–259. https://doi.org/10.1046/j.1526-4637.2002.02032.x

Masters, W. H., & Johnson, V. E. (1966). *Human sexual response* (1st ed.). Little, Brown.

Masters, W. H., & Johnson, V. E. (1970). *Human sexual inadequacy* (1st ed.). Little, Brown.

Matlin, M. W. (2012). *The psychology of women* (7th ed.). Wadsworth.

McCabe, M. P., Sharlip, I. D., Atalla, E., Balon, R., Fisher, A. D., Laumann, E., Lee, S. W., Lewis, R., & Segraves, R. T. (2016). Definitions of sexual dysfunctions in women and men: A consensus statement from the Fourth International Consultation on Sexual Medicine 2015. *The Journal of Sexual Medicine, 13*(2), 135–143. https://doi.org/10.1016/j.jsxm.2015.12.019

McClelland, S. I. (2009). *Intimate justice: Sexual satisfaction in young adults* (Publication Number UMI Microform 3365820) The City University of New York]. ProQuest Dissertations & Theses A&I. New York, NY.

McCool, M. E., Apfelbacher, C., Brandstetter, S., Mottl, M., & Loss, J. (2016). Diagnosing and treating female sexual dysfunction: A survey of the perspectives of obstetricians and gynaecologists. *Sexual Health, 13*(3), 234–240. https://doi.org/10.1071/SH15187

McInturff, K. (2016). *The best and worst places to be a woman in Canada 2016: The gender gap in Canada's 25 biggest cities* [PDF]. Canadian Centre for Policy Alternatives. https://www.policyalternatives.ca/sites/default/files/uploads/publications/National%20Office/2016/10/Best_and_Worst_Places_to_Be_a_Woman2016.pdf

McPhillips, K., Braun, V., & Gavey, N. (2001). Defining (hetero)sex: How imperative is the "coital imperative"? *Women's Studies International Forum, 24*(2), 229–240. https://doi.org/10.1016/S0277-5395(01)00160-1

Meana, M., Binik, Y. M., Khalife, S., & Cohen, D. R. (1997). Biopsychosocial profile of women with dyspareunia. *Obstetrics and Gynecology, 90*(4, Pt. 1), 583–589. https://doi.org/10.1016/s0029-7844(98)80136-1

MEDS Pharmacy. (n.d.). *FAQ's*. Retrieved April 28, 2021, from https://www.medspharmacy.ca/faqs

Meston, C. M., Levin, R. J., Sipski, M. L., Hull, E. M., & Heiman, J. R. (2004). Women's orgasm. *Annual Review of Sex Research, 15*, 173–257. http://citeseerx.ist.psu.edu/viewdoc/download?doi=10.1.1.361.2552&rep=rep1&type=pdf

Meston, C. M., & Stanton, A. M. (2019). Understanding sexual arousal and subjective-genital arousal desynchrony in women. *Nature Reviews Urology*. https://doi.org/10.1038/s41585-018-0142-6

Milbrand, L. (2020). *12 things sex therapists wish you knew*. Retrieved January 20, 2021, from https://www.thehealthy.com/sex/things-sex-therapists-wish-you-knew/

Miller, S. A., & Byers, E. S. (2008). An exploratory examination of the sexual intervention self-efficacy of clinical psychology graduate students. *Training and Education in Professional Psychology, 2*(3), 137–144. https://doi.org/10.1037/1931-3918.2.3.137

Miller, S. A., & Byers, E. S. (2009). Psychologists' continuing education and training in sexuality. *Journal of Sex & Marital Therapy, 35*(3), 206–219. https://doi.org/10.1080/00926230802716336

Miller, S. A., & Byers, E. S. (2010). Psychologists' sexual education and training in graduate school. *Canadian Journal of Behavioural Science, 42*(2), 93–100. https://doi.org/10.1037/a0018571

Mintz, L. (2015, October 4). The orgasm gap: Simple truth & sexual solutions. *Psychology Today*. https://www.psychologytoday.com/gb/blog/stress-and-sex/201510/the-orgasm-gap-simple-truth-sexual-solutions

Mintz, L. (2017). *Becoming cliterate: Why orgasm equality matters—and how to get it*. Harper Collins.

Mitchell, K. R., Geary, R., Graham, C. A., Datta, J., Wellings, K., Sonnenberg, P., Field, N., Nunns, D., Bancroft, J., Jones, K. G., Johnson, A. M., & Mercer, C. H. (2017). Painful sex (dyspareunia) in women: Prevalence and associated factors in a British population probability survey. *British Journal of Obstetrics and Gynaecology, 124*(11), 1689–1697. https://doi.org/10.1111/1471-0528.14518

Mitchell, K. R., Jones, K. G., Wellings, K., Johnson, A. M., Graham, C. A., Datta, J., Copas, A. J., Bancroft, J., Sonnenberg, P., Macdowall, W., Field, N., & Mercer, C. H. (2016). Estimating the prevalence of sexual function problems: The impact of morbidity criteria. *The Journal of Sex Research, 53*(8), 955–967. https://doi.org/10.1080/00224499.2015.1089214

Moore, T. (2018). Why some women don't masturbate. *Mel*. https://melmagazine.com/en-us/story/why-some-women-dont-masturbate

Moreau, C., Kågesten, A. E., & Blum, R. W. (2016). Sexual dysfunction among youth: An overlooked sexual health concern. *BMC Public Health, 16*(1), 1170–1170. https://doi.org/10.1186/s12889-016-3835-x

Moreira, E. D., Brock, G., Glasser, D. B., Nicolosi, A., Laumann, E. O., Paik, A., Wang, T., Gingell, C., & GSSAB Investigators' Group. (2005). Help-seeking behaviour for sexual problems: The Global Study of Sexual Attitudes and Behaviors. *International Journal of Clinical Practice, 59*(1), 6–16. https://doi.org/10.1111/j.1742-1241.2005.00382.x

Morgan, C. (2020, February 27). Wife claims most women TOLERATE sex as an 'obligation' to stop their partner from 'straying' – but critics claim her husband must 'not be doing it right'. *Daily Mail*. https://www.dailymail.co.uk/femail/article-8051301/Woman-claims-mose-females-TOLERATE-sex-relationships.html

Muehlenhard, C. L., & Shippee, S. K. (2010). Men's and women's reports of pretending orgasm. *The Journal of Sex Research, 47*(6), 552–567. https://doi.org/10.1080/00224490903171794

Nagoski, E. (2015). *Come as you are: The surprising new science that will transform your sex life*. Simon and Schuster.

Nappi, R. E., Cucinella, L., Martella, S., Rossi, M., Tiranini, L., & Martini, E. (2016). Female sexual dysfunction (FSD): Prevalence and impact on quality of life (QoL). *Maturitas, 94*, 87–91. https://doi.org/10.1016/j.maturitas.2016.09.013

Nappi, R. E., Kingsberg, S., Maamari, R., & Simon, J. (2013). The CLOSER (CLarifying Vaginal Atrophy's Impact On SEx and Relationships) Survey: Implications of vaginal discomfort in postmenopausal women and in male partners. *The Journal of Sexual Medicine, 10*(9), 2232–2241. https://doi.org/10.1111/jsm.12235

Nathan, S. G. (1986). Are clinical psychology graduate students being taught enough about sexuality? A survey of doctoral programs. *The Journal of Sex Research, 22*(4), 520–524. https://doi.org/10.1080/00224498609551332

Nguyen, J., & Duong, H. (2020). *Anatomy, abdomen and pelvis, female external genitalia*. StatPearls Publishing. https://www.ncbi.nlm.nih.gov/books/NBK547703/

Nicolosi, A., Laumann, E. O., Glasser, D. B., Brock, G., King, R., Gingell, C., & GSSAB Investigators' Group. (2006). Sexual activity, sexual disorders and associated help-

seeking behavior among mature adults in five anglophone countries from the Global Survey of Sexual Attitudes and Behaviors (GSSAB). *Journal of Sex & Marital Therapy, 32*(4), 331–342. https://doi.org/10.1080/00926230600666469

NuGyn Inc. (n.d.-a). *Eros device | NuGyn Eros-Therapy | Female sexual dysfunction*. Retrieved December 11, 2017, from http://eros-therapy.com/products-page/eros-products/eros-therapy-device/

NuGyn Inc. (n.d.-b). *For healthcare providers*. Retrieved July 7, 2020, from https://eros-therapy.com/for-healthcare-providers/

Nusbaum, M. R. H., Helton, M. R., & Ray, N. (2004). The changing nature of women's sexual health concerns through the midlife years. *Maturitas, 49*(4), 283–291. https://doi.org/10.1016/j.maturitas.2004.06.014

Nylanderlundqvist, E., & Bergdahl, J. (2003). Vulvar vestibulitis: Evidence of depression and state anxiety in patients and partners. *Acta Dermato-Venereologica, 83*(5), 369–373. https://doi.org/10.1080/00015550310003764

O'Connell, H. E., Eizenberg, N., Rahman, M., & Cleeve, J. (2008). The anatomy of the distal vagina: Towards unity. *The Journal of Sexual Medicine, 5*(8), 1883–1891. https://doi.org/10.1111/j.1743-6109.2008.00875.x

O'Connell, H. E., Hutson, J. M., Anderson, C. R., & Plenter, R. J. (1998). Anatomical relationship between urethra and clitoris. *The Journal of Urology, 159*(6), 1892–1897. https://doi.org/10.1016/S0022-5347(01)63188-4

Oaklander, A. L., Sharma, S., Kessler, K., & Price, B. H. (2020). Persistent genital arousal disorder: A special sense neuropathy. *Pain Reports, 5*(1), e801-e801. https://doi.org/10.1097/PR9.0000000000000801

Oakley, S. H., Mutema, G. K., Crisp, C. C., Estanol, M. V., Kleeman, S. D., Fellner, A. N., & Pauls, R. N. (2013). Innervation and histology of the clitoral–urethal complex: A cross-sectional cadaver study. *The Journal of Sexual Medicine, 10*(9), 2211–2218. https://doi.org/10.1111/jsm.12230

Ogletree, S. M., & Ginsburg, H. J. (2000). Kept under the hood: Neglect of the clitoris in common vernacular. *Sex Roles, 43*(11), 917–926. https://doi.org/10.1023/A:1011093123517

OHCHR, UNAIDS, UNDP, UNECA, UNESCO, UNFPA, UNHCR, UNICEF, UNIFEM, & WHO. (2008). *Eliminating female genital mutilation: An interagency statement*. https://apps.who.int/iris/bitstream/handle/10665/43839/9789241596442_eng.pdf

Ohl, L. E. (2007). Essentials of female sexual dysfunction from a sex therapy perspective. *Urologic Nursing, 27*(1), 57–64. http://0-search.ebscohost.com.aupac.lib.athabascau.ca/login.aspx?direct=true&db=rzh&AN=106273025&site=eds-live (CNE Series)

Orenstein, P. (2016a). *Girls & sex: Navigating the complicated new landscape* (1st ed.). Harper.

Orenstein, P. (2016b, October 26). *What young women believe about their own sexual pleasure* [Video]. TED Conferences. https://www.ted.com/talks/peggy_orenstein_what_young_women_believe_about_their_own_sexual_pleasure?language=en

Parish, S. J., Cottler-Casanova, S., Clayton, A. H., McCabe, M. P., Coleman, E., & Reed, G. M. (2020). The evolution of the female sexual disorder/dysfunction definitions, nomenclature, and classifications: A review of DSM, ICSM, ISSWSH, and ICD. *Sexual Medicine Reviews*, Advance online publication. https://doi.org/10.1016/j.sxmr.2020.05.001

Parish, S. J., Goldstein, A. T., Goldstein, S. W., Goldstein, I., Pfaus, J., Clayton, A. H., Giraldi, A., Simon, J. A., Althof, S. E., Bachmann, G., Komisaruk, B., Levin, R., Spadt, S. K., Kingsberg, S. A., Perelman, M. A., Waldinger, M. D., & Whipple, B. (2016). Toward a more evidence-based nosology and nomenclature for female sexual dysfunctions—Part II. *The Journal of Sexual Medicine, 13*(12), 1888–1906. https://doi.org/10.1016/j.jsxm.2016.09.020

Parish, S. J., Meston, C. M., Althof, S. E., Clayton, A. H., Goldstein, I., Goldstein, S. W., Heiman, J. R., McCabe, M. P., Segraves, R. T., & Simon, J. A. (2019). Toward a more evidence-based nosology and nomenclature for female sexual dysfunctions—Part III. *The Journal of Sexual Medicine, 16*(3), 452–462. https://doi.org/10.1016/j.jsxm.2019.01.010

Pascoal, P. M. (2017). Directed masturbation. In A. Wenzel (Ed.), *The SAGE encyclopedia of abnormal and clinical psychology* (Vol. 3, pp. 1108–1110). SAGE Reference.

Pauls, R. N., Kleeman, S. D., Segal, J. L., Silva, W. A., Goldenhar, L. M., & Karram, M. M. (2005). Practice patterns of physician members of the American Urogynecologic Society regarding female sexual dysfunction: Results of a national survey. *International Urogynecology Journal, 16*(6), 460–467. https://doi.org/10.1007/s00192-005-1286-5

Peixoto, M. M., & Nobre, P. (2015). Prevalence of sexual problems and associated distress among lesbian and heterosexual women. *Journal of Sex & Marital Therapy, 41*(4), 427–439. https://doi.org/10.1080/0092623X.2014.918066

Peplau, L. A., Rubin, Z., & Hill, C. T. (1977). Sexual intimacy in dating relationships. *Journal of Social Issues, 33*(2), 86–109. https://doi.org/10.1111/j.1540-4560.1977.tb02007.x

Perelman, M. A. (2009). The Sexual Tipping Point®: A mind/body model for sexual medicine. *The Journal of Sexual Medicine, 6*(3), 629–632. https://doi.org/10.1111/j.1743-6109.2008.01177.x

Pfaus, J. G. (2009). Pathways of sexual desire. *The Journal of Sexual Medicine, 6*(6), 1506. https://doi.org/10.1111/j.1743-6109.2009.01309.x

Pfaus, J. G., & Jones, S. L. (2018). Central nervous system anatomy and neurochemistry. In I. Goldstein, A. H. Clayton, A. T. Goldstein, N. N. Kim, & S. A. Kingsberg (Eds.), *Textbook of female sexual function and dysfunction: Diagnosis and treatment* (pp. 25–52). John Wiley & Sons Ltd.

PinkCherry. (n.d.). *Clitoral suction stimulator sex toys*. Retrieved July 7, 2020, from https://www.pinkcherry.ca/collections/vibrators-clitoral-suction-stimulation

Planned Parenthood. (n.d.). *Sexual consent*. Retrieved April 29, 2021, from https://www.plannedparenthood.org/learn/relationships/sexual-consent

Planned Parenthood Federation of America. (2003). Masturbation: From myth to sexual health. *Contemporary Sexuality, 37*(3), i–vii.

Pope Paul VI. (1968). *Humanae vitae*. http://w2.vatican.va/content/paul-vi/en/encyclicals/documents/hf_p-vi_enc_25071968_humanae-vitae.html

Post, M. W. M., Gianotten, W. L., Heijnen, L., Lambers, E. J. H. R., & Willems, M. (2008). Sexological competence of cifferent rehabilitation disciplines and effects of a discipline-specific sexological training. *Sexuality and Disability, 26*(1), 3–14. https://doi.org/10.1007/s11195-007-9068-2

Prendergast, S. A., & Rummer, E. H. (2016). *Pelvic pain explained: What everyone needs to know*. Rowman & Littlefield.

PSSD Canada. (n.d.). *Mental health support*. Retrieved May 2, 2021, from https://www.pssdcanada.ca/mentalhealthsupport

Pukall, C. (2021, March 5-7). *Post-SSRI/SNRI sexual dysfunction: A review* [Research presentation]. ISSWSH Annual Meeting, Dallas, TX, United States. https://www.isswshmeeting.org/2021/abstract-page?where_days=3&where_person=57

Pukall, C. F., Goldstein, A. T., Bergeron, S., Foster, D., Stein, A., Kellogg-Spadt, S., & Bachmann, G. (2016). Vulvodynia: Definition, prevalence, impact, and pathophysiological Factors. *The Journal of Sexual Medicine, 13*(3), 291–304. https://doi.org/10.1016/j.jsxm.2015.12.021

Puppo, V. (2013). Anatomy and physiology of the clitoris, vestibular bulbs, and labia minora with a review of the female orgasm and the prevention of female sexual dysfunction. *Clinical Anatomy, 26*(1), 134–152. https://doi.org/10.1002/ca.22177

Quinn-Nilas, C., Milhausen, R. R., McKay, A., & Holzapfel, S. (2018). Prevalence and predictors of sexual problems among midlife Canadian adults: Results from a national survey. *The Journal of Sexual Medicine, 15*(6), 873–879. https://doi.org/10.1016/j.jsxm.2018.03.086

Rape Abuse and Incest National Network. (n.d.). *What consent looks like*. Retrieved April 29, 2021, from https://www.rainn.org/articles/what-is-consent

Rasmussen, M. L. (2012). Pleasure/desire, sexularism and sexuality education. *Sex Education, 12*(4), 469–481. https://doi.org/10.1080/14681811.2012.677204

Reed, B. D., Advincula, A. P., Fonde, K. R., Gorenflo, D. W., & Haefner, H. K. (2003). Sexual activities and attitudes of women with vulvar dysesthesia. *Obstetrics and Gynecology, 102*(2), 325–331. https://doi.org/10.1016/s0029-7844(03)00571-4

Reed, B. D., Legocki, L. J., Plegue, M. A., Sen, A., Haefner, H. K., & Harlow, S. D. (2014). Factors associated with vulvodynia incidence. *Obstetrics and Gynecology, 123*(2 Pt 1), 225–231. https://doi.org/10.1097/AOG.0000000000000066

Reed, B. D., Harlow, S. D., Sen, A., Legocki, L. J., Edwards, R. M., Arato, N., & Haefner, H. K. (2012). Prevalence and demographic characteristics of vulvodynia in a population-based sample. *American Journal of Obstetrics and Gynecology, 206*(2), 170.e1–170.e9. https://doi.org/10.1016/j.ajog.2011.08.012

Regnerus, M., Price, J., & Gordon, D. (2017). Masturbation and partnered sex: Substitutes or complements? *Archives of Sexual Behavior, 46*(7), 2111–2121. https://doi.org/10.1007/s10508-017-0975-8

Rehman, U. S., Fallis, E. E., & Byers, E. S. (2013). Sexual satisfaction in heterosexual women. In D. Castañeda (Ed.), *The essential handbook of women's sexuality* (Vol. 1, pp. 25–45). Praeger.

Reisman, Y. (2017). Sexual consequences of post-SSRI Syndrome. *Sexual Medicine Reviews, 5*(4), 429–433. https://doi.org/10.1016/j.sxmr.2017.05.002

Reissing, E. D., Binik, Y. M., Khalif, S., Cohen, D., & Amsel, R. (2003). Etiological correlates of vaginismus: Sexual and physical abuse, sexual knowledge, sexual self-schema, and relationship adjustment. *Journal of Sex & Marital Therapy, 29*(1), 47–59. https://doi.org/10.1080/713847095

Reissing, E. D., & Di Giulio, G. (2010). Practicing clinical psychologists' provision of sexual health care services. *Professional Psychology: Research and Practice, 41*(1), 57–63. https://doi.org/10.1037/a0017023

Richters, J., de Visser, R., Rissel, C., & Smith, A. (2006). Sexual practices at last heterosexual encounter and occurrence of orgasm in a national survey. *The Journal of Sex Research, 43*(3), 217–226. https://doi.org/10.1080/00224490609552320

Richters, J., de Visser, R. O., Badcock, P. B., Smith, A. M. A., Rissel, C., Simpson, J. M., & Grulich, A. E. (2014). Masturbation, paying for sex, and other sexual activities: The Second Australian Study of Health and Relationships. *Sexual Health, 11*(5), 461–471. https://doi.org/10.1071/SH14116

Robinson, D. B., MacLaughlin, V., & Poole, J. (2019). Sexual health education outcomes within Canada's elementary health education curricula: A summary and analysis. *The Canadian Journal of Human Sexuality, 28*(3), 243–256. https://doi.org/10.3138/cjhs.2018-0036

Roos, A.-M., Thakar, R., Sultan, A. H., & Scheer, I. (2009). Female sexual dysfunction: Are urogynecologists ready for it? *International Urogynecology Journal, 20*(1), 89–101. https://doi.org/10.1007/s00192-008-0735-3

Rosen, R. C., & Barsky, J. L. (2006). Normal sexual response in women. *Obstetrics and Gynecology Clinics of North America, 33*(4), 515–526. https://doi.org/10.1016/j.ogc.2006.09.005

Rosen, R. C., Connor, M. K., Miyasato, G., Link, C., Shifren, J. L., Fisher, W. A., Derogatis, L. R., & Schobelock, M. J. (2012). Sexual desire problems in women seeking healthcare: A novel study design for ascertaining prevalence of hypoactive sexual desire disorder in clinic-based samples of U.S. women. *Journal of Women's Health, 21*(5), 505–515. https://doi.org/10.1089/jwh.2011.3002

Rosen, R. C., Kountz, D., Post-Zwicker, T., Leiblum, S., & Wiegel, M. (2006). Sexual communication skills in residency training: The Robert Wood Johnson Model. *The Journal of Sexual Medicine, 3*, 37–46. https://doi.org/10.1111/j.1743-6109.2005.00135.x

Rubin, R., King, S., Winter, A., Minton, J., Gagnon, C., & Goldstein, I. (2017). In office treatment of clitorodynia: Lysis of clitoral adhesions to adjacent skin following dorsal

nerve block. *The Journal of Sexual Medicine, 14*(6), e362. https://doi.org/10.1016/j.jsxm.2017.04.037

Rubin, R. S. [@rachelsrubin1]. (2017, February 26). *#urologists treat phimosis.Who examines and treats female prepucial issues? #whoownstheclitoris @AmerUrological @jsexmed @ISSWSH @ISSM_INFO* [Tweet]. Retrieved October 5, 2020, from https://twitter.com/rachelsrubin1/status/835884232593522689

Rxisk. (2019, April 1). Assisted dying: Going gentle or not so gentle. *RxISK Blog*. https://rxisk.org/assisted-dying-going-gentle-or-not-so-gentle/

Sackett, S., Gates, E., Heckman-Stone, C., Kobus, A. M., & Galask, R. (2001). Psychosexual aspects of vulvar vestibulitis. *The Journal of Reproductive Medicine, 46*(6), 593–598.

Sadownik, L. A. (2000). Clinical profile of vulvodynia patients. A prospective study of 300 patients. *Journal of Reproductive Medicine, 45*(8), 679–684. https://www.researchgate.net/profile/Leslie_Sadownik/publication/12335011_Clinical_profile_of_vulvodynia_patients_A_prospective_study_of_300_patients/links/5ae7661f0f7e9b837d392b96/Clinical-profile-of-vulvodynia-patients-A-prospective-study-of-300-patients.pdf

Sadownik, L. A., Seal, B. N., & Brotto, L. A. (2012). Provoked vestibulodynia: A qualitative exploration of women's experiences. *British Columbia Medical Journal, 54*(1). https://www.bcmj.org/sites/default/files/public/BCMJ_54_Vol1_provoked.pdf

Sadownik, L. A., Smith, K. B., Hui, A., & Brotto, L. A. (2017). The impact of a woman's dyspareunia and its treatment on her intimate partner: A qualitative analysis. *Journal of Sex & Marital Therapy, 43*(6), 529–542. https://doi.org/10.1080/0092623X.2016.1208697

Safarinejad, M. R. (2006). Female sexual dysfunction in a population-based study in Iran: prevalence and associated risk factors. *International Journal of Impotence Research, 18*(4), 382–395. https://doi.org/10.1038/sj.ijir.3901440

Salisbury, C. M. A., & Fisher, W. A. (2013). "Did you come?" A qualitative exploration of gender differences in beliefs, experiences, and concerns regarding female orgasm occurrence during heterosexual sexual interactions. *The Journal of Sex Research, 51*(6), 616–631. https://doi.org/10.1080/00224499.2013.838934

Sánchez-Fuentes, M. d. M., Santos-Iglesias, P., & Sierra, J. C. (2014). A systematic review of sexual satisfaction. *International Journal of Clinical and Health Psychology, 14*(1), 67–75. https://doi.org/10.1016/S1697-2600(14)70038-9

Sand, M., & Fisher, W. A. (2007). Women's endorsement of models of female sexual response: The nurses' sexuality study. *The Journal of Sexual Medicine, 4*(3), 708−719. https://doi.org/10.1111/j.1743-6109.2007.00496.x

Sansone, R. A., & Wiederman, M. W. (2000). Sexuality training for psychiatry residents: A national survey of training directors. *Journal of Sex & Marital Therapy, 26*(3), 249–256. https://doi.org/10.1080/00926230050084641

Scott, K. (2019). *The best and worst places to be a woman in Canada 2019: The gender gap in Canada's 25 biggest cities* [PDF]. https://www.policyalternatives.ca/sites/default/files/uploads/publications/National%20Office/2019/03/Best%20and%20Worst%20Places%20to%20Be%20a%20Woman%202019.pdf

Segnini, I., & Kukkonen, T. M. (2005). Psychological management of arousal disorders. In I. Goldstein, C. M. Meston, S. Davis, & A. Traish (Eds.), *Women's sexual function and dysfunction: Study, diagnosis and treatment* (pp. 127–144). CRC Press.

Sex and U. (n.d.). *What is consent?* https://www.sexandu.ca/consent/what-is-consent/

Sex Information & Education Council of Canada. (2019). *Canadian guidelines for sexual health education*. http://sieccan.org/wp-content/uploads/2019/06/SIECCAN-Canadian-Guidelines-for-Sexual-Health-Education.pdf

Sex Information & Education Council of Canada. (2020). *Questions & answers: Sexual health education in schools and other settings*. http://sieccan.org/wp-content/uploads/2020/08/Questions-and-Answers-Sexual-Health-Education-in-Schools-and-Other-Settings.pdf

Sexplanations. (2015, July 23). *How to choose a professional* [Video]. YouTube. https://www.youtube.com/watch?v=LCxI-HoDewM

Sharma, J. B., & Kalra, B. (2016). Female sexual dysfunction: Assessment. *Journal of the Pakistan Medical Association, 66*(5), 623–626. http://jpma.org.pk/PdfDownload/7759.pdf

Sheppard, C., Hallam-Jones, R., & Wylie, K. (2008). Why have you both come? Emotional, relationship, sexual and social issues raised by heterosexual couples seeking sexual therapy (in women referred to a sexual difficulties clinic with a history of vulval pain). *Sexual and Relationship Therapy, 23*(3), 217–226. https://doi.org/10.1080/14681990802227974

Shifren, J. L., Johannes, C. B., Monz, B. U., Russo, P. A., Bennett, L., & Rosen, R. (2009). Help-seeking behavior of women with self-reported distressing sexual problems. *Journal of Women's Health, 18*(4), 461–468. https://doi.org/10.1089/jwh.2008.1133

Shifren, J. L., Monz, B. U., Russo, P. A., Segreti, A., & Johannes, C. B. (2008). Sexual problems and distress in United States women: Prevalence and correlates. *Obstetrics and Gynecology, 112*(5), 970–978. https://doi.org/10.1097/AOG.0b013e3181898cdb

Simon, J. A. (2020, March 5-8). *How the US government and the media conspired to convince women that menopausal hormone therapy was dangerous* [Conference session]. ISSWSH Annual Meeting, Orlando, FL, United States. https://www.isswshmeeting.org/2020/program

Smith, K. B., & Pukall, C. F. (2014). Sexual function, relationship adjustment, and the relational impact of pain in male partners of women with provoked vulvar pain. *The Journal of Sexual Medicine, 11*(5), 1283–1293. https://doi.org/10.1111/jsm.12484

Solursh, D. S., Ernst, J. L., Lewis, R. W., Prisant, L. M., Mills, T. M., Solursh, L. P., Jarvis, R. G., & Salazar, W. H. (2003). The human sexuality education of physicians in North American medical schools. *International Journal of Impotence Research, 15*(S5), S41–S45. https://doi.org/10.1038/sj.ijir.3901071

Spolia, T. (2016, February 16). Myth: Girls don't masturbate. *The Gazette*. https://westerngazette.ca/culture/myth-girls-dont-masturbate/article_53f28b68-2f15-11e9-9664-6ff49b961a4f.html

Stanford. (2007, December 12). *What our mothers never taught us: Changes in female sexual function throughout the lifespan* [Video]. YouTube. https://www.youtube.com/watch?v=nlP5rY2pfG0

Statistics Canada. (2013). *National household survey (NHS) profile, 2011* (Catalogue no. 99-004-XWE). http://www12.statcan.gc.ca/nhs-enm/2011/dp-pd/prof/index.cfm?Lang=E

Stein, A. (2009). *Heal Pelvic Pain: The Proven Stretching, Strengthening, and Nutrition*. McGraw-Hill.

Sutherland, O. (2012). Qualitative analysis of heterosexual women's experience of sexual pain and discomfort. *Journal of Sex & Marital Therapy, 38*(3), 223–244. https://doi.org/10.1080/0092623X.2011.606880

Taylor, R. B. (2001). Please don't call me 'provider'. *American Family Physician, 63*(12), 2340–2343. https://www.aafp.org/afp/2001/0615/p2340.html

TEDx Talks. (2016a, October 29). *The pleasure principle: The secret to a better sex life | Laurie Betito | TEDxMontrealWomen* [Video]. YouTube. https://www.youtube.com/watch?v=lnigGtrwAfs

TEDx Talks. (2016b, December 13). *Women's sexuality isn't 'complicated' | Sarah Barmak | TEDxToronto* [Video file]. YouTube. https://www.youtube.com/watch?v=cQqmMVOsriI

TENGA, OCW, & PSB. (2019). *TENGA 2019 self-pleasure report: How Americans masturbate and its role in self-care*. http://www.feelmore.global/wp-content/uploads/2019/05/us_report.pdf

The Alan Guttmacher Institute. (1994). *Uneven and unequal: Insurance coverage and reproductive health services*. Author.

The Asexual Visibility & Education Network. (n.d.-a). *Asexuals and attitudes toward sex*. Retrieved June 10, 2020 from https://www.asexuality.org/?q=attitudes.html

The Asexual Visibility & Education Network. (n.d.-b). *Overview*. Retrieved June 10, 2020, from https://www.asexuality.org/?q=overview.html

The Church of Jesus Christ of Latter-day Saints. (1995, September 23). *The family: A proclamation to the world*. https://www.churchofjesuschrist.org/study/scriptures/the-family-a-proclamation-to-the-world/the-family-a-proclamation-to-the-world?lang=eng

The Church of Jesus Christ of Latter-day Saints. (2011). *For the strength of youth* [PDF]. The Church of Jesus Christ of Latter-day Saints. https://www.lds.org/bc/content/shared/content/english/pdf/ForTheStrengthOfYouth-eng.pdf

The Church of Jesus Christ of Latter-Day Saints. (2018a, September 1). *Alberta - LDS statistics and church facts*. Retrieved September 16, 2020, from https://news-ca.churchofjesuschrist.org/facts-and-statistics/province/alberta

The Church of Jesus Christ of Latter-Day Saints. (2018b, September 1). *Canada - LDS statistics and church facts*. Retrieved September 16, 2020, from https://news-ca.churchofjesuschrist.org/facts-and-statistics/country/canada

The SexMed Advocate [@SexMedAdvocate]. (2020, June 17). ✕ *Please don't tell a female patient that she doesn't need surgery right now to fix her vulvar PAIN...because she* [GIF attached; Tweet]. Twitter. Retrieved June 17, 2020, from https://twitter.com/SexMedAdvocate/status/1273273369232900096

The SexMed Advocate [@SexMedAdvocate]. (2021). *A depressing thread popped up today in one of the #vestibulodynia support groups. Patients are saying how many years, doctors* [Tweet]. Retrieved March 3, 2021, from https://twitter.com/SexMedAdvocate/status/1367196802793963520

The Vatican. (n.d.). *Catechism of the Catholic Church. Part three: Life in Christ. Section two: The ten commandmaents. Chapter two: "You shall love your neighbour as yourself." Article 6: The sixth commandment.* http://www.vatican.va/archive/ccc_css/archive/catechism/p3s2c2a6.htm

Things I Learned Researching Sex [@Things1Learned]. (2021, March 7). *Dr. Irwin Goldstein of @SDSexualMed responded: We are also studying #PSSD - the key to us is that despite the #anxiety* [Tweet]. https://twitter.com/Things1Learned/status/1368644181564948481

Thomas, H. N., & Thurston, R. C. (2016). A biopsychosocial approach to women's sexual function and dysfunction at midlife: A narrative review. *Maturitas, 87*, 49–60. https://doi.org/10.1016/j.maturitas.2016.02.009

Thomtén, J. (2014). Living with genital pain: Sexual function, satisfaction, and help-seeking among women living in Sweden. *Scandinavian Journal of Pain, 5*(1), 19–25. https://doi.org/10.1016/j.sjpain.2013.10.002

Tight Lipped [@TightLippedPod]. (2021, April 5). *My vagina hurts | as a gynecologist, this is outside my scope | Your bill is 60,000* [Tweet]. https://twitter.com/TightLippedPod/status/1379190916800466971

Tolman, D. L. (1994). Doing desire: Adolescent girls' struggles for/with sexuality. *Gender & Society, 8*(3), 324–342. https://doi.org/10.1177/089124394008003003

TVO. (2007, July 1). *Elisabeth Lloyd on the case of the female orgasm* [Video]. Big Ideas. https://www.tvo.org/video/archive/elisabeth-lloyd-on-the-case-of-the-female-orgasm

Tyagi, V., Scordo, M., Yoon, R. S., Liporace, F. A., & Greene, L. W. (2017). Revisiting the role of testosterone: Are we missing something? *Reviews in Urology, 19*(1), 16–24. https://doi.org/10.3909/riu0716

van Lankveld, J. J., Weijenborg, P. T., & ter Kuile, M. M. (1996). Psychologic profiles of and sexual function in women with vulvar vestibulitis and their partners. *Obstetrics and Gynecology, 88*(1), 65–70. https://www.academia.edu/1828260/Psychologic_profiles_of_and_sexual_function_in_women_with_vulvar_vestibulitis_and_their_partners

Vancouver Coastal Health. (n.d.). *BC Centre for Sexual Medicine (BCCSM) - VGH Hospital*. Retrieved October 6, 2020, from http://www.vch.ca/Locations-Services/result?res_id=353

Verrastro, V., Saladino, V., Petruccelli, F., & Eleuteri, S. (2020). Medical and health care professionals' sexuality education: State of the art and recommendations. *International Journal of Environmental Research and Public Health, 17*(7), 1–11. https://doi.org/10.3390/ijerph17072186

Volpe, A. (2019, April 22). The enduring myth of 'complicated' female sexuality. *Elemental*. https://elemental.medium.com/the-enduring-myth-of-complicated-female-sexuality-736db9233fd0

Vulvar Healing [@healingvulva]. (2021, March 25). *Enough said* [Instagram image]. Retrieved March 25, 2021, from https://www.instagram.com/p/CM1IoYkAxrC/

Wade, L. D., Kremer, E. C., & Brown, J. (2005). The incidental orgasm: The presence of clitoral knowledge and the absence of orgasm for women. *Women & Health, 42*(1), 117–138. https://doi.org/10.1300/j013v42n01_07

Wallin, P. (1960). A study of orgasm as a condition of women's enjoyment of intercourse. *The Journal of Social Psychology, 51*(1), 191–198. https://doi.org/10.1080/00224545.1960.9922028

Waterman, C. K., & Chiauzzi, E. J. (1982). The role of orgasm in male and female sexual enjoyment. *The Journal of Sex Research, 18*(2), 146–159. https://doi.org/10.1080/00224498209551145

Weerakoon, P., & Stiernborg, M. (1996). Sexuality education for health care professionals: A critical review of the literature. *Annual Review of Sex Research, 7*(1), 181–217. http://search.ebscohost.com/login.aspx?direct=true&db=a9h&AN=9705250162&site=ehost-live&scope=site

Wetzel, G. (2018, February 3). *Let's talk about sex: The reality of the sexual pleasure disparity* [Video]. TEDxStLawrenceU. https://www.ted.com/talks/grace_wetzel_let_s_talk_about_sex_the_reality_of_the_sexual_pleasure_disparity/transcript?language=en

White, G., & Jantos, M. (1998). Sexual behavior changes with vulvar vestibulitis syndrome. *Journal of Reproductive Medicine, 43*(9), 783–789.

Wiederman, M. W., & Sansone, R. A. (1999). Sexuality training for professional psychologists: A national survey of training directors of doctoral programs and

predoctoral internships. *Professional Psychology: Research and Practice, 30*(3), 312–317. https://doi.org/10.1037//0735-7028.30.3.312

Winston, S. (2010). *Women's anatomy of arousal*. Mango Garden Press.

Wojnarowska, F. (1997). Psychological characteristics and outcome of patients attending a clinic for vulval disease. *Journal of the European Academy of Dermatology and Venereology, 8*(2), 121–129. https://doi.org/10.1016/S0926-9959(96)00574-0

World Health Organization. (2006). *Defining sexual health: Report of a technical consultation on sexual health, January 28-31, 2002, Geneva*. https://www.who.int/reproductivehealth/topics/gender_rights/defining_sexual_health/en/

World Health Organization. (2018). *International classification of diseases for mortality and morbidity statistics*. https://icd.who.int/

World Health Organization, & UNFPA. (2010). *Measuring sexual health: Conceptual and practical considerations and related indicators* [PDF]. https://www.who.int/reproductivehealth/publications/monitoring/who_rhr_10.12/en/

Wright, J. J., & O'Connor, K. M. (2015). Female sexual dysfunction. *The Medical Clinics of North America, 99*(3), 607–628. https://doi.org/10.1016/j.mcna.2015.01.011

Xie, Y., Shi, L., Xiong, X., Wu, E., Veasley, C., & Dade, C. (2012). Economic burden and quality of life of vulvodynia in the United States. *Current Medical Research & Opinion, 28*(4), 601–608. https://doi.org/10.1185/03007995.2012.666963

Yee, B. Y. (2019). Time to stop labeling physicians as providers. *Forbes*. https://www.forbes.com/sites/brucelee/2019/05/05/time-to-stop-labeling-physicians-as-providers/

Yule, M. A., Brotto, L. A., & Gorzalka, B. B. (2017). Sexual fantasy and masturbation among asexual individuals: An in-depth exploration. *Archives of Sexual Behavior, 46*(1), 311–328. https://doi.org/10.1007/s10508-016-0870-8

Zippan, N., Stephenson, K. R., & Brotto, L. A. (2020). Feasibility of a brief online psychoeducational intervention for women with sexual interest/arousal disorder. *The Journal of Sexual Medicine, 17*(11), 2208–2219. https://doi.org/10.1016/j.jsxm.2020.07.086