# 1 Introduction, Epidemiology and Etiology of Sexual Dysfunctions in Men and Women

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**Abstract**

The epidemiology and etiology of male and female sexual dysfunctions should be addressed within a comprehensive biopsychosocial perspective. This perspective considers the interaction between the organic, psychological and cultural factors shaping human sexual response and functioning, allowing for more complete and tailored interventions. In this chapter, we will provide an overview of the epidemiology and etiology of male and female sexual dysfunctions, considering their position within a medical and a psychosocial framework, and further present evidence-based etiological and maintenance factors specific to men and women's sexual difficulties. We also discuss the interplay of the medical and psychosocial spaces and how both spaces can improve healthcare in the context of sexual dysfunctions. We stress current limitations in the field of epidemiology and etiology of sexual dysfunctions, such as the great gap in evidence regarding sexual and gender minorities, or the lack of a cultural frame regarding how epidemiology and etiology have been approached in sexual dysfunctions research.

## Sexual Dysfunctions in the Biopsychosocial Context

Sexual dysfunctions in men and women are believed to be better approached by a biopsychosocial perspective. This perspective brings together the organic, psychological, and social components of sexuality, considering their interaction in the

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etiology, maintenance, and adaptation to sexual dysfunctions. The definition of sexual health established by the World Health Organization (WHO) has greatly contributed to the communication and partnership between different scientific areas. The concept of sexual health, defined as a state of physical, emotional, mental, and social well-being in the way individuals experience their sexuality, rather than the mere absence of physical illness or dysfunction [1], has promoted the dialog between medical and social sciences. This biopsychosocial perspective leads us to the understanding of the individuals in their context, which necessarily involves the consideration of background variables, including individuals' historical and even political scene, in the expression of sexual difficulties and their treatment. Currently, several scientific and professional organizations embrace this biopsychosocial dimension, which has echoed in the way we look at the etiology and/or maintenance of sexual dysfunctions. The etiological aspects are paramount in the way we design the therapeutic plan; an integrative view of the organic, psychological, and social aspects regarding the etiology of sexual dysfunctions will result in a more careful and refined analysis of the predisposition and maintenance mechanisms of sexual dysfunctions. Eventually, that will improve the definition of the therapeutic targets; therapeutic targets will be adjusted to individuals' context, and, therefore, treatments may have better chances of success.

In this chapter, we propose to present the epidemiology of male and female sexual dysfunctions, acknowledging that the evidence includes both clinical populations, i.e., those who received a formally recognized diagnosis, and data collected from the general/non-clinical population. In the last one, the concept of sexual difficulty, rather than sexual dysfunction, has empirical value and gives us a broader view of how individuals experience their sexuality. Additionally, the etiological aspects will be considered, not only from an organic and medical perspective but also from a psychosocial view. Specificities regarding sexual dysfunctions in men and women, as well as etiological aspects regarding particular sexual conditions, will be considered as well. In the end, we hope to present some remarks on the interplay role of the medical and psychosocial aspects in order to promote lines of action for clinical practice.

## Epidemiology of Women's Sexual Dysfunctions

The estimated prevalence of female sexual dysfunction is quite high, with around 40% of women reporting one or more sexual complaints [2]. Evidence about sexual desire difficulties in Britain indicates that 34.2% of women report low sexual desire; the highest prevalence is found in the range between 55 and 64 years old [3]. In Canada, similar data show that 40% of women between 40 and 59 years old report low sexual desire [4]. If we consider data regarding the difficulty in spontaneous versus responsive sexual desire (data from Flanders), 19% of women report lack of spontaneous sexual desire, 14% report difficulties in responsive desire, and 9% report difficulties in both [5]. It is important to mention that 15% to 35% of women report a discrepancy between their sexual desire and their partner's sexual desire

[3], and the distress associated with this discrepancy is a variable of great clinical interest [6]. Complaints of low sexual desire are expected to be the most frequent sexual complaints in women, although in non-Western countries complaints associated with orgasm or arousal/lubrication difficulties are the most frequent [7]. Additionally, women with low sexual desire are nine times more likely to report sexual arousal problems [8]. Vaginal lubrication difficulties are seen in 8% to 28% of women [9, 10], although the associated distress rates are only 3.3% [10]. With regard to Persistent Genital Arousal Disorder (PGAD) its prevalence is unknown, although it is estimated that between 0.6% to 1% of women may suffer from this condition [11, 12]. The percentage of women reporting orgasm difficulties can range from 3% to 34% [13], although more recent data point that 3% to 10% of women in the European and North American context may suffer from those [14]. Surprisingly, only half of women seem to report distress associated with the inability to reach orgasm [15]. Data on genito-pelvic pain indicate that 10% to 28% of women of reproductive age have genital pain [16]. With regard to vaginismus, data are equally limited, suggesting that the prevalence may reach 6.2% [17], but may rise to 68% in non-Western and more conservative communities [18]. In fact, epidemiological data seem to be quite dependent on the cultural context. The "sexual regime" of each country or culture seems to play a fundamental role, with the prevalence of female sexual dysfunctions being higher in patriarchal systems [19].

In the epidemiological context of sexual dysfunctions in women, it is important to acknowledge that the evidence is quite dated and that the data vary depending on the different terminology that researchers use. It is equally important to recognize the role of the cultural context in the expression of sexual complaints as the evidence suggests that culture plays a role in the type and prevalence of reported symptoms, with differences between Western and non-Westerns cultures.

## Epidemiology of Men's Sexual Dysfunctions

Data on the prevalence of male sexual dysfunctions reveal that erectile dysfunction is highly prevalent, increasing with age [20]. Prevalence rates have varied from 9.5% to 18% (findings from Australia, United Kingdom and U.S.A; [3, 21, 22]). Despite the prevalence can go up to 75% in men older than 70 years old [9], approximately 10% of men under the age of 40 may present erectile difficulties [22]. Indeed, data regarding men seeking first time help for erectile dysfunction showed that one out of four men were younger than 40 [23]. Incidence data point to 25.9 new cases per 1000 men in the U.S.A, naturally increasing along each decade of age [24]. In the Dutch context, the incidence rate (cases per 1000 person-year) was 99, ranging from 77 to 205 (age 50–59 and 70–78, respectively) [25]. Recent data on the prevalence of erectile difficulties is somehow surprising, as numbers are quite high, varying from 37.2% to 48.6% (Brazil and Italy, respectively) [26]. In obese, non-diabetic men, erectile difficulties are frequent as well—42.1% [27]. Prevalence rates of premature ejaculation strongly depend on the diversity of definitions and whether or not the condition was assigned by a trained clinician [28]. Still, rates

ranging from 20% to 30% have been found [28], with specific rates of 2.3% to 3% regarding lifelong premature ejaculation, 3.9% to 4.8% regarding acquired premature ejaculation, 8.5% to 11% regarding variable premature ejaculation, and 5% to 7% regarding subjective premature ejaculation [29, 30]. Despite these numbers, and the overlapping between premature ejaculation and psychological comorbidities, men seem to seek little assistance [31]. As for delayed ejaculation, the prevalence rates seem to be little expressive, with only about 3% of men presenting the condition [32]. Yet, in U.S.A 8% to 20% of men reported difficulties achieving climax or ejaculation [33], but only 0.7% reported the same difficulty in Britain [34]. Older age may be associated with delayed ejaculation [32].

Despite sexual desire difficulties are often seen in the context of female sexuality, 3% to 28% of men reported low sexual desire [35, 36]. In young men (18–29 years), the prevalence can range from 6% to 19%, while in older men can go up to 27% (60–67 years) [33, 37, 38]. Data can be different if we consider solitary versus dyadic sexual desire (desire to engage in sexual behavior with one's self versus with a partner, respectively). Fourteen percent of men seem to report low dyadic sexual desire, and 68% report low solitary sexual desire [39]. The incidence rate was seen to be higher regarding solitary desire [40]. Looking at sexual fantasies, which are an important marker, absence of sexual fantasies is more prevalent in older men (20%) [41]. Sexual desire difficulties may be prevalent in gay men, with numbers ranging from 19% to 57% [42, 43].

Finally, is worth recognizing that the numbers here presented vary as a function of the assessment methodologies that were used by researchers. Also, the numbers may not be representative of the countries and cultures that receive little attention in sexuality research.

## Medical Approach to the Etiology of Sexual Dysfunctions

### Specific Etiological Factors in Women

Both in men and women, testosterone, or its biochemical metabolite 5α-DHT, modulates many physiological and biochemical pathways. Considering only its sexual implications, in adulthood, it determines sexual differentiation, contributes to maintain the functional state, and modulates the sexual behavior [44]. Although the underlying mechanisms are not completely understood, testosterone positively modulates sexual desire in women in the central nervous system, and it has a role, together with estradiol, in the increased blood flow to the vagina, labia, vulva and clitoris, and in the lubrication of the vagina during sexual arousal [45]. Similarly to men, androgen levels decline progressively with age in women, and with the decreased ovarian function and adrenal precursor steroids availability [46]. However, menopause seems to have no effect in this process, as long as the androgen levels found in women in their 70s are similar to those premenopausal. Different studies have failed to demonstrate a correlation between the presence of hypoactive sexual desire in women or its severity, and the levels of testosterone. In fact, when reaching

levels of testosterone above those present in the premenopausal period, sexual desire may actually decrease, suggesting a bimodal effect [47].

In contrast, after menopause, an abrupt drop in circulating estrogens is observed. These changes lead to many changes in the physiology of women, including the deterioration of the vagina epithelia. It appears flattened, with an absence of papillae, and a lower proportion of cells containing glycogen, which leads to a decrease of Lactobacilli and an increase in the pH. Also, the collagen I/III ratio is lower, resulting in reduced tissue strength [48], so it is more susceptible to trauma and it can result in pain, ulceration or bleeding during or after sexual intercourse. This scenario can result in inflammation and further worsening of the atrophy [49].

Although some relation has been observed, there is no clear correlation between hormone levels and PGAD. This disorder has been related with a myriad of other conditions as bipolar disorder, anxiety, depression, overactive bladder, interstitial cystitis and pudendal neuralgia; but their pathophysiological mechanisms remain widely unknown [50].

## Specific Etiological Factors in Men

In the last 30 years there has been an increasing interest in the study of the physiopathology of sexual dysfunctions in both men and woman, but there is still a long way to go in some disorders. Erection is the result of a complex coordination of neural, vascular and hormonal mechanisms that work together to achieve and maintain rigidity during sexual intercourse [51]. When some of these mechanisms is disrupted, different types of ED are defined: vascular, neurological or hormonal, with a variable presence of psychological factors in almost all of them, that can ease or worsen the previous condition. Isolated psychogenic ED is a non-well defined entity, that usually affects younger patients, with rates of prevalence as high as 30% of those adults under 40 [52]. The relationship between vascular ED and cardiovascular disease (CVD) has been well established through the last 20 years, considering in fact ED as an independent risk factor for CVD, and to be present an average of 2–3 years before the onset of the first coronary event [53]. Therefore, comorbidities known to cause CVD, as smoking, diabetes, hypertension, dyslipidemia, overweight, or sedentary lifestyle, are mandatory to assess and investigate when a man complains about ED [54]. The high prevalence of these comorbidities in general population makes vasculogenic ED, by far, the most common subtype of ED [55]. Age is an independent risk factor for both ED and CVD [56]. Thereby, a recent study found a decrease in the peak systolic flow of the cavernosal arteries in a cohort of healthy male patients through the years, supporting the idea that even in men without comorbidities, ED will be more prevalent with age [57]. With respect to diabetes, two pathogenic pathways, neurologic and vascular, can be present, resulting in very high prevalence rates as high as 52.5% in this subgroup of patients [58]. The progressive obliteration of the arteries due to arteriosclerosis usually associated with a poor glucose control can be followed or preceded by a lesion of the distal branches of the pudendal nerve, making it difficult to transfer the erectogenic

stimuli. This is the reason why this subgroup of patients is considered difficult to treat [59], and why neurogenic ED can be present in other disorders causing central or peripheral nerve damage, as multiple sclerosis, spinal cord injuries or chronic renal failure [60]. The most common cause of iatrogenic ED is after radical pelvic surgery, where nerve damage is supposed to have an important role and has been widely investigated in the literature. However, the reported incidence of ED after surgery shows an extremely variability, with figures ranging from 12% to 96%, due to methodological differences [61].

Late onset hypogonadism, also referred as age-associated testosterone deficiency syndrome or, more recently and correct, as "functional hypogonadism", is a biochemical and clinical syndrome characterized for the presence of a wide spectrum of clinical symptoms and low testosterone levels, which is related to age. In men, average levels of androgens decline constant and progressively through the years [62]. Focusing on sexual function, it is known that testosterone deficiency can cause low sexual desire, and also a decrease in morning erections and ED. So when a man complain of these conditions, it is mandatory to assess testosterone levels [63], especially in the elder population, given that androgen therapy could improve or solve these problems [64].

Despite the high prevalence of ejaculation disorders, as PE and DE, their biological pathophysiology has not been so widely investigated and has not been precisely established [65]. Acquired PE has been related to conditions as inflammation or infection of the prostate, abnormal hormonal levels (LH, prolactin and TSH), and low levels of serotonin, which, in some cases, could be successfully treated to improve the dysfunction [66]. In the case of lifelong PE, the most widely accepted hypothesis is that in men with low 5-hydroxytryptamine (5-HT) the hyposensitivity of the $5\text{-HT}_{2C}$, or the hypersensitivity of the $5\text{-HT}_{1A}$ receptors that are located in the neuronal centers, can lead to a more rapid threshold for ejaculation, with lower stimulation [67]. This theory also explains that those men with a higher set point can better control the process, and that those with an abnormally high set point experience delayed, or even absent ejaculation with normal erection [68]. Several studies in the literature have used imaging techniques as magnetic resonance to investigate the functional and structural neural basis of PE, with findings as higher activation in the middle temporal gyrus; larger volume of the caudate nucleus; cortical, parietal, occipital and cingulate cortical thickening; altered structural connectivity of the fronto-cingulate-parietal control network; and lower activation of the left inferior frontal gyrus and left insula [65]. Although all of them try to better understand the condition, and to put some light in the darkness, there is still a need to put together these results and demonstrate the importance of these findings in daily clinical practice.

## Psychosocial Approach to the Etiology of Sexual Dysfunctions

Over the last few decades, several models conceptualizing sexual dysfunctions have emerged. These models vary in the way they regard the role of different psychosocial factors in the etiology and/or maintenance of sexual dysfunctions. The

precursor model of Masters and Johnson (the so-called linear model of sexual response) which was aimed at characterizing the physiological processes involved in arousal, plateau, orgasm, and resolution stages [69], gave little emphasis to the subjective and contextual processes involved in sexual response [70]. Nevertheless, the model proposed two core etiological factors regarding sexual dysfunctions: performance anxiety and *spectatoring*, i.e., spectator of oneself during sexual activity. The phenomenon of sexual performance anxiety appears to characterize individuals with sexual difficulties and emerges as a specific component of the broader concept of anxiety [71]. Therefore, while anxiety has the potential to increase the sexual response in men and women, increasing their erectile response and vaginal lubrication, more specific components such as the anticipation of failure or poor sexual performance are associated with clinical conditions of sexual dysfunction [72]. In the clinical context, is it important for the health professional to define the weight of this etiological variable, as well as the sources that promote it, e.g., cultural standards? partner pressure? Regarding the role of anxiety and its triggers, Barlow proposes a more elaborate model with greater empirical value, mostly focused on male sexual dysfunction, and in particular, on erectile dysfunction [73]. From a series of studies focusing on physiological variables (namely, erectile response) but also psychological or subjective measures, it became clear that what most differentiated men with and without erectile dysfunction, more than their erectile response, was the fact that men with dysfunction respond with more negative affect through sexual stimulation, a feeling of loss of control, preoccupation with performance or the negative consequences of sexual performance, and an underestimation of their erectile response [74]. The man with sexual dysfunction ends up focusing on non-erotic cues, with implications for his adaptive response. Basson, who were more aligned with the domain of female sexuality, proposed an alternative model, considering relationship aspects, namely, emotional intimacy [75]. Emotional intimacy is seen as a driving source of sexual response, especially in terms of sexual arousal and desire. Although a basic condition is necessary—be it organic or psychological—that guarantees the ability to process sexual stimuli, there is an important relational purpose for the understanding of sexual (dys)function [76].

Another interesting model is that of the sexual scripts of Gagnon and Simon [77]. Sexual scripts emerge from more general scripts, i.e., social scripts, and result from a social learning process that defines what is correct and expected at a given time, in a given society. These scripts incorporate a sociocultural, interpersonal, and individual dimension that guides individuals in how they should live their sexuality and build their sexual interactions [78]. These sexual scripts will thus guide individuals in what they should and should not do sexually, how, and with whom. According to this model, it is expected that individuals with sexual dysfunctions present more rigid, conventional, or routine sexual scripts, which contribute to the maintenance of their symptoms [79]. A contextual look would therefore be essential for understanding the etiology and maintenance factors of sexual dysfunctions. More recently, and in articulation with a cognitive-behavioral clinical intervention proposal, Nobre suggested the cognitive-emotional model according to which a series of cognitive structures, of information processing, are at the core of erroneous interpretations of

negative sexual events (e.g., sexual failure). These cognitive structures promote a vicious cycle that feeds dysfunctional thoughts in the sexual context as well as emotional states that are not compatible with the capacity to perform sexually [80, 81]. Data collected over several years and in independent investigations allowed researchers to characterize different sexual difficulties, in men and women, with and without heterosexual preferences, pointing potential etiological and maintenance factors of sexual dysfunctions [82]. Examples of these factors are lack of erotic thoughts, preoccupation with erections during sexual activity, the anticipation of failed sexual performance, thoughts of sexual abuse, or preoccupation with body image [82]. Finally, and because we will not cover all models of a psychosocial nature, we highlight the Dual Control Model of sexual response. This model postulates that the sexual response results from the balance between relatively independent mechanisms of sexual arousal and inhibition [83, 84]. In this regard, it is interesting to analyze the factorial structure of the model, as it resulted in an excitation mechanism and two inhibition mechanisms [85, 86]. The latter refers to the predisposition to sexual inhibition due to the fear of sexual performance failure, and inhibition due to the fear of the negative consequences associated with the sex (e.g., STD, unwanted pregnancy). It is interesting to see that sexual inhibition due to fear of sexual performance failure echoes other models (Barlow model, Nobre and Pinto-Gouveia model), supporting the role of learned cultural standards about sexual performance—often, unrealistic standards—, in male and female sexual functioning. Empirical evidence on the Dual Control Model suggests that sexual inhibition, especially the fear of sexual performance failure, is a vulnerability factor for sexual dysfunction in men and women [87, 88].

Furthermore, there is a consensus to improve the focus on the individuals' proximal relationship context. Accordingly, it is paramount that the focus is on the dyad or partners and not on the individual carrying the symptom or the sexual complaint. What sometimes causes the complaint is not the sexual symptoms themselves, but the fact that there is a discrepancy in the sexual response between the elements of the couple, or the fact that one of the elements has unrealistic and very high expectations regarding the sexual functioning of the other. This contextual and relationship view becomes an asset in understanding the etiological and maintenance variables of sexual complaints.

## Specific Etiological Factors in Women

In addition to the models presented, a series of studies have made it possible to assess psychosocial etiological factors specific to each sexual dysfunction or difficulty. For example, in women's sexual desire difficulties, the quality of the relationship seems to be a determining factor, to the point that satisfaction with the partner in one specific day, promotes sexual activity the next day [89]. Relationship duration seems to play a negative role [90], while conservative sexual beliefs and medical aspects have an indirect effect, influencing female sexual desire through lack of

erotic thoughts and perception of sexual failure [91]. Insecure and anxious attachment styles, i.e., dysfunctional relationship styles, characterized the expression of sexual desire in women [92]. Thoughts of sexual abuse were also associated with lower sexual desire [93]. Additionally, communication in the relational context has also a central role, being a key target in therapy [94]. On the other hand, cultural aspects can be important etiological mechanisms of sexual desire difficulties in women. These include social narratives favoring female passivity and responsiveness [95], poor sex education, overload of professional and parental tasks, or even demanding and unrealistic standards of female attractiveness [96]. Likewise, and considering patterns of sexual arousal, while sexually explicit stimuli (stimuli with a focus on genital interaction) seem to induce greater genital activation, subjective sexual arousal in women is prompted by stimuli that suggest a relational context [97, 98]. In fact, relational satisfaction seems to be associated with fewer arousal difficulties [99]. In addition, women with PGAD reported more dysfunctional sexual beliefs (sexual conservatism or sexual desire regarded as a sin), as well as thoughts of sexual abuse and lack of affection during sexual activity [100]; likewise, the quality of the dyadic relationship was associated with the levels of distress [101].

With regard to orgasm difficulties, the data suggest that a history of sexual victimization may play an etiological role, particularly in women who experienced physical sensations and orgasm during abuse [102]. Similar to desire difficulties, the presence of thoughts of sexual failure and lack of erotic thoughts during sexual activity predicted orgasm difficulties in women [103]. Women with genito-pelvic pain also reported a higher probability of sexual and physical abuse [104, 105], which places this problem in a relational and interpersonal context. Anxiety factors such as catastrophizing thoughts and hypervigilance towards pain also triggered the perception of genito-pelvic pain [106].

## Specific Etiological Factors in Men

Regarding male sexual dysfunctions, there is also evidence about vulnerability factors specific to each clinical condition. Cases of erectile dysfunction are often accompanied by depressive and anxiety symptoms, resulting in a context of psychological distress [107]. Lower erectile capacity is also associated with situational events where psychological distress arises in response to a critical event [108]. On the other hand, the perception of intimacy has been shown to be a protective factor in erectile dysfunction [109]. Additionally, much has been written about the importance of cognitive factors in erectile dysfunction. High expectations of sexual performance coupled with dysfunctional processing styles of sexual information result in a sense of loss of control, guilt for poor sexual performance, and cognitive distraction during sexual activity, contributing to the maintenance of erectile difficulties [82]. In the context of non-heterosexual relationships, sexual minority associated distress seems to be linked with erectile difficulties in men who have sex with men [110]. All these factors are relevant in the design of biopsychosocial interventions

for erectile dysfunction. Although the evidence is more limited, cases of premature ejaculation seem to be characterized by a style of internalization, in which the man attributes to himself the responsibility for his dysfunctional sexual response, blaming himself and monitoring the partner for confirmation signs of his poor sexual performance [111]. These men have a more preoccupied personality style and are less motivated to look for new sensations, fearing novelty [112]. Delayed ejaculation cases also appear to be characterized by an anxiety profile, lack of confidence, in which a pattern of negative self-talk interferes with reaching climax even with a good erectile response [113]. Regarding the difficulties of sexual desire in men, although the literature is also insufficient, the data suggest that some psychosocial determinants such as duration of the relationship, professional stress, little confidence in achieving an erection, higher education and more demanding careers, or even the desire to having children or having young children are associated with lower sexual desire in men [39, 114–116]. The combination of cognitive and emotional aspects proved to be an important predictor of desire difficulties, with a special emphasis on concerns with erectile capacity and the lack of erotic thoughts during sexual intercourse [117].

## Combining the Medical and Psychosocial Factors Toward a Comprehensive Approach to Sexual Dysfunction

The biopsychosocial view of sexual dysfunctions promotes a more comprehensive analysis of the etiological and maintenance factors of sexual difficulties, focusing on the interaction between etiological aspects and looking for better forms of intervention, as well as more adjusted ways to address the specificities of each individual or partner(s). Therefore, it is a vision that makes it possible to overcome the reductionist dichotomy of organic versus psychological, improving assessment and intervention practices, and stimulating the articulation between the different scientific and professional domains [118]. The different fields are not incompatible; on the contrary, they make it possible to maximize interventions. In this regard, some scientific and professional societies have promoted this vision, resulting in proposals for the integrative assessment and intervention in sexual problems. Indeed, existing integrative approaches have shown promising results [119]. In order to further explore the link between the organic and the psychosocial, important networks, including the European Sexual Medicine Network, have invested in this approach as a way to ensure greater interdisciplinary and, therefore, better services in the field of human sexuality [120]. This biopsychosocial approach to the etiological aspects of sexual dysfunctions needs further empirical work, especially if we consider that the etiological factors of a psychosocial order are permeable to the cultural, historical, and even political context, and those are in constant change. It is, therefore, essential to follow this evolutionary process for a better understanding of the etiology and maintenance factors of sexual dysfunctions.

## Final Remarks

This section intended to present evidence on the epidemiology and etiological factors associated with sexual dysfunction in men and women. It is important to highlight methodological limitations. Among them, we highlight the reduced information about the etiological aspects and prevalence in sexual and gender minorities. This limitation clearly excludes the possibility of a rigorous analysis of the etiological aspects or the specific needs of these populations, resulting in a less effective and less socially fair intervention approach. Furthermore, and although this chapter has focused on the context of sexual dysfunctions, the tendency to look at other equally relevant constructs such as issues of sexual pleasure or sexual well-being is also worthy of attention. Indeed, the gap between men and women in access to sexual pleasure requires an analysis of the factors that promote this gap and the respective consideration by professionals and clinicians in the area of sexuality [121]. The same is true for the concept of sexual distress. It has emerged as a more comprehensive view of sexual dysfunction, referring to the negative emotional response resulting from the sexual functioning of individuals, and being a fundamental criterion for the diagnosis of sexual dysfunction [122, 123]. In fact, the prevalence of sexual dysfunctions is lower when this criterion is considered [124]; the application of cutoff points (e.g., IIEF or FSFI) to understand the prevalence and etiology of sexual dysfunctions is insufficient as it assumes the presence versus absence of dysfunction as a fundamental criterion, rather than the actual impact of the symptomatology on the life of individuals [125]. Finally, we consider that some evidence about the psychosocial etiological factors is dated. Available data may fail to reflect the transformative character of the biopsychosocial vision.

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