

# The patient woman or the woman patient? Examining the demographic differences between women seeking and not seeking treatment for sexual dysfunction

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Although female sexual dysfunctions affect a significant number of women around the world, the majority of those struggling do not ever seek professional treatment. As past research mostly focused on logistical and psychological barriers to help-seeking, there remains a gap in knowledge of what demographic characteristics potentially differentiate those individuals who do versus do not solicit support. The objective of this study was to explore a set of demographic variables and their links to treatment-seeking behaviours, including: age, ethnicity, education, income, employment, sexual orientation, relationship status, religion, and history of non-consensual sexual experiences. We used data from four completed studies that asked participants about their history of treatment-seeking, and our analytic sample included  $N = 869$  self-identified women ( $M = 31.41$ ,  $SD = 11.30$ , range 19–78). Education, age, income, and employment significantly predicted help-seeking behaviours with treatment-seekers being more likely to be older, more educated, currently employed, and earning higher income. No significant associations were found for the other variables. Overall, the results demonstrate that there are notable demographic differences that separate help-seekers from non-seekers. As sexual well-being is an important aspect of one's quality of life, risk factors that prevent people from seeking care for distressing sexual concerns should be a major public health priority. The limitations to the conclusions drawn in the paper due to data characteristics and analytic strategy are also discussed.

**KEYWORDS:** Demographic predictors, sexual dysfunction, treatment-seeking, women

## OVERVIEW OF TREATMENT-SEEKING

Little is known about what demographic characteristics predict treatment-seeking for sexual problems in women. Variables such as relationship status, despite potentially not being causal factors that inhibit treatment-seeking, could still be very valuable correlational factors that could help clinicians identify which specific populations are less likely to access treatment. As sexual functioning problems can affect individuals of any demographic, being able to identify who is less likely to seek treatment will help clinicians develop strategies that will ultimately provide equal chances for care for all women experiencing sexual dysfunctions.

A recent Canadian study of both clinical and community samples estimated that nearly six out of ten people face barriers when trying to access treatment for their sexual dysfunction

(Lafortune et al., 2023). Indeed, there still exist many other major logistical and financial barriers to receiving treatments, including the low availability of specialized diagnostics and evidence-based treatments, significant cost, coverage and regulatory/policy issues, as well as overly long waitlists to see professionals (Goldmeier et al., 2004; Kingsberg et al., 2019). Additionally, for many minority women, language and cultural differences have also been found to be significant obstacles to receiving care (Mengesha et al., 2018). Together, due to these factors, when it comes to addressing sexual problems, the most common action taken by individuals is usually inaction, as one global study found that approximately 78.0% of women made no effort to seek help or advice (Moreira et al., 2005). Unfortunately, even in those who did, the most common step taken was speaking to one's partner instead of a provider (Moreira et al., 2005).

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Fear of disclosure is a major obstacle for many women wanting to receive treatment. For some older individuals, shame, embarrassment, and fear were cited as significant reasons for hiding their struggles from a clinician (Gott & Hinchliff, 2003). The social stigma and biases surrounding female sexuality are still evident across many cultures (Kingsberg et al., 2019) and have been reported regardless of the woman's age, sexual orientation, marital status, ethnicity, or education level, thus contributing to many women's decision to remain complacent (Fairchild et al., 2016; Kingsberg et al., 2017). Related findings have shown that this hesitation could be further exacerbated by previous negative experiences or dismissal by professionals when concerns were raised by the patient (Kingsberg et al., 2019). Interestingly, some data suggest that when doctors routinely asked patients about sexual health concerns, patients will report higher rates of treatment-seeking compared to those patients who do not get probed by their doctors (Moreira et al., 2008). Similarly, results from Politi et al. (2009) underline that patient trust has also been linked to an increased inclination towards disclosure, especially when the clinician did not make assumptions or appeared to be judgmental (Politi et al., 2009).

When it comes to sexual health literacy, not knowing how to bring up the subject and how to articulate their symptoms may also lead some women to downplay the extent of their symptoms (Kingsberg et al., 2019). Likewise, a lack of awareness on how to identify sexual dysfunctions as well as insufficient education on the availability of effective treatment have further been recognised as barriers to treatment-seeking (Evangelia et al., 2010; Moreira et al., 2008). In fact, one American survey found that around two-thirds of postmenopausal respondents were only somewhat familiar with or completely unaware of the possible remedies for their symptoms (Kingsberg et al., 2017). As a result, a significant number of women also report delaying or foregoing help-seeking due to not knowing the existence of a possible treatment (Kingsberg et al., 2019). Unfortunately, even for women who are familiar with the available options, many still have misconceptions about their safety, as exemplified by the widespread myths regarding the safety of vaginal estrogen treatment (Kingsberg et al., 2019; Manson et al., 2014). Overall, inaccurate information on effective treatments is often perpetuated by the media, who may be more prone to also advertise unproven, non-scientific remedies, highlighting the role for researchers in knowledge translation to the public (Cassidy et al., 2018).

Furthermore, a number of variables have been identified as being facilitators and inhibitors to treatment-seeking. For instance, in a study by Evangelia et al. (2010), levels of bother significantly correlated with increased help-seeking in women. Additionally, being very or somewhat dissatisfied with their sexual function and believing that sex is a very or extremely important part of overall life were also associated with an increased likelihood of treatment-seeking (Moreira et al., 2005). Similarly, one study showed that individuals with more sexual problems, as well as lower sexual and relational satisfaction, tend to seek out treatment at a higher rate (Lafortune et al., 2023). Conversely, perspectives such as "I thought it was a normal part of getting older/I am comfortable the way I am" and "I didn't think it

was very serious/I was waiting to see if the problem goes away" have been linked to a decreased likelihood of treatment-seeking (Moreira et al., 2005, p. 14). Here, evidence suggests some individuals might also view getting help as an indication of personal inadequacy or a threat to their self-esteem, hence further preventing them from reaching out for professional support (Bergvall & Himelein, 2013). A strong endorsement of traditional gender norms was likewise found to be correlated with a decreased likelihood to seek out professional support (Parnell et al., 2023).

## OVERVIEW OF FEMALE SEXUAL DYSFUNCTION

The current edition of the *Diagnostic and Statistical Manual of Mental Disorders* (5th ed.; DSM-5; American Psychiatric Association, 2013) defines sexual dysfunction as "a clinically significant disturbance in a person's ability to respond sexually or to experience sexual pleasure" (American Psychiatric Association, 2013, p. 423). The three categories of female sexual dysfunction in the DSM-5 include: female orgasmic disorder, female sexual interest/arousal disorder (FSIAD), and genito-pelvic pain/penetration disorder. Female orgasmic disorder is defined as "either marked delay in/infrequency of/absence of orgasm or reduced intensity of orgasm during 75–100% of sexual encounters" (Shepardson & Carey, 2016, p. 142). FSIAD is specified as the "lack of or reduced sexual interest/arousal as indicated by at least 3 symptoms (absent or reduced sexual interest, fantasies, initiation or receptivity to partner's initiation, pleasure or sensations during sexual encounters, arousal in response to sexual cues)" (Shepardson & Carey, 2016, p. 142). Genito-pelvic pain/penetration disorder is classified as having "persistent or recurrent difficulties with vaginal penetration, pain or fear of pain during intercourse, or tensing of pelvic floor muscles during penetration" (Shepardson & Carey, 2016, p. 142). Overall, women's sexual dysfunction appears to be more complex and multifaceted in comparison to men's, including an interaction of various anatomical, psychological, physiological, and social-interpersonal components (Salonia et al., 2004).

There have been a number of large population-based prevalence studies on female sexual dysfunctions. Looking at individual symptoms and not diagnoses, a meta-analysis of 135 studies estimates female orgasm problems in a general population of premenopausal women to be close to 26%, pain disorders and lubrication difficulties to be about 26%, low desire concerns to be around 28%, and sexual arousal problems to be close to 23% (McCool et al., 2016). Broadly speaking, the Global Study of Sexual Attitudes and Behaviors estimated that, among women from a variety of countries, around half (49%) of the respondents reported experiencing at least one sexual problem (Moreira et al., 2005). Here, relevant risk factors associated with dysfunction include general health status, psychiatric/psychological disorders, and chronic diseases (Evangelia et al., 2010). Additionally, emotional and interpersonal challenges, on top of biological ones, can interfere with normal sexual functioning as well (Evangelia et al., 2010). Of note, not all women experiencing sexual problems also experience personal distress. One

American study showed that only about half of those women who reported dysfunctions also reported related distress regarding their sexual problems (Shifren et al., 2008). Nevertheless, as sexual well-being is an essential aspect of quality of life, identifying and reducing barriers to help-seeking is a crucial step in the treatment process (Hatzimouratidis & Hatzichristou, 2007). Finally, it is also important to note that just as not all those struggling with sexual dysfunctions seek out treatment, in a similar manner, not all those who seek out treatment are prompted to do so because they are having issues with sexual dysfunctions. For instance, some women would seek out support for desire discrepancy with their partner, other sub-clinical problems, or simply wanting to improve their pleasure or enjoyment.

## GOALS OF THIS STUDY

The primary objective of this paper was to explore nine demographic variables as possible predictors of treatment-seeking: education, age, ethnicity, income, employment, sexual orientation, religion, relationship status, and history of non-consensual sexual experiences. We chose these variables on the basis that these may be helpful for primary care clinicians who are often the first point of contact between patients and the healthcare system.

Higher education in certain parts of the world, such as Northern Europe and Central/South America, has been found to be more associated with treatment-seeking in general (Moreira et al., 2005). However, in some other European and Canadian studies, education does not seem to be a significant correlate (Hobbs et al., 2019; Lafortune et al., 2023; Moreira et al., 2008). Hence, more research on the impact of education on sexual health treatment-seeking is needed. Additionally, and perhaps surprisingly, higher household income did not predict an increased frequency of treatment-seeking behaviours in past multi-national studies (Moreira et al., 2005, 2008; Lafortune et al., 2023). Likewise, recent findings indicated that employment status also did not differentiate between help-seekers and non-help-seekers, at least not in a Canadian or British sample (Hobbs et al., 2019; Lafortune et al., 2023). We elected to examine income and employment as predictors in our sample.

Regarding age, there is mixed evidence regarding whether it is linked to different rates of help-seeking behaviours. While some global studies claimed that younger women are more likely to reach out for professional support (Hobbs et al., 2019; Moreira et al., 2005), other global studies failed to replicate this (Moreira et al., 2008). Additionally, in regard to ethnicity, one mixed-gender Canadian sample showed that White and non-White individuals did not differ in treatment-seeking behaviours (Lafortune et al., 2023); however, another multi-national study on women found that East Asian women were least likely to seek treatment, whereas Central/South American women were most likely to seek treatment (Moreira et al., 2005). Hence, there is no solid conclusion yet on how ethnicity is related to treatment-seeking behaviours.

Moreover, concerning the help-seeker's sexual orientation, one Canadian study by Lafortune et al. (2023) observed that

queer men and women were more likely to have sought out services for their sexual dysfunction than heterosexual men and women. However, this finding was not replicated in a British sample by Hobbs et al. (2019). Furthermore, the same Canadian study also found that religious individuals were more likely to ask for support than non-religious individuals (Lafortune et al., 2023). On the other hand, Bergvall and Himelein (2013) did not find this difference in their sample of Swedish and American college students.

Finally, we could not identify any study that has examined the correlation between experiences of non-consensual sexual contact and help-seeking behaviours. Similarly, there is only minimal evidence pointing to that, at least in Canada, those in a relationship in general were more likely to have sought out treatment than those who were single (Lafortune et al., 2023). As such, this highlights some important knowledge gaps in the current literature that our study aims to address.

## METHODS

### Participants

The participants examined were 869 self-identified women gathered from four previously collected datasets by the senior author, with three studies being published and one in preparation (Table 1). The participants were drawn from studies focused on sexual health experiences during the COVID-19 pandemic (Zhang et al., 2023), an evaluation of virtual reality (Milani et al., 2023), an exploratory study of virtual reality therapy for individuals with vaginismus (unpublished), and a study testing psychological treatment for women with sexual problems after breast cancer (Brotto et al., 2024). Only baseline demographic information from the four datasets was used in the current study, and no post-treatment data were used. The participants were required to be at least 19 years old and fluent in English. Cisgender women, as well as gender-diverse females of any sexual orientation, were included. We also included participants regardless of whether they had a self-described sexual problem or not.

### Procedure

Eligible participants had previously provided informed consent, which was approved by the University of British Columbia Clinical or Behavioural Research Ethics Board. Prior to participating, every individual confirmed that they read and understood the consent form and agreed to partake in the research study. Participants were originally recruited through a variety of means including: online advertisements, university online programs, government registries, or local communities. All demographic measures were collected via online questionnaires using the program Qualtrics. Data from each of these four studies were stored on our institution's private and secure cloud server, cleaned previously by trained researchers who worked on the original studies, and eventually merged into a single dataset for the

**TABLE 1.** Descriptions of the Four Studies Contributing to the Pooled Dataset

	Goal of the Original Study	Participant Description	N	$M_{\text{age}}$ (SD)	Other Demographic Information
<b>Study 1 (Brotto et al., 2024)</b>	Addressing sexual concerns after breast cancer treatment (online study)	Women with a history of breast cancer at least 3 months beyond the end of their treatment & exceed the clinical cut-off for sexual distress	116	50.01 (9.45)	Ethnicity: 79.3% White Gender Identity: 99.1% Self-identified Women Sexual Orientation: 88.7% Heterosexual
<b>Study 2 (Milani et al., 2023)</b>	Investigating women's experience and response to sexually immersive virtual environments (in-person study)	Self-identified women	46	21.00 (2.56)	Ethnicity: 31.1% White Gender Identity: 100% Self-identified Women Sexual Orientation: 88.6% Heterosexual
<b>Study 3 (unpublished)</b>	Examining the application of virtual reality and concurrent psychoeducation to address vaginismus (in-person study)	People with a vagina	85	27.91 (7.95)	Ethnicity: 47.6% White Gender Identity: 90.7% Self-identified Women Sexual Orientation: 49.4% Heterosexual
<b>Study 4 (Zhang et al., 2023)</b>	Looking at COVID-elicited responses to sexual health (online study)	All-gender Canadians	1019	30.23 (9.90)	Ethnicity: 70.4% White Gender Identity: 64.1% Self-identified Women Sexual Orientation: 53.2% Heterosexual

present analyses. All demographic variables in the current study were present across all four original datasets. From there we only included participants who provided a response to the question asking about whether they sought treatment or not.

## Measures

Our independent variables were consistently asked across the studies; however, response options provided differed somewhat across studies; as such, we combined response options into larger categories. For age, response options were regrouped into "< 24 years old," "25 to 34 years old," and "> 34 years old." For religion, we dichotomized responses as "Non-religious" and "Religious." For education, responses were categorized as "< 4-year college," "Graduated 4-year college," and "Post-graduate degree." Ethnicity was dichotomized into "White" and "Non-White," and relationship status was dichotomized into "Currently single" and "Currently partnered." For sexual orientation, participants were categorized as "Heterosexual" and "Non-heterosexual." For annual income, it was divided into "< \$60,000" and "> \$60,000," while employment status was regrouped into "Currently employed" and "Not employed." History of non-consensual sexual experience was categorized dichotomously as yes or no.

The dependent variable was treatment-seeking, and participants were asked whether they had sought out sexual dysfunction treatment, with response options yes or no.

## Data Analysis

Analyses were performed using IBM SPSS Statistics 29.0 software. Participants who did not answer "Yes" or "No" to the question regarding past treatment-seeking behaviours were excluded. Questions left blank, and ones that had "Other" were categorized as missing values in the analyses. "Prefer not to answer" was a response option to the question asking about history of sexual abuse, and across the four studies, the percentage of respondents who chose "prefer not to answer" for this question ranged from 1.1% to 5.1%. Data analyses were conducted through chi-square tests of independence with  $p$  values set to 0.05. This method was chosen due to the categorical nature of our variables. We did not apply any correction factor to our analyses given that the study was exploratory and involved post-hoc testing of unplanned comparisons treated as hypotheses for further investigation (Armstrong, 2014). Lastly, we have included the actual sample size for various analyses where the full sample did not provide data.

## RESULTS

### Participant Demographics

Our sample was highly educated, with 24.9% ( $n = 212$ ) having a post-graduate degree, 33.5% ( $n = 285$ ) having graduated four-year college, and 41.5% ( $n = 353$ ) having a less than four-year college education. For age, 35.4% ( $n = 307$ ) were less than

24 years old, 34.1% ( $n = 296$ ) were aged 25 to 34, and 30.5% ( $n = 265$ ) were more than 34 years old. On ethnicity, 68.6% ( $n = 591$ ) of the participants were White, and 31.4% ( $n = 270$ ) of the participants were non-White. Non-White ethnicities in our sample include Arab/West Asian (1.4%), Black (1.4%), Hispanic or Latin American (1.5%), Indigenous (2.8%), East Asian (11.5%), South Asian (5.2%), Southeast Asian (1.9%), and Other (5.9%). In terms of sexual orientation, 64.3% ( $n = 548$ ) were heterosexual, and 35.7% ( $n = 304$ ) were non-heterosexual. In terms of religiosity, 68.0% ( $n = 552$ ) were not religious, and 32.0% ( $n = 260$ ) were religious. Moreover, with regard to income level, 47.3% ( $n = 379$ ) earned less than \$60,000 annually, and 52.7% ( $n = 422$ ) earned more than \$60,000 annually. Furthermore, 53.8% ( $n = 443$ ) were employed, and 46.2% ( $n = 380$ ) were unemployed. Additionally, 70.8% ( $n = 603$ ) of the participants were in a partnered relationship, while 29.2% ( $n = 249$ ) were single at the time of their participation. Finally, 54.6% ( $n = 456$ ) of the sample have had experience of non-consensual sexual contact, whereas the other 45.4% ( $n = 379$ ) did not.

## Predictors of Treatment-Seeking

**Education.** A chi-square test of independence was performed to examine the relationship between educational attainment and treatment-seeking behaviour. There was a significant association found between the two variables,  $X^2(2, N = 850) = 17.108$ ,  $p < 0.001$ , with 3.1% of women who had less than a four-year college education, and 6.0% of women who had graduated four-year college, and 11.8% of women with a post-graduate degree having reported seeking treatment. Those with less than four-year college education were less likely to seek out treatment than those with a post-graduate degree.

**Age.** A chi-square test of independence found a significant association between age and treatment-seeking,  $X^2(2, N = 868) = 15.257$ ,  $p < 0.001$ , with 2.0% of women younger than 24 years of age, and 7.4% of women between 25 and 34, and 9.4% of women more than 34 years old having reported having sought treatment for a sexual problem. Those who were younger than 24 years of age were less likely to seek out treatment than those aged 25 and older.

**Income.** A chi-square test of independence found a significant association,  $X^2(1, N = 801) = 4.502$ ,  $p = 0.034$  with 4.2% of women with less than \$60,000 annual income, and 7.8% of women with more than \$60,000 annual income having reported seeking treatment. Those who earned more than \$60,000 per year were more likely to have sought out treatment than those earning less.

**Employment.** A chi-square test of independence found a significant association between employment and treatment-seeking,  $X^2(1, N = 823) = 8.276$ ,  $p = 0.004$ , with 8.6% of employed women, and 3.7% of unemployed women having reported seeking treatment. Those who were employed were more likely to seek out treatment than those who were unemployed.

**Sexual Orientation.** A chi-square test of independence was not significant for the relationship between sexual orientation and treatment-seeking behaviour,  $X^2(1, N = 852) = 0.743$ ,

$p = 0.389$ , with 6.8% of heterosexual women and 5.3% of non-heterosexual women having reported seeking treatment.

**Religion.** A chi-square test of independence found no significant association between religion and treatment-seeking,  $X^2(1, N = 812) = 0.395$ ,  $p = 0.530$ , with 5.4% of religious women and 6.5% of non-religious women having reported seeking treatment.

**Non-consensual Sexual Contact.** A chi-square test of independence was performed to examine the relationship between non-consensual sexual contact and treatment-seeking behaviour, and was found to not be significant,  $X^2(1, N = 835) = 0.212$ ,  $p = 0.645$ , with 6.6% of women with non-consensual experience and 5.8% of women without experience having reported seeking treatment.

**Ethnicity.** No significant relationship between ethnicity and treatment-seeking was found,  $X^2(1, N = 861) = 0.178$ ,  $p = 0.673$ , with 5.9% of White women and 6.7% of non-White women having reported seeking treatment.

**Relationship Status.** A chi-square test of independence found no relationship between relationship status and treatment-seeking,  $X^2(1, N = 852) = 2.426$ ,  $p = 0.119$ , with 6.8% of partnered women and 4.0% of single women having reported seeking treatment.

## DISCUSSION

### Overview of Findings

This paper examined various demographic predictors of treatment-seeking for women experiencing sexual dysfunction. We found that more education, older age, higher income and being employed significantly predicted having sought treatment for a sexual problem. No significant associations were found for the other variables of ethnicity, sexual orientation, religion, relationship status, and non-consensual sexual contact.

### Explanation of Significant Predictors

First, we found that education predicted treatment-seeking such that individuals with a post-graduate degree were more likely to seek treatment than those who had less than a 4-year college education. This is in line with the evidence that at least in Northern Europe and Central/South America, more education is linked to a higher help-seeking frequency (Moreira et al., 2005). On the other hand, a recent Canadian study and a recent British study found no differences in education between people who have and have not sought out support (Hobbs et al., 2019; Lafortune et al., 2023). As such, to account for our findings, it is possible that women with higher education attainment are also more educated on sexual health knowledge, and where and how to seek treatment, though this is not always supported in past literature (Bourke et al., 2014). Given the discrepancy between our and others' findings, more in-depth research on whether and how education impacts treatment-seeking is still needed. Additionally, it is also possible that this discrepancy resulted from

the fact that, unlike previous papers, we differentiated “Graduated 4-year college” from “Post-graduate degree,” whereas [Moriera et al. \(2005\)](#) and [Lafortune et al. \(2023\)](#) grouped these categories into one collective under “At least some college.” Consequently, our analysis might have been more sensitive to differing levels of post-secondary education.

Regarding age, we saw a greater proportion of help-seeking behaviours in middle-aged to older women. Indeed, many older adults cited distress to themselves and their partners as a major reason for seeking support ([Fitter et al., 2009](#); [Hinchliff et al., 2019](#)). Here, it may be that the lower likelihood of being in a relationship among the younger participants ([Statistics Canada, 2023](#)) may be associated with a lower likelihood of having a fear of the impact of sexual problems on a partner. However, [Hobbs et al. \(2019\)](#) and [Moreira et al. \(2005\)](#) actually found a trend in the opposite direction to be true, where younger women surpassed older women in their likelihood of reaching out, at least in Britain but also more globally. As such, the discrepancy in these findings may stem from the fact that different studies explored age in different ways; we grouped those aged 34 to 78 into one category, whereas the other studies explored age in a more continuous manner. Consequently, some of the nuances of the association might have been lost due to our categorization. We acknowledge this as a limitation in our dataset.

Regarding income, those who earned more than \$60,000 per year were more likely to seek out treatment than those earning less. Here, despite the importance of treating sexual dysfunctions to enhance one’s quality of life, it is also evident that not every woman who wants and needs treatment can afford to pay for them, making access to support at times a luxury for many. On the other hand, past research has also not consistently found income to predict treatment-seeking, both in Canada and more globally as well ([Moreira et al., 2005, 2008](#); [Lafortune et al., 2023](#)). As a result, although we can speculate many sexual dysfunction treatments are more affordable for those earning more, nonetheless, it could also be true that the societal stigma surrounding female sexuality is common across all socioeconomic classes ([Kingsberg et al., 2019](#)). For example, it is possible that, for some women, in spite of having the financial security to pay for a treatment, they still don’t feel comfortable enough to request it. In line with this, a potentially significant distinction in our study is that our sample mostly consisted of self-selected participants, in comparison to the more probabilistic sampling techniques used by the three previous papers ([Lafortune et al., 2023](#); [Moreira et al., 2005, 2008](#)). Hence, our findings might be biased by the fact that the participants might have been more open about their sexual health in general, both to a researcher and possibly to a treatment provider as well.

Contrary to others ([Hobbs et al., 2019](#); [Lafortune et al., 2023](#)), we did find a significant association between employment status and treatment-seeking behaviours. Unlike the measures done by [Hobbs et al. \(2019\)](#) and [Lafortune et al. \(2023\)](#), where they differentiated between various career subgroups such as “intermediate occupation” and “managerial/professional,” we did not do so with our measures. Hence, our data could potentially provide a broader, more general picture on the relationship between

being employed versus unemployed and treatment-seeking behaviours. Moreover, it is also possible that having a job may allow for more financial support to access sexual dysfunction treatments, either directly through increased disposable income or indirectly through ways such as insurance coverage. As such, future studies should explore more nuanced ways that these two variables may be associated. For example, others ([Avery-Clark, 1986](#)) found that working and non-working women differed in their likelihood for different sexual dysfunctions, and since some sexual dysfunctions may be more likely to be associated with treatment-seeking than others ([Ibine et al., 2020](#)), it may be that employment status also interacts with sexual dysfunction subtypes. Similarly, one Iranian study on women’s reasons for not seeking help had “time constraints” cited as one of the most common reasons for staying complacent regarding their sexual dysfunction ([Vahdaninia et al., 2009](#)). Hence, it is possible that the effort spent on scheduling and searching for treatment is more troublesome for women with more time-intensive careers.

Furthermore, we did not find ethnicity, sexual orientation, religion, relationship status, and non-consensual sexual contact to predict treatment-seeking, but we cannot rule out insufficient power as an explanation. Interestingly, as the variables that yielded significant results were all related to SES instead of individual characteristics, it might be possible that systematic barriers related to them might be, in fact, more detrimental than the other barriers related to personal characteristics such as ethnicity or sexual orientation. In accordance with this, one previous study did demonstrate a link between socioeconomic status and reproductive healthcare disparities ([Hall et al., 2012](#)). They found that younger, undereducated, underinsured, and immigrant women were less likely to access reproductive health services in America ([Hall et al., 2012](#)). Here, we can also hypothesize that, due to the associated societal shame and stigma, these systemic barriers may be even more detrimental for accessing sexual dysfunction treatments than for other reproductive health services ([Kingsberg et al., 2019](#)).

Some past literature points to the fact that, globally, certain ethnicities, such as East Asian women, are less likely to seek treatment, and other ethnicities, such as Central/South American women, are more likely to seek treatment ([Moreira et al., 2005](#)). However, other literature showed that White and non-White individuals did not differ in treatment-seeking behaviours, at least not in Canada ([Lafortune et al., 2023](#)). Indeed, it is evident that cultural differences have varying levels of acceptance of female sexuality ([Hall, 2019](#)). Hence, it is also reasonable to expect that this might affect women’s feelings of comfort or discomfort towards seeking help. At the same time, another Canadian literature did not conclude this finding that ethnicity is a significant correlate ([Moreira et al., 2005](#)). Therefore, it is possible that at least in the Canadian context, our results concur with the existing evidence that ethnicity does not seem to be associated with treatment-seeking behaviours for sexual dysfunctions. Nonetheless, it is important to highlight that East Asian women living in East Asia will face notably different cultural pressures and influences on their sexuality compared to ethnically East Asian women living in Canada. As such,

subsequent research could aim to study acculturation or immigration as a mediator variable within this relationship.

Additionally, some findings point to gender identity and sexual orientation being significant predictors. Specifically, [Lafortune et al. \(2023\)](#) found that cisgender Canadian men and gender-diverse individuals sought treatment at a higher likelihood than cisgender women, and queer individuals (other than those identifying as asexual) were more likely to reach out for help than heterosexual men and women. However, not all studies found this ([Hobbs et al., 2019](#)). Understandably, for many queer women, fears of homonegativity or past experiences of discrimination have been speculated by some as factors that lessened their interest in getting professional support ([Kuyper & Vanwesenbeeck, 2011](#)). Interestingly, research by [Flynn et al. \(2019\)](#) found that the likelihood of talking to a provider about sexual problems or concerns also differed among various sexual minority groups, with bisexual women surpassing the rate for heterosexual women, and gay/lesbian women having the lowest likelihood of all sexual orientations. Unfortunately, again due to our need for statistical power, we simplified our variable of sexual orientation into the binary of heterosexual and non-heterosexual. Consequently, some of the nuances reported by [Lafortune et al. \(2023\)](#) on how treatment-seeking behaviours could differ among sexual minority groups might have been lost in our study. Notably, [Hobbs et al. \(2019\)](#), who followed the same binary categorization of their queer participants also did not discover a significant association.

Whether being in a relationship or not predicts sexual dysfunction treatment seeking is also equivocal. In fact, only one past Canadian study has been done on this area and found that those in a relationship are more proactive in seeking support ([Lafortune et al., 2023](#)). As sexual distress has been found to be positively correlated with treatment-seeking behaviours, it might also be interesting to consider whether partnered or single women are, on average, more distressed by sexual dysfunctions ([Velten & Margraf, 2023](#)). It is possible that for some couples, the additional pressure from the partner's reactions could exacerbate the woman's sexual difficulties. Indeed, past research by [Stephenson and Meston \(2012\)](#) has shown that partner and relational distress were significant factors in motivating women to seek treatment for sexual problems. However, it is also possible that for other couples, an empathetic partner could offer emotional support which could have buffered the woman's sexual distress. In line with this, a study by [Ojanlatva et al. \(2005\)](#) found that greater perceived partner support is linked to increased personal sexual satisfaction. Hence, distress might have been an important mediator underlying experiences of sexual dysfunctions and differences in help-seeking behaviours between partnered and single women.

In terms of religious beliefs, one previous Canadian study found that religious individuals are more likely than secular individuals to seek support ([Lafortune et al., 2023](#)). However, it is important to note that this conclusion was actually derived from the combined help-seeking data of both men and women, rather than separated results according to gender. Evidently, as many religions greatly differ on their acceptance of men's versus

women's sexual health, our study findings might be more helpful in the sense of focusing specifically on the female experience, and hence providing a more clarified picture on its relation to religious beliefs. On the other hand, another study by [Bergvall and Himelein \(2013\)](#) pointed out that at least in Swedish and American college students, religious participants and non-religious participants were equally open to seeking treatment for sexual dysfunctions. Additionally, other scholars have pointed out that different religions might influence how and to whom treatment-seeking is directed ([Sungur & Bez, 2016](#)). For instance, some Muslim couples will seek out faith healers such as "hodjas" before trying out therapy by secular providers ([Abbott et al., 2012](#)). At the same time, it is also true that many spiritual teachings, such as Christianity, look negatively upon women's sexual health ([Runkel, 1998](#)). Indeed, past research has found that in some Swedish or American college students, self-stigma is correlated with a lower likelihood of seeking out sexual dysfunction treatment ([Bergvall & Himelein, 2013](#)). Ultimately, because different religions can differ greatly from each other in terms of their attitudes towards female sexuality, it might be helpful for future researchers to conduct a more nuanced examination of the association between individual various spiritual teachings and help-seeking behaviours.

Finally, despite not finding a significant effect of having a history of non-consensual sexual contact on treatment-seeking for sexual dysfunctions, this is an important question to explore that has been only minimally studied in the literature to date. One past study did show that survivors of sexual assault tend to seek out medical services, but not mental health services, at an increased rate after the traumatic incident ([Kimerling & Calhoun, 1994](#)). However, it was not differentiated whether this was directly related to sexual dysfunction repercussions due to the assault, or other negative consequences in general, such as sexually transmitted infections or unwanted pregnancies. It is also important to note that having experienced non-consensual sexual contact, such as sexual abuse, has been identified as an important risk factor for having sexual dysfunctions ([Carreiro et al., 2016](#)). However, the exact mechanism of how this experience would affect future treatment-seeking tendencies in terms of sexual dysfunctions is still unknown. One potential mediator here is perhaps the shame that often comes with disclosing experiences of non-consensual sexual contact. Indeed, [Bhuptani et al. \(2019\)](#) found that the woman's experiential avoidance related to the traumatic event is directly correlated with whether she has faced victim-blaming in response to her disclosure. As such, it is possible that if a woman's sexual functioning has been impaired by the assault, she might then feel hesitant to seek out help due to a fear of shame or revictimization in response to her disclosure.

## Strengths and Limitations

The strength of this paper is that we focused on an understudied topic and contributed to this literature. The minimal past research on demographic predictors of treatment-seeking has mostly examined mixed-gender participants as well as using sex

assigned at birth. Hence, our findings help to address a gap in the field that specifically explores female sexual dysfunctions, but not from only a cisgender lens, which is a limitation. In addition, the current dataset included a broad sample of individuals with sexual problems who were recruited using a variety of different means.

Nonetheless, there are a few limitations to this study that should be considered. First, a portion of our data were collected during the COVID-19 pandemic, which may have affected the ecological validity and generalizability of the findings. Second, the nature of all self-reported data is that they could have been subjected to recall biases or social desirability effects, which could have also affected our study conclusions (Althubaiti, 2016), and it would have been helpful to instead obtain administrative data on treatment-seeking. Third, as participants could only answer “yes” or “no” to the sexual dysfunction and treatment-seeking questions, we were not able to control for the number of or the severity of sexual dysfunctions, as well as not able to control for the type of nor the outcome of the treatment sought. Fourth, due to the categorical nature of our data, it is also notable that some of the nuances of the demographic predictors and treatment-seeking behaviours could be lost in the process – for example, the grouping age into “< 24 years old,” “25 to 34 years old,” and “> 34 years old” instead of keeping it as a continuous variable. Consequently, future endeavours could examine the topic at hand from a qualitative lens.

Additionally, it is also important to highlight that chi-square tests, despite being able to indicate the existence of a correlation, cannot reveal the strength of the relationship between two variables nor directionality. Hence, subsequent research could build on our findings by looking at how strongly age, education, income, and employment are associated with treatment-seeking behaviours, for instance, examining whether there is one demographic variable that is the most robust predictor out of all. Finally, another significant limitation of ours is that all of our four original studies focused on topics related to sexual health. As a result, the sample is potentially biased towards participants who are relatively more comfortable or more interested in their sexuality. Together, due to these limitations, some potential nuances and further details of the findings could have gone undetected in our research.

## Future Directions

Future research should expand on the current findings by examining treatment preferences by demographic group. For example, whether older individuals are more likely to talk to their medical doctors rather than sex therapists and what is their reason behind this preference. Other efforts could also focus specifically on those who did not engage in any help-seeking behaviours. Specifically, it might be of value to explore why some groups are less inclined to reach out. As such, subsequent studies could then look into how to improve access to care for those more complacent demographics. Lastly, other relevant variables that might be insightful for future researchers to investigate include the effects of rurality, disability, personality traits,

sex education, and accessibility/feasibility of the sexual dysfunction treatments. Finally, future studies should also attempt to replicate our results with larger sample sizes to see if any non-significant results could be overturned with greater statistical analysis power.

## Conclusion

The decision to seek out treatment for female sexual dysfunctions is a multi-faceted and complicated process. However, despite the fact that these problems can happen to anyone, our findings suggest that not every woman seeks out and hence, receives support, with an equal likelihood. Our paper is significant in its efforts to contribute to the increasingly needed body of knowledge on what demographic variables predict treatment-seeking behaviours. As a result, the findings could have great implications for future research being able to identify which populations are less likely to receive help and hence lay the foundation for interventions that will bring equally accessible support to all women experiencing sexual dysfunction.

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