Original Article

Female sexual dysfunction—knowledge, attitude, practices, and barriers encountered by medical fraternity across the country: A web-based cross-sectional study

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Abstract

Introduction: Sexual dysfunction in women is common yet often remains underdiagnosed due to the lack of adequate training and experience of the doctors to manage female sexual dysfunctions. This study was done to assess the knowledge and attitude of medical professionals toward female sexual dysfunction and the various practices and barriers they encounter while managing women with sexual dysfunction. **Materials and Methods:** A web-based cross-sectional study was done using the snowball sampling method. A well-structured, self-administered, and pre-validated questionnaire containing 27 items was administered through social media. Data was collected and evaluated to assess their knowledge, practices they follow, and barriers encountered while managing female sexual dysfunction. **Results:** A total of 513 doctors participated in the study. Out of all, only 11.1% of the doctors were often seeing patients with sexual dysfunction. Loss of desire (44%), painful intercourse (33%), lack of lubrication (18%), and anorgasmia (5%) are common symptoms with which women present. The majority of doctors (78.9%) were comfortable in starting a conversation, over half (52.6%) were confident in making a diagnosis, and 51.3% were confident in providing sexual counseling. Yet, only 11.1% were routinely screening women for sexual dysfunctions, and 33.8% were providing counseling regarding sexual issues. Lack of time (31.6%), lack of adequate training (57.3%), unavailability of effective treatment (11.9%), patient discomfort (60.62%), and patient's reluctance to seek treatment (15.8%) were the barriers encountered by doctors. When assessed for knowledge, around 30.9% had excellent knowledge (≥75th percentile) about female sexual dysfunction. **Conclusion:** Sexual dysfunction among women is an important health issue that significantly affects the social, mental, and physical well-being of those suffering from it. Screening for sexual dysfunction should be done routinely in day-to-day clinical practice to improve the overall quality of life of a couple.

Keywords: Female sexual dysfunction, sexual dysfunction, sexual health

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Introduction

Normal sexual function is a complex integration of the physical, mental, and social aspects of human life. Any alteration in any

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of these domains can lead to sexual dysfunction, which can significantly affect the quality of life of a couple. The reported prevalence of sexual dysfunction in women is around 38–63%.[1-4] Social stigma and taboos related to female sexual issues, attitude toward female sexuality and sexual problems, lack of resources, lack of knowledge about whom to consult for such problems, and embarrassment in discussing sexual issues with the health care providers are some of the reasons for under-reporting of the symptoms.[5-7] On the other hand, due to a lack of training in sexuality-related issues, most doctors feel uncomfortable and underconfident about starting the conversation about female sexual dysfunction, leading to an underdiagnosis of the condition.[8-11] Despite the availability of various guidelines and screening tools, taking sexual histories and screening women for sexual dysfunctions is not a common practice among medical practitioners.

This study was planned to assess the knowledge, perceptions, and existing practices regarding female sexual dysfunction among the medical fraternity and the barriers they encounter in managing these patients. Understanding the lacunae would help us plan further strategies to improve our practices regarding sexual dysfunction.

Materials and Methods

A web-based cross-sectional study was done using the snowball sampling method. Ethical clearance was taken from the Institutional Ethical committee. A well-structured and self-administered questionnaire containing 27 items was designed. The questionnaire was sent to five experts, one each from the departments of gynecology, psychiatry, medicine, urology, and to a general duty medical officer for validation and expert comments. The necessary modifications were made as per the suggestions from the experts. The modified questionnaire was pilot tested on 10 doctors for flow, validity, and sensibility. Once the questionnaire was finalized, an interest form describing the background, nature, and purpose of the study was circulated through social media platforms to the target population. Those who showed interest were then sent the consent form and the questionnaire. Participants were able to assess the questionnaire only after filling out the consent form. Demographic data of the study population [Table 1] and common practices followed by the doctors for the management of patients with female sexual dysfunction were recorded [Table 2]. A total of seven statements were framed to assess their knowledge and attitude toward patients with sexual dysfunction [Table 3]. Each correct response was awarded one mark. There were two statements regarding the underlying cause and management options where more than one option could be ticked. The total score of 20 was assigned. According to the score, they were categorized into poor (<25th percentile), good (25th–50th percentile), very good (50th–75th percentile), and excellent (>75th percentile) knowledge. A correlation between the knowledge score and different variables like age, sex, duration of practice, specialty, and city of practice was done.

Table 1: Univariate description of the socio-demographic characteristics of the respondent

Variables	*n*=513	Percentage
Gender		
Female	428	83.4%
Male	85	16.56%
Age		
21–30 years	52	10.1%
31–40 years	263	51.3%
41–50 years	97	18.9%
>50 years	101	19.7%
Designation		
Consultant	408	79.5%
Senior resident	37	7.2%
Junior resident	27	5.3%
Medical officer	41	8%
Type of Institute working		
Government hospital	260	50.7%
Corporate hospital	101	19.7%
Private clinic	152	29.6%
Place of practice		
Metropolitan city	317	61.8%
Middle tier city	145	28.3%
Rural area	51	9.9%
Duration of practice		
<5	155	30.2%
5–10	108	21.1%
10–15	81	15.8%
>15	169	32.9%
Specialty		
Urologist	3	0.6%
General physician	17	3.3%
Medical officer	105	20.5%
Gynecologist	371	72%
Psychiatrist	17	3.3%
Have you received any special training pertaining to female sexual dysfunction?		
No	483	94.1%
Yes	30	5.9%

Study population

Gynecologists, urologists, psychiatrists, general physicians, and general duty medical officers working across the country.

Inclusion criteria

1. Gynecologists, urologists, urologists, general physicians, and general duty medical officers.

Exclusion criteria

1. Those who did not consent to participate.
2. Incomplete questionnaires.

Data analysis

Statistical analysis was done using statistical package for the social sciences (SPSS) 26. The demographic characteristics of the respondents were examined according to frequency with

Table 2: Common practices followed by doctors

Variables	*n*=513	Percentage
How often do women present to you with a symptom of sexual dysfunction?		
Never seen	172	33.5%
Rarely	284	55.4%
Often	57	11.1%
What is the most common symptom women present to you with?		
Loss of interest/desire	226	44%
Painful intercourse	169	33%
Lack of lubrication/vaginal dryness	92	18%
Inability to achieve orgasm/anorgasmia	26	5%
How often do you screen a woman for sexual dysfunction in your practice?		
Always	57	11.1%
Never	128	25.0%
Sometimes	328	63.9%
Do you feel comfortable in starting your conversation regarding the sexual dysfunction with the patient?		
No	108	21.1%
Yes	405	78.9%
Are you confident in making the diagnosis of female sexual dysfunction?		
No	243	47.4%
Yes	270	52.6%
Are you confident in providing counseling to couples/women with female sexual dysfunction?		
No	250	48.7%
Yes	263	51.3%
Do you routinely counsel if a couple with sexual dysfunction presents to you?		
No	340	66.2%
Yes	173	33.8%

percentages. The normal distributions were checked by applying the Shapiro–Wilk test. A significant difference in the mean has been checked by applying the Mann–Whitney U test for the two groups. Further, the Kruskal–Wallis test was then employed to compare differences among groups, followed by the Tukey test in case of significant differences. A $P < 0.05$ was considered statistically significant. Independent sample Mann–Whitney U test and independent sample Kruskal–Wallis test have been applied to check whether the distribution of knowledge score is the same across categories of the independent variables having two categories and more than two categories, respectively.

Results

A total of 513 doctors participated in the study. The demographic data of the study participants is shown in Table 1. The majority of participants (94.1%) admitted that they have not received any formal training to manage female sexual dysfunction. The most common symptom with which women presented was loss of desire/interest (44%). Painful intercourse (33%), vaginal dryness/lack of lubrication (18%), and anorgasmia (5%) were the other symptoms with which women presented [Figure 1].

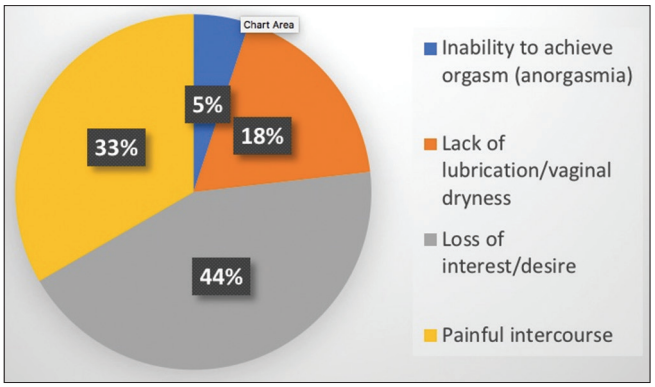

Figure 1: Common symptoms women present with

Table 2 shows the practices followed by doctors to screen women for sexual dysfunction. Only 11.1% of the gynecologists said they often see women with sexual dysfunction. Around 78.9% were comfortable with starting a conversation regarding sexual dysfunction, and 52.6% were confident in making the diagnosis. Around 51.3% were confident in providing sexual counseling to the couple; however, only 33.8% of the doctors were counseling couples regarding sexual function. A total of seven statements were used to assess the knowledge and attitude regarding sexual dysfunction [Table 3]. Based on the responses, the knowledge score was calculated. Among the participants, 20.39% scored below the 25th percentile (poor knowledge), 24.32% between the 25th and 50th percentile (fair knowledge), 24.32% between the 50th and 75th percentile (good knowledge), and 30.92% above the 75% percentile (excellent knowledge). There was no significant association between the knowledge score and place of work, city of work, or duration of practice. A significant difference in the knowledge score was seen between female and male doctors, but that could be because very few male doctors (16.6%) participated in the study [Table 4].

While managing women with sexual dysfunction, patients' discomfort and lack of adequate knowledge were the most common barriers among the study population [Table 5].

Discussion

Sexual dysfunction in women is a complex disorder that is often multifactorial. The reported prevalence of female sexual dysfunction in the literature is 38–63%.[1-4] Interpersonal issues, relationship problems, previous unpleasant experiences, psychological issues, endocrine disorders, chronic medical or surgical conditions, and neurological conditions can lead to an alteration in sexual function.[11,12] The diagnosis of female sexual dysfunction is based on the International Statistical Classification of Disease and Related Health Problems (ICD-10)[13] and the Diagnostic and Statistical Manual of Mental Disorder, 5th edition (DSM-V).[14] According to the DSM-V, female sexual dysfunction is divided into three categories: desire/interest disorders, arousal disorders, and genito-pelvic pain disorders. To call it dysfunction the symptoms should cause significant distress, should be present for almost 75% of the times, and

Table 3: Statements used to assess knowledge score

Variables	Scores	*n*=513	Age (%)
1. Female sexual dysfunction is as common as male sexual dysfunction	Agree=1	347	67.7%
	Disagree=0	112	21.8%
	No response=0	54	10.5%
2. Screening should only be done for priority diseases. Since FSD is not a priority disease screening is not required	Agree=0	334	65.1%
	Disagree=1	111	21.6%
	No response=0	68	13.3%
3. Sexual life is private and a doctor should not probe into the matter unless the patient herself wants to discuss	Agree=0	139	27.1%
	Disagree=1	320	62.4%
	No response=0	54	10.5%
4. There are no guidelines on how to screen, diagnose, counsel, and treat a women with FSD	Agree=0	344	67.1%
	Disagree=1	105	20.4%
	No response=0	64	12.5%
5. Since there is no effective treatment available, there is no point in screening the patient for FSD	Agree=0	405	78.9%
	Disagree=1	47	9.2%
	No response=0	61	11.8%
6. Who, in your understanding, should screen women for female sexual dysfunction	Gynecologists	154	30%
	Sexual medicine specialist	54	10.5%
	Physician	7	1.3%
	Any of the mentioned=1	270	52.6%
	Others=0	28	5.5%
	No response=0	0	0%
7. How often do you think a treating doctor should enquire a woman about any sexual dysfunction	At every visit=1	227	44.2%
	Annually	94	18.3%
	Should not be done unless women report with symptoms=0	192	37.5%
	No response=0	0	0%
8. Are you aware of the DSM-IV/V classification of the female sexual dysfunction	Yes=1	139	27%
	No=0	374	73%
	No response=0	0	0%
9. Which of the following questionnaires in your knowledge can be used to assess female sexual dysfunction	FSFI=0	175	34.1%
	SDI=0	139	27.1%
	BSSC-W=0	57	11.1%
	All=1	135	26.3%
	No response=0	7	1.4%
10. In your opinion which of the following can lead to temporary alteration in female sexual dysfunction	Psychiatric disorder=1	347	67.6%
	Relationship problems=1	459	89.5%
	Childhood abuse or previous unpleasant experience=1	363	70.8%
	Psychotropic drugs=1	412	80.3%
	Pregnancy=1	257	50%
	Breastfeeding=1	310	60.4%
	No response=0	11	2.1%
11. What are the treatment options for the female sexual dysfunction	Healthy diet=1	236	46%
	Exercise and meditation=1	300	58.5%
	Tricyclic anti-depressant=1	168	32.7%
	Cognitive behavioral therapy=1	313	61.0%
	Selective serotonin reuptake inhibitor=1	189	36.8%
	No response=0	166	32.4%
Total Score	20		

Table 4: Mean difference of knowledge score among variable categories

Variables	Mean±S.D. (knowledge score)	*P*	Group significantly differs
Gender[a]			
Female	11.02±4.60	0.038	Yes
Male	9.56±4.11		
Age[b]			
21–30 years	11.07±3.08	0.297	None
31–40 years	11.15±4.25		
41–50 years	9.17±4.36		
>50 years	10.77±5.72		
Designation[b]			
Consultant	10.55±4.75	0.596	None
Senior resident	12.36±4.32		
Junior resident	10.88±2.64		
Medical officer	10.41±3.09		
Type of institute working[b]			
Government hospital	11.03±4.46	0.331	None
Corporate hospital	9.53±4.69		
Private clinic	10.98±4.54		
Place of practice[b]			
Metropolitan city	11.14±4.58	0.033	Middle-tier city–metropolitan city
Middle-tier city	9.23±4.30		
Rural area	12.07±3.99		Middle-tier city–rural area
Duration of practice[b]			
<5	10.41±3.76	0.403	None
5–10	11.28±4.31		
10–15	11.63±4.78		
>15	10.12±5.15		

a—Independent sample Mann–Whitney *U* test. b—Independent sample Kruskal–Wallis test.

Table 5: Barriers encountered in the management of female sexual dysfunction

Variable		*n*=513	Age (%)
Patients are not comfortable talking about FSD		311	60.62%
I do not have enough knowledge and training to screen, diagnose, and treat FSD		294	57.30%
Lack of time		162	31.6%
Patients themselves do not want to be treated as they do not feel sexual functions are not important		81	15.8%
There is no available treatment so there is no point in screening women for sexual dysfunction		61	11.9%
Are you interested in providing counseling related to sexual issues to the couple	Yes	334	65.1%
	No	170	34.9%
	No response	0	0%

should be present for at least 6 months. Various screening/rating scales have been developed for assessing different domains of sexual dysfunction in both men and women. Arizona sexual experience scale (ASEX), change in the sexual functioning questionnaire (CSFQ), sexual functioning questionnaire (SFQ), derogatis interview for sexual functioning (DISF), and female sexual function index (FSFI) are the few most commonly used scales. Out of all sexual dysfunction screening/rating scales FSFI which consists of 19 items, is specific to female. It is a self-reported, brief instrument that assesses six domains of female sexual dysfunction, namely, desire, arousal, lubrication, orgasm, satisfaction, and pain.[15,16] It has been seen that in most communities, women do not feel comfortable talking about sexuality and sexual problems other than reproductive issues. A study done by Singh *et al.*[17] reported that around 82% of women had some sort of sexual dysfunction, out of which 62% were not comfortable talking about the problem even with their partners, and none of them had ever consulted any doctor for this problem. McCool *et al.*[18] in their study found that 57% of obstetricians and gynecologists believe that there is underreporting of the disorder. Singh and Mathur[19] in their study stated that out of all the patients seen by the doctors, only 1.2% of the patients reported sexual dysfunction. Similarly, in the present study, 88.9% of the doctors had rarely or never seen women with sexual dysfunction in their clinics, which could either be due to the low prevalence of the condition or underreporting of the symptoms. In the present study, it was seen that the most common symptom with which women presented was the loss of desire (44%), followed by painful intercourse (33%), lack of lubrication (18%), and inability to achieve orgasm/anorgasmia (5%). The results were similar to a study by Jaafarpour *et al.*[20] where 42% of women suffered from orgasmic disorders, 42.5% from genito-pelvic pain, 45.3% from desire disorders, and 37.5% from arousal disorders. In another study by Hisasue *et al.*[21] 15.2%–32.2% of women had orgasmic disorder, 27.7%–57.9% had desire disorder, 29.7%–57.9% had arousal disorder, and 12.5–51.2% had lubrication disorders. In a study by Singh and Mathur[19] the authors reported that 18.2% of the gynecologists were screening their patients routinely for sexual dysfunction. McCool *et al.*[18] also reported that only 21% of obstetricians and gynecologists were doing routine screening for all patients. In the present study, 11.1% of the doctors were routinely screening women for sexual dysfunction. Lack of training regarding female sexual disorders is a known cause of poor communication and under-diagnosis of the cases. Millman *et al.*[22] reported that only 12% of the resident doctors felt their residency program provided them with adequate knowledge and exposure to sexual dysfunction in women. McCool *et al.*[18] also reported that 89% of the obstetricians and gynecologists in their study stated that their training regarding sexual dysfunction in women was poor. Similar to previous studies, the present study also reported that majority of participants lack formal (94.1%) training about female sexual dysfunction. In our study, most of the participants (78.9%) were comfortable starting conversations regarding sexual dysfunction with their patients. Similar results were seen in studies done by McCool *et al.*[18] and Singh and Mathur[19] where the authors found that most of the gynecologists were comfortable discussing the sexual concerns of the patients. Over half of the participants in our study (52.6%) were confident in making a diagnosis of female sexual dysfunction, 51.3% were confident in providing counseling to couples with female sexual dysfunction, and 33.8% were already providing counseling. However, McCool *et al.*,[18] in their study reported that 85% of obstetricians and gynecologists were experiencing challenges in diagnosing and providing treatment to women with female sexual dysfunction. In the study done by

Singh and Mathur,[19] almost 85.4% of doctors admitted that they are not confident in managing women with sexual dysfunction. While assessing the knowledge and attitude of the practitioners regarding female sexual dysfunction, it was seen that only 30.92% scored above the 75th percentile and around 24.32% between the 50th and 75th percentile. Similar results were seen in a survey done by Li *et al.*[23] on 3013 obstetricians and gynecologists, where the authors found that knowledge regarding sexual dysfunction screening and management was poor among the obstetricians and gynecologists. In this study, a significant difference in the distribution of knowledge scores was seen between males and females (*P* value = 0.038), which could be because of the few male participants in the study as compared to female participants. There was no significant association in the knowledge score when compared with respect to the age of the practitioner, place of work, city of work, or duration of practice [Table 4].

McCool *et al.*[18] in their study reported that time constraints (62.6%), lack of financial compensation (61.7%), uncertinity of treatment (19.1%), unavailability of screening method/questionnaire (13.6%), and fear of litigation (8.9%) were the major barriers to the management of women with sexual dysfunction. In our study we found, patient discomfort (60.6%), inadequate knowledge and training (57.3%), lack of time (31.6%), patient's reluctance (15.8%), and unavailability of effective treatment (11.9%) were the common barriers. Despite all the obstacles, around 65.1% of the doctors in the present study were still interested in providing sexual counseling, reflecting a positive attitude toward the management of patients.

Conclusion

Sexual dysfunctions are complex disorders that are often difficult to diagnose and treat. A good communication and skill-full history taking in a manner that a woman can trust the care provider is the first and foremost step in management of sexual issues, and one must master it. More than one session may be required before a woman can discuss her sexual concerns, and she should be given time to do so. The conversation should be in a non-judgmental manner. Medical professionals should receive some minimum training in dealing with sexual health and related issues so that they can at least counsel, screen, and diagnose the condition and refer the patient to an appropriate facility if needed. Female sexual dysfunction is a prevalent condition that needs to be addressed in a similar manner as any other disease.

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Conflicts of interest

There are no conflicts of interest.

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