Female sexual dysfunction: A clinical case series

Shrutakirthi Damodar Shenoi, Smitha S. Prabhu
Department of Dermatology and Venereology, Kasturba Medical College, Manipal, Manipal Academy of Higher Education, Manipal, Karnataka, India

Address for correspondence:
Dr. Smitha S. Prabhu, Additional Professor, Department of Dermatology and Venereology, Kasturba Medical College, Manipal, Manipal Academy of Higher Education, Manipal, Karnataka, India.
E-mail: drsmithaprabhu@yahoo.com

Abstract

Introduction: Female sexual dysfunction (FSD) is a much-neglected area of medicine possibly due to the stigma attached to sexual functioning in most religions and cultures. **Materials and Methods:** Here, we report a case series of 12 females with FSD from the data collated from the sexual dysfunction clinic of a tertiary care hospital in South India. **Results:** Of the 370 patients who were seen in the sexual dysfunction clinic, only 12 (3.24%) were women aged from 22 to 58 years with a duration of marriage 3 months to 25 years. The commonly encountered problems were dyspareunia and hypoactive sexual disorder. Three had nonconsummated marriages. After evaluation, two patients were treated with antipsychotics and all were offered psychosexual counseling. **Conclusion:** Female sexual dysfunction remains unrecognized and under reported, especially in patriarchal cultural societies of the Indian subcontinent.

Key words: Diagnostic and Statistical Manual of Mental Disorders-5, dyspareunia, female sexual dysfunction, female sexual interest, psychosexual counseling

Introduction

Female sexuality and sexual health is complex in nature, influenced by psychological, physiological, social, cultural, and religious factors. The sexual response cycle consists mainly of desire, arousal, and orgasm. As per the Diagnostic and Statistical Manual of Mental Disorders – 5th Edition (DSM – 5), female sexual dysfunction (FSD) can be classified into as female sexual interest/arousal disorder, female orgasmic disorder, and genito-pelvic pain/penetration disorder.[1]

In India, reports of FSD are few and far between. We audited the patients reporting to the sexual dysfunction clinic of the dermatology department in a tertiary care hospital in South India and report a series of 12 females with sexual dysfunction.

Materials and Methods

We collated the data collected from the sexual dysfunction clinic at a tertiary care hospital, with an aim of studying females presenting with sexual dysfunction.

Results

Out of 370 patients with sexual dysfunction from October 2017 to December 2019, there were only 12 females amounting to 3.24% of the total. Their clinical profile is depicted in Table 1.

The age of patients ranged from 22 to 58 years, with a mean of 34 years. Their married life ranged from 3 months to 25 years. Decreased desire and dyspareunia were seen in four patients each, both decreased desire and dyspareunia in three patients, making these two the most common causes for FSD. One female with fear of painful penetration, one with dyspareunia, and one with low desire to the point of aversion to sex had not consummated their marriage. Two patients with concomitant dysthymia were started on psychotropics. Associated sexual dysfunction in male partners was reported in three. All husbands, but one, were distressed about their wife's condition. Interestingly, ten out of the 12 women were graduates (83.33%), and the rest having had completed primary and secondary school education, respectively. Treatment consisted of psychosexual counseling involving both couples, use of lubricants before intercourse, and use of bupropion 150 mg daily in one woman, who desired medical treatment. Another woman with dysthymia was started on sertraline 25 mg, later increased to 50 mg. The rest of the women with hypoactive sexual disorder refused medical treatment. None of the women were available for regular follow-up, although one woman who started bupropion reported moderate improvement in her condition at follow-up 3 months later [Table 1].

Access this article online

Quick Response Code:

Website: www.ijstd.org

DOI: 10.4103/ijstd.IJSTD_67_20

How to cite this article: Shenoi SD, Prabhu SS. Female sexual dysfunction: A clinical case series. Indian J Sex Transm Dis 2022;43:208-10.

Submitted: 04-Jun-2020 **Revised:** 28-Sep-2021
Accepted: 03-Nov-2021 **Published:** 17-Nov-2022

Table 1: Demographic characteristics of the patients

Age in years	Educational qualifications	Duration of married life	Complaints, duration	Partner problems	Associated conditions	Management
30	Graduate	6 years	Decreased interest in sex and arousal – 2 years	Distress	Worry about son's cardiac disease	Psychosexual counseling
30	Graduate	2 years	Aversion to sex since beginning. Marriage not consummated	Husband has a recent onset of erectile dysfunction	History of sexual abuse in childhood hypoythyroidism	Psychosexual counseling
29	Graduate	2.5 years	Nonconsummation of marriage due to entry pain	Phimosis	Nil	Psychosexual counseling and lubricants
58	Primary school	25 years	Pain and burning with reduced desire – 8 years	Husband distressed	Migraine, radiculopathy, and dysthymia	Tablet Bupropion SR 150 mg daily, lubricants
36	Graduate	14 years	Decreased interest since childbirth – 13 years	Distress	Worried about son's ADHD. No privacy at home	Psychosexual counseling
50	Graduate	23 years	Decreased interest and dryness - 8 years	None	Dysthymia	Tablet Sertraline 50 mg and lubricants
27	Graduate	7 years	Pain on deep penetration – 2 years	Distress	Migraine	Psychosexual counseling, gynecology consult
30	Graduate	7 years	Dyspareunia – 6 months	Husband has premature ejaculation	Nil	Psychosexual counseling and gynecology consult
38	Graduate	15 years	Decreased interest and pain on penetration – 10 years	Husband distressed	On psychotropics for 8 years	Weight reduction and lubricants
27	Graduate	6 months	Pain during insertion – 2 months	Husband not interested in sex and has phimosis	Relationship problems with husband	Psychosexual counseling of both partners
22	Secondary school	3 months	Severe dyspareunia – 3 months with decreased desire and lubrication –since marriage	Husband distressed	White discharge	Treatment of vaginal discharge and lubricants
31	Graduate	3 years	Fear of pain and penetration – 3 years. Nonconsummated marriage	Recent onset premature ejaculation in husband	Nil	Psychosexual counseling

ADHD=Attention Deficit Hypersensitivity Disorder, SR=Sustained Release

Discussion

In the Indian culture, there is a taboo regarding matters of sex, especially in females, and most often, apathy and lack of sexual interest in female is considered as normal. Even if a couple realize that they have sexual dysfunction, they are hesitant to seek treatment for the same, and often do not know which specialist to approach. Having dedicated clinics gives them an opportunity to discuss their personal sexual issues.

Worldwide prevalence of FSD is approximately 40%,[2] whereas Indian data give prevalence rates between 55.5%[3] and 73.2%.[4]

FSD is classified into female sexual interest/arousal disorder, female orgasmic disorder, and genito-pelvic pain/penetration disorder, along with categories common to both genders like substance/drug-induced and other unspecified subsets in the latest DSM-5 criteria.[1] The various causes of FSD include psychological (relationship issues with partner, anxiety issues, and memories of past negative sexual experience), hormonal (decrease in sexual desire at menopause), vascular (vessel damage during pelvic surgery), neural (in diabetics), drug induced (secondary to antidepressant therapy), and the presence of chronic diseases such as cancer, diabetes, chronic kidney disease, and rheumatic diseases.[5]

In our series, seven patients (58.33%) had dyspareunia or painful sexual intercourse. The current term "genito-pelvic pain/penetration disorder" includes dyspareunia and vaginismus. Dyspareunia is defined as marked or persistent pain with sexual activity that causes marked distress or interpersonal conflict.[6] It can be classified as entry dyspareunia that is pain at initial penetration of vaginal introitus and deep dyspareunia that is pain at deep vaginal penetration. The causes of early dyspareunia include local dermatologic diseases such as lichen sclerosus, vaginismus, and vulvodynia, whereas the cause of deep dyspareunia is pelvic pathology such as pelvic inflammatory disease. Inadequate lubrication, vaginal infections, postpartum dyspareunia, and postmenopausal vaginal atrophy are causes of both entry and deep dyspareunia.[7]

There were seven patients (58.33%) who had sexual interest disorder, previously known as hypoactive sexual desire disorder. It is characterized by a lack of desire and sexual fantasies causing considerable distress and interpersonal difficulty. This has complex roots ranging from upbringing in a strict environment, cultural taboo, personal insecurity, and even sexual abuse and posttraumatic stress disorder.

There were three females between 29 and 31 years whose marriage was nonconsummated. One had been sexually abused as a child and had sexual aversion, while another had fear of pain and bleeding, and one had true dyspareunia. Erectile dysfunction, phimosis, and premature ejaculation were present in each of the partners. Nonconsummated marriages are common in developing countries, common reasons being vaginismus[8] and premature ejaculation.[9] Social reasons such as lack of privacy, religious taboo, and even lack of awareness about genital anatomy and functioning are more prevalent in Asian and Middle Eastern cultures.[10]

Level of education of the patient could not be correlated with lack of sexual education and sexual dysfunction. This is in contrast to world literature, where FSD is proportional to the lower level of education in females as well as in their partners.[11]

Management of FSD is based on a thorough history, physical examination, and relevant investigations wherever indicated. Organic causes such as pelvic inflammatory disease, endometriosis, and tumors should be ruled out for deep dyspareunia. Treatment is planned after categorizing

the particular dysfunction. Couple counseling and sex education are often necessary in most cases. Lifestyle modifications, pelvic floor strengthening exercises, psychosexual counseling, psychoeducation, medications, and occasionally, medical therapy are used. Pelvic floor exercises which strengthen the pelvic muscle are found to be easy to perform, and very effective in cases with genital/pelvic pain. Medications used include conjugated estrogens, tricyclic antidepressants or other psychotropics, and topical lubricants. Bupropion sustained-release 150–400 mg per day is being increasingly used in women with arousal and orgasmic disorders. It is a norepinephrine–dopamine reuptake inhibitor as well as acetylcholine receptor antagonist which has an additional action of increasing the pleasurable response.[12] One among our five patients with decreased sexual desire was started on bupropion for low sexual interest and another on sertraline for dysthymia. All were offered psychosexual counseling, and use of lubricant gels was advised in those with pain disorder.

Conclusion

FSD is still an unexplored as well as orphaned medical field, and this is due to amalgamation of various factors including religious and cultural taboo, lack of knowledge, misperceptions, and hesitancy to seek treatment among patients and partners, as well as lack of expertise in treating the same. Moreover, there is no dedicated branch of medicine to treat this condition, and those patients who want to seek treatment may approach dermatologists, gynecologists, urologists, or psychiatrists depending upon their level of perception of the condition. Rising quackery in this arena and false advertisements by nonmedical "sex experts" further complicate the issue. Sex education and counseling as well as education of health-care workers is extremely important in this scenario.

Financial support and sponsorship

Nil.

Conflicts of interest

There are no conflicts of interest.

References

1. American Psychiatric Association. Diagnostic and Statistical Manual of Mental Disorders: Diagnostic and Statistical Manual of Mental Disorders. 5th ed. Arlington, VA: American Psychiatric Association; 2013.
2. Shifren JL. In: Chakrabarti A, editor. Overview of Sexual Dysfunction in Women – Epidemiology, Risk Factors and Evaluation. UpToDate; 2020. Available from: https://www.uptodate.com/contents/overview-of-sexual-dysfunction-in-women-epidemiology-risk-factors-and-evaluation?search=overview-of-sexual-dysfunction-in-women-epidemiology-risk-factors-and-evaluation. [Last accessed on 2020 Jun 03].
3. Mishra VV, Nanda S, Vyas B, Aggarwal R, Choudhary S, Saini SR. Prevalence of female sexual dysfunction among Indian fertile females. J Midlife Health 2016;7:154-8.
4. Singh JC, Tharyan P, Kekre NS, Singh G, Gopalakrishnan G. Prevalence and risk factors for female sexual dysfunction in women attending a medical clinic in south India. J Postgrad Med 2009;55:113-20.
5. Magon N, Chauhan M, Kalra B. Female sexual dysfunction – Indian scenario. Available from: http://apiindia.org/wp-content/uploads/medicine_update_2013/chap70.pdf. [Last accessed on 2020 Jun 03].
6. Lewis RW, Fugl-Meyer KS, Corona G, Hayes RD, Laumann EO, Moreira ED Jr., *et al.* Definitions/epidemiology/risk factors for sexual dysfunction. J Sex Med 2010;7:1598-607.
7. Seehusen DA, Baird DC, Bode DV. Dyspareunia in women. Am Fam Physician 2014;90:465-70.
8. Ghorbani B, Arefi S, Saber YM, Sadri-Ardekani H. Successful infertility treatment and spontaneous pregnancy in an unconsummated marriage after 7 years. J Reprod Infertility 2006;7:284-9.
9. Zargooshi J. Male sexual dysfunction in unconsummated marriage: Long-term outcome in 417 patients. J Sex Med 2008;5:2895-903.
10. Badran W, Moamen N, Fahmy I, El-Karaksy A, Abdel-Nasser TM, Ghanem H. Etiological factors of unconsummated marriage. Int J Impot Res 2006;18:458-63.
11. Küçükdurmaz F, Efe E, Malkoç Ö, Kolus E, Amasyalı AS, Resim S. Prevalence and correlates of female sexual dysfunction among Turkish pregnant women. Turk J Urol 2016;42:178-83.
12. Dawson ML, Shah NM, Rinko RC, Veselis C, Whitmore KE. Evaluation and management of female sexual dysfunction. Clin Rev 2018;28:27-38.