

Female Sexual Dysfunction: Indian Perspective and Role of Indian Gynecologists

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Abstract

Background: One rarely finds Indian women talking about their sexuality like this due to sex taboo in our society. This does not mean that sexual dysfunction is uncommon in Indian women. Female sexual dysfunction is widely prevalent. **Aim and Objective:** Indian women seek less assistance for them, despite undergoing physical and marital problems. Data of prevalence of such problems was collected to understand the scope of these problems and how Indian women deal with it. The objective was to understand prevalence of sexual dysfunction in women attending Gynaecology OPD and their perception about sex. **Material and Methods:** A questionnaire based prevalence study comprising of 520 patients from January, 2018 to June, 2018 was done. The questionnaire was designed on the basis of prior used ones in various studies and modified according to current patient scenario at the tertiary centre where study was conducted. **Results:** The data collected showed that sexual problems are not reported even when they were widely prevalent. 64% of women can't talk regarding this to their partners too. 82% patients had some sort of sexual problem. Only 18% patients said that they have no sexual problem and were satisfied with their sexual life. However, none of them consulted or took any form of assistance from any medical personnel. **Conclusion:** Indian women are reluctant and shy to discuss sexual problem unlike westerners who are more open and demanding when it comes to their needs. Gynecologists need to discuss with the patients about their sexuality and pertaining issues with utmost warmth, care and respect. They need to pull out the problem from within their patients and handle it effectively.

Keywords: Dyspareunia, female sexual dysfunction, sex therapy clinics

INTRODUCTION

One rarely finds Indian women talking about their sexuality like this due to sex taboo in our society. This does not mean that sexual dysfunction is uncommon in Indian women. Female sexual dysfunction (FSD) is widely prevalent. However, the treatment is rarely sought. Many women consider sex as a part of reproduction only without knowing its effect on the overall physical and mental health. This field has been less commonly understood and studied and hence, there are not many treatment options available. In 2013, the revised definitions for FSD from the Second International Consensus of sexual medicine classification system for female sexual disorders were produced to emphasize upon this condition. Indian women seek less assistance for them despite undergoing physical and marital problems. Hence, to understand the magnitude of problem in North India, a data of prevalence of these problems in woman attending our tertiary care hospital were collected. These data were collected with the aim of emphasizing on this subject among the fraternity.

Problem statement and the Indian scenario

The epidemiology of FSD is difficult to determine due to the fact that it has not been studied extensively and different classification systems have been employed. About 30 years ago, a study reported that 76% of women described some symptoms of sexual dysfunction.^[1] A United States-based study around 10 years back reported that approximately 40% of women had sexual concerns with 12% having distressing sexual problems.^[2] In PRESIDE study done by Rosen *et al.* 2009 to investigate the correlates of sexual distress in women with self-reported low sexual desire using the Female Sexual Distress Scale (range 0–48) with a score of 15 or higher indicating presence of distress. They concluded

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that out of 10,429 women with low desire, 27.5% had sexual distress (mean age 48.6 years, 81% with a current partner). Dissatisfaction with sex life was much more common in women with low desire and distress (65%) than in those without distress (20%).^[3]

In 1970s, Agarwal first published a study of 17 female cases of frigidity associated with ignorance related to sexual activity, fear of pregnancy, marital disharmony, and lack of emotional ambience, tiredness, and poor precoital attentiveness.^[4] An unpublished study from Chandigarh documented 13 female patients out of 464 patients reported of sex-related problems. Vaginismus, dyspareunia, and lack of sexual desire were the main problems reported.^[5] In 2007, a study from South India found orgasmic difficulties in 28.6% females.^[6]

In another cross-sectional survey of 149 married women in a medical outpatient clinic of a tertiary care hospital, Singh *et al.* recently reported FSD in 73.2% subjects of the population. The complaints elicited were difficulties with desire in 77.2%, arousal in 91.3%, lubrication in 96.6%, orgasm in 86.6%, satisfaction in 81.2%, and pain in 64.4% of the subjects.^[7]

In another study, 63.67% patients with infertility and 46.35% women without infertility had FSD.^[4] In a recent study done on 153 females in Ahmedabad between 2105–2016, 55.5% women had one or the other sexual dysfunction.^[8] In a retrospective review by Pal *et al.* 2017, of the 237 patients attending the sexual clinic, 235 (99.2%) were male and rest were female. They concluded that there is a paucity of data regarding the prevalence of sexual dysfunction in the clinical population from Eastern India and a high gender disparity among the patients attending the special clinic.^[9]

More research and data are needed to determine the prevalence of each sexual dysfunction in population of Indian women and the relations these dysfunctions have with different diseases and drug therapies.

Changing definitions of female sexual dysfunction

The classification of sexual dysfunctions was simplified in the Diagnostic and Statistical Manual of Mental Disorders (DSM V). The female dysfunctions are studied under the group of:

- Sexual interest/arousal disorder
- Genitopelvic pain/penetration disorder
- Female orgasmic disorder.

The DSM-5 includes the requirement of experiencing the disorder 75%–100% of the time to make any diagnosis of sexual disorder, with the notable exception of substance or medication-induced disorders. Moreover, it is now minimum required the duration of approximately 6 months. Finally, in order to make a diagnosis, the disorder must be deemed to have caused significant distress.^[10]

The revised definitions for FSD from the Second International Consensus of Sexual Medicine are as follows:^[11,12]

Sexual desire/interest disorder

Diminished or absolute lack of sex desire, absent sexual

thoughts or fantasies, and a lack of responsive desire; motivations for attempting to become sexually aroused are scarce or absent; lack of interest is considered to be beyond the normal decrease experienced with increasing age and relationship duration. Sexual aversion disorder is extreme anxiety or disgust at the anticipation of or attempt at any sexual activity.

Sexual arousal disorder

This is of various subtypes. Subjective arousal disorder, i.e., there is no feeling of sexual arousal from any type of sexual stimulation; however, vaginal lubrication or other signs of physical response occur; Genital sexual arousal disorder, in which the woman complains of impaired genital sexual arousal, which may include minimal vulvar swelling or vaginal lubrication from any type of sexual stimulation and reduced sexual sensations from caressing genitalia; however, subjective sexual excitement occurs with nongenital sexual stimuli; Combined genital and subjective arousal disorder, in which there is absent or diminished feelings of sexual arousal from any type of sexual stimuli plus complaints of absent or impaired genital sexual arousal; and Persistent genital arousal disorder in which there is spontaneous, intrusive, and unwanted genital arousal in the absence of sexual interest and desire; arousal is unrelenting by orgasms and endures for hours or days.

Genitopelvic pain/penetration disorder

This includes dyspareunia which is persistent or recurrent pain with attempted or completed vaginal entry and/or penovaginal intercourse and vaginismus, which is persistent or recurrent difficulties with vaginal entry of a penis, finger, or other object, despite the woman's expressed desire to participate.

Orgasmic disorder

Despite self-report of high sexual arousal or excitement, there is a lack of orgasm, markedly diminished intensity of orgasmic sensations, or marked delay of orgasm from any kind of stimulation.

METHODOLOGY

In order to understand the prevalence of sexual problems in Department of Obstetrics and Gynaecology, Maulana Azad Medical College, New Delhi, we did a questionnaire-based study comprising of 520 patients from January 2018 to June 2018. The questionnaire was designed on the basis of prior used ones in various studies but was finally designed in context to our patient scenario.^[7,8] We modified the existing questionnaire according to our local needs. Patients were recruited from the general outpatient department (OPD) of department of obstetrics and gynecology. The women were between the age group of 20–45 years and were sexually active. Women with established medical or surgical comorbidities were not included in the study. The reason for OPD visit was for common gynecological problems such as abnormal uterine bleeding, vaginal discharge, dysmenorrhea, urinary symptoms, itching in perineum, and infertility. Most of the woman belonged to lower socioeconomic status. Four trained

gynecologists, who were sensitized about the issue and they were not treating them filled the questionnaire forms in a different room. The patients' privacy and anonymity was taken care of. Informed written consent from patients was obtained. The questions were asked in a sensitive manner. They were questioned about the sexual desire, arousal, pain, lubrication, satisfaction, pleasure, feelings about sex, coital frequency in 4 weeks, their understanding regarding sex and the factors, which led to decreased involvement in sexual activities. The results were computed in the form of percentage. The new consensus statement was followed to make the diagnosis of sexual dysfunction in women.

Objective of the study

Primary objective

The prevalence of sexual dysfunction in women attending gynecology OPD.

Secondary objective

Perception about sex in women attending gynecology OPD.

RESULTS

The data collected clearly show that sexual problems are widely prevalent, but women do not report these problems frequently. Eighty-two percent patients had some sort of sexual problems. Sixty-four percent of women cannot talk regarding this to their partners only 18% patients said that they have no sexual problem and were satisfied with their sexual life. None of them consulted or took any form of assistance from any medical personnel. The reasons they cited were that they were shy, thought it is normal, did not know if this problem can be treated or had compromised with the condition. The reasons were usually overlapping. In this study, 63% women reported of desire dysfunction, 77% complained of arousal disorder, 51% had lubrication disorder, 56% had dyspareunia, and 74% had sex-related anxiety. When asked about the sexual frequency, only 4% women had sex more than ten times in last 1 month. It is important to note that 78% women knew the importance of sex in life. The reasons for decreased sexual activity were found to be ill health in 25% women, lack of privacy in 26% women, 32% women had other social reasons, 13% had lack of libido, and 3% had fear of pregnancy. The prevalence of sexual problems in the women attending outpatient clinic of tertiary care center in North India is mentioned in Table 1. The perception of women about sex is mentioned in Table 2.

DISCUSSION

Irrespective of the method used, there is a reasonable consensus that the prevalence of women who report at least one manifest sexual dysfunction is in the order of approximately 40%–50%, irrespective of age.^[13] This study was conducted to emphasize on this fact so that health care providers think over this rampant and highly understated issue, which affects the quality of life of many women. There are many factors affecting female sexual life such as interpersonal and contextual factors, personal psychological factors, and biological factors such as puberty,

Table 1: Prevalence of sexual problems in the women attending outpatient gynecology clinic of tertiary care center in North India

Sexual problems (n=520)	Percentage of population
Lack of sexual desire	52
Always	39
Sometimes	34
Can't say	27
Lack of arousal	31
Always	14
Sometimes	63
Can't say	23
No pleasurable thoughts about sex	41
Always	56
Sometimes	21
Can't say	23
Dyspareunia	22
Always	12
Sometimes	38
Can't say	50
Lack of lubrication	55
Always	12
Sometimes	39
Can't say	49
Anxiety before sex	34
Always	32
Sometimes	42
Can't say	26
Does not enjoy the act	27
Always	88
Sometimes	10
Never	2
Sexual frequency in 4 weeks	
1-3	12
4-7	36
7-10	48
>10	4

pregnancy, postpartum period, and menopause. A major fall occurs following bilateral ovariectomy.^[13] In a prospective cohort study by Smith *et al.* where 780 women undergoing menopausal transition were surveyed each year for up to 7 years, a total of 1927 women-years were included in the analysis. They found that women doing more than average physical work had greater sexual function scores and thus higher rates of enjoyment, passion, and satisfaction. Higher family income was inversely related to sexual function score and more frequent dry sex. Married women had significantly lower sexual function scores, as well as those with frequent irritability or vaginal dryness. Hence, they concluded that factors affecting FSD are complex and varied in nature.^[14]

Evaluating the sexual dysfunction involves taking the details through history, evaluation through pro formas and questionnaire-based models like Female Sexual Function Index,^[15] the Sexual Satisfaction Scale for Women,^[16] and the Scale for Quality of Sexual Function, which has been

Table 2: Perception of women about sex attending gynecology clinic in tertiary care hospital

Perceptions (n=520)	Percentage
Do you know that sex is important part of your life?	
Yes	78
No	22
Are you satisfied with your sex life?	
Yes	82
No	12
Can't say	6
Reasons for inactive sex life?	
Health issues	25
Social reasons	32
Lack of privacy	26
Decreased libido	14
Fear of pregnancy	3
Do you talk to your partner about sexual problems?	
Yes	36
No	64
Why you did not seek treatment of the sexual problems?	
Was shy of talking to anybody	42
Thought this happens to everyone	24
Did not know there is a treatment possible	35
Had no issues with the sexual problem being present	51

developed specifically as an outcome measure for therapies in men and women.^[17] The Permission, Limited Information, Specific Suggestions, and Intensive Therapy model is used to initiate the discussions about sexual dysfunction and its management.^[18] The Ask, Legitimize, Limitations, Open up, Work together model facilitates completion of the sexual history and initiation of treatment or further evaluation.^[18]

The treatment of FSD is complicated because of several factors such as similar presentation of different types of dysfunction, limited proven treatment options, lack of gynecologists awareness with the available options, limited availability of treatment, and limited expertise in treatment.^[19] Management of FSDs varies from nonpharmacological, pharmacological therapy to treatment of underlying physical and psychological disease. Different types of dysfunctions have different therapy. Woman with sexual dysfunction may benefit with nonpharmacological therapies like (counseling, addressing the emotional concerns, and lifestyle modifications) are combined with the pharmacological therapies. The only pharmacologic treatment for the treatment of any female sexual disorder, which is approved by the U.S. Food and Drug Administration is conjugated equine estrogen for postmenopausal dyspareunia. Testosterone gel and dehydroepiandrosterone (DHEA) treatment are still under the trial. Due to limited treatment options available for FSD, there is need for more medical research and long-term clinical drug trials.^[20,21] Drugs such as PDE5 inhibitors, prostaglandins, nitric oxide, testosterone, dopaminergic agonist, and synthetic alpha melanocortin stimulating hormone are still under trial.^[20] Bupropion has been shown to improve the adverse

sexual effects associated with antidepressant use but data are limited.^[22] Psychotherapy or sex therapy is useful for the management of the psychological, relational, and sociocultural factors impacting a woman's sexual function.^[22]

Role of Indian gynecologists

Female sexuality and discussion about 'it' is considered a taboo. Women from all the classes find it very uncomfortable to discuss the issue with their physicians. The majority, if not only, sexual dysfunction which Indian women complain of, is dyspareunia.^[23]

Indian data are limited regarding the prevalence of sexual dysfunction. Singh *et al.* reported its prevalence to be in two-third of women ($n = 149$).^[7] This shows the high disease burden in the country. There are no especially designed "Sex Therapy Clinics." Even if the patient present with some complaints, due importance is not given by the health-care providers, unlike other symptoms such as abnormal uterine bleeding.

A common and multidisciplinary approach to FSD promotes better communication and outcome.^[24] A major responsibility lies on our shoulders, as a gynecologist to bring forth and emphasize upon this issue.

McCool-Myers *et al.* 2018 performed systematic review and qualitative analysis and found that FSD is a highly prevalent medical issue affecting 41% of reproductive-age women worldwide. It was also concluded that the sexual and reproductive lives of women are hugely impacted by FSD, and a number of social, psychological, and biological factors impact the prevalence of sexual dysfunction. Future prevention strategies should target modifiable factors, for example, physical activity and access to sex education while international efforts in empowering women should continue.^[25]

In our study, though the problem was not small, we could only elicit it after we made an attempt to do so. As a clinician working in a tertiary care centre, gynaecologists can be of immense help to them by counselling, discussing and providing the options of treatment modalities. The role of gynaecologists is also important because many gynecological problems like adenomyosis, endometriosis, premature ovarian failure, adnexal lesions, chronic PID, and other genitourinary problems can affect the sexual life. In Indian set up, it is the doctor who will have to take the first step, because of the social stigma and shyness of the women to talk regarding all these issues. Decision regarding possibility of treatment from our side along with the help of counselors and psychiatrist should be made. Community based awareness programmes may also be very helpful. Medical therapy wherever indicated is to be utilized to treat the problem. Special attention needs to be given to women at high risk of having sexual dysfunctions like post-hysterectomy, post cancer treatment and postmenopausal women. Nerve preserving surgeries are evolving, which are less likely to cause these dysfunctions. Acquiring necessary surgical expertise to prevent these after surgery side effects seems to be a good idea.

Sensitization of patients as well as gynecologists is necessary to treat this problem. Learning and acquiring knowledge about the subject will improve our approach to manage these conditions. The strengths of the present study was its prospective nature and large sample size. Since it was hospital based study, so it might not give true prevalence of female sexual dysfunction in community. It can be considered as one of its limitation. However, women in hospital are coming from community only and we have taken women of reproductive age group with all common gynecological problems in our study. Also we have excluded women with established surgical and medical morbidities were excluded. So, somehow our study population can be considered closer to community in general. The other limitation could be considered as beneficiary bias. But that was taken care of as the treating gynaecologists and the gynaecologists who filled questionnaire were different. Women were taken to a different room and questionnaire was filled by different team there.

CONCLUSIONS

Female sexuality is a complex phenomenon, and it would be a wiser alternative to have deep insight into the participants. Specialization of gynecologists in this field will have a better impact on quality of life of Indian women.

“Sex counsellors” may play an important role in this regard. We would also like to emphasize upon the establishment of “FSD clinics” or “Female Sex Therapy Clinics.” These clinics should have couple-centered approach. This will be an eye-opener for women, when they can realize about treatability of sexual dysfunctions. Active indulgence of gynecologists in diagnosing and managing FSD s is the need of the hour.

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Conflicts of interest

There are no conflicts of interest.

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