Clinical Approach to Sexual Dysfunction in Females

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ABSTRACT

Sexual functioning is a complex process and governed by various bio-psycho-social factors. Sexual dysfunction has high prevalence in females (43%) as compared to males (31%). A proper and comprehensive approach is needed for the assessment of a case of female sexual dysfunction. It includes thorough history taking, physical examination, laboratory investigations and thus formulation of diagnosis. A better approach to case of female sexual dysfunction helps clinicians for early diagnosis and management of such cases and improving overall quality of life of the patient.

KEYWORDS: Sexual dysfunction, Sexual behaviour, Sexual history, Genital examination

INTRODUCTION

Sexual functioning is a complex process, governed by various bio-psycho-social factors and interruption in any of these areas leads to sexual dysfunction. Nowdays, identification and management of sexual dysfunctions are in states of continuous transition because of evolving research in field of sexual dysfunctions.

The most recent edition of the Diagnostic and Statistical Manual (DSM 5), states that sexual dysfunctions "are a heterogeneous group of disorders that are typically characterized by a clinically significant disturbance in a person's ability to respond sexually or to experience sexual pleasure" [1] . As per DSM-5, female sexual dysfunction includes female sexual interest/arousal disorder, female orgasmic disorder, and genito-pelvic pain/penetration disorder. These sexual problems are only considered dysfunctions when they cause distress.

Sexual dysfunction has very high prevalence. It is found that about 43% of women as compared to 31% of men have one or other kind of sexual dysfunction [2] . In a study by Hayes et.al, hypoactive sexual desire is the most prevalent complaint among females 64% (range 16–75%) , followed by difficulty in arousal 31% (range 12–64%), difficulty in orgasm 35% (range 16–48%) and pain during sexual activity 26% (range 7–58%) [3]. In India few studies are available regarding prevalence of female dysfunction. A study done

in psychiatry OPD of a tertiary care teaching hospital in north India by Awasthi and his colleagues (2008) found 17% females reported one or more difficulties in sexual activity. These difficulties were in the form of headache after sexual activity (10%), orgasmic difficulties (9%), pain during intercourse (7%), lack of vaginal lubrication (5%), vaginal tightness (5%), bleeding after intercourse (3%) and vaginal infection (2%)[4]. Another study done in the tertiary care hospital`s psychiatry OPD in south India by Singh and his colleagues (2009),reported female sexual dysfunction (FSD) in 73.2% women of the sample. The complaints elicited were difficulties with arousal in 91.3% , lubrication in 96.6%, orgasm in 86.6%, satisfaction in 81.2%, desire in 77.2%, and pain in 64.4% of the subjects [5].

CULTURE AND SEXUAL BEHAVIOUR

In broader sense, culture can be defined as unique behaviour, values and attitudes that are common to a group and shape their emotions, behaviours and life patterns; has strong influence on attitudes towards any sexual activity or behaviour [6]. One of the reasons for variation in pattern of sexual dysfunction might be difference in diagnostic threshold for normal and abnormal sexual practices, for example excessive masturbation is considered as an illness in some of the Asian countries but not in others[7]. Another example of how culture influences sexual function is - culture bound syndromes that is considered as a syndrome within a specific culture and presented with variety of somatic and psychiatric symptoms including sexual dysfunction, for example, female dhat syndrome in which females complains of passing whitish discharge (safed pani) per vaginum and associated with vague somatic manifestations in the form of burning hands and feet, dizziness, backache, and progressive weakness in the body. Females attribute these symptoms to loss of vital fluid from the body as described by their culture. On evaluation, these women had little evidence of infection and the quantity of discharge did not seem to be more than the normal physiological discharge [8,9]. By this way, culture helps to understand the way in which behaviour is perceived by the participants. Culture not only affects sexual behaviour but also reporting of sexual problems, their proper assessment and management.

CLASSIFICATION OF SEXUAL DYSFUNCTION

'Female Sexual Dysfunction' in DSM-5 include four categories: Female Orgasmic Disorder, Female Sexual Interest/Arousal Disorder (FSIAD, which encompasses what were previously termed Hypoactive Sexual Desire Disorder and Female Sexual Arousal Disorder in the DSM IV),

Genito-Pelvic Pain/Penetration Disorder(which encompasses what were previously termed vaginismus and dyspareunia), and Substance/Medication-Induced Sexual Dysfunction.

Female Sexual Interest Arousal Disorder

This category in DSM-5 is the combination of previous two categories i.e. hypoactive sexual desire disorder and female sexual arousal disorder.

Female Orgasmic Disorder

Female orgasmic disorder criteria as per DSM-5 include a marked delay in orgasm, infrequency or absence of orgasm, or less intense orgasm for at least six months. In this disorder orgasmic difficulties may be present since first sexual act (lifelong) or may start after a period of normal sexual function (acquired).

Genito-Pelvic Pain/Penetration Disorder

In DSM-5, vaginismus and dyspareunia are combined in genito-pelvic pain/penetration disorder. This disorder of sexual pain is defined as fear or anxiety, marked tightening or tensing of the abdominal and pelvic muscles, or actual pain with vaginal penetration that is persistent or recurrent for at least six months. This may be lifelong or acquired after a period of no dysfunction.

As per DSM-5,to diagnose any one of these disorders, the symptoms must be(a) present at least 6 months, (b) cause clinically significant distress in the individual [not solely in the individual's sexual partner(s)], and (c) not be better explained by another issue, such as relationship distress or other stressors [1].

Disorders according to sexual cycle	ICD-10	DSM-5
Sexual desire disorders	Lack or loss of sexual desire Sexual aversion Excessive sexual drive	Female sexual interest/arousal disorder
Arousal disorders	Failure of genital response	
Orgasmic disorders	Orgasmic dysfunction Lack of sexual enjoyment	Orgasmic disorder
Sexual pain disorders	Nonorganic dyspareunia Nonorganic Vaginismus	Genito-pelvic pain/penetration disorder Substance/Medication induced sexual dysfunction

Table No.1 Difference in classification of female sexual dysfunction in ICD - 10 and DSM - 5

ASSESSMENT OF A CASE OF FEMALE SEXUAL DYSFUNCTION

For any illness to be managed adequately clinician should know how to assess the particular illness. In general practice, clinician should know how to assess the cases of sexual dysfunction without developing barrier with the patient e.g. one should know how to use terms related to sexuality, not to disturb patient's privacy, cultural influences.

Aims of clinical assessment

1. To define what is the dysfunction?
2. To assess whether it is organic or non-organic?
3. What are the immediate causes?
4. What are the correct management options and prognosis?

Prerequisites for assessment of sexual dysfunction

Assessment for sexual dysfunction should be conducted in a comfortable surrounding maintaining adequate privacy so that patient feels free to speak about his/her problems. Interviewer should be empathic, non-judgemental and understanding. He should use neutral terms and simple language which can be understood by patient easily. Interviewer can take help of anatomical drawings for assessment. Adequate reassurance should be provided to the patient that sexual dysfunctions are common and treatable condition. Interviewer should not make assumptions about patients and their problems. One should take help of a female attendant or a relative while examining the patient of opposite gender.

The assessment of a case of female sexual dysfunction involves assessment of predisposing, precipitating, and maintaining (perpetuating) factors. To understand these factors status of couple's current sexual relationship and complete evaluation of both sexual partners is needed. A bio psychosocial approach is recommended and should include thorough history taking and physical examination of the patient [10].

History[11]

1. Demographic profile: Age, Sex, Occupation, Relationship status, Sexual orientation

2. Current functioning:

Onset: lifelong or acquired

Generalised: occurs in most situations or with most partners

Situational :

a. Only with current partner

b. In any committed relationship

c. Only with masturbation

d. In socially proscribed circumstance (e.g., affair)

e. In definable circumstance

Frequency

Sexual compulsivity

3. Past sexual history

Childhood sexuality: Parental attitudes about sex, Learning about sex from parents, from books, magazines, or friends at school or through religious group, viewing sex play or intercourse of person other than parent, viewing sex between pets or other animals

Childhood sex activities: genital self stimulation before adolescence, sexual play or exploration with another child

Adolescence: age of onset of puberty, sense of self as feminine or masculine, sex activities like masturbation, homosexual activities, dating, experience of kissing, first coitus

Adult sexual activities: experience of premarital and marital sex

Special issues: history of rape, spousal abuse, chronic illness, history of sexually transmitted diseases, abortions, miscarriages, paraphilias etc.

4. Bio-psycho-social history

The psychosocial history deals with evaluation of interplay of various biological, psychological and socio cultural factors and their effect on sexual functioning [12]. When the patient is in a current sexual relationship, both the partners need to be evaluated [13]. A biopsychosocial approach is helpful in these. Biological factors may include medical/anatomical problems that affect genital sexual response or hormonal changes that affects libido. Socio-cultural factors to consider, include the woman's attitudes about menopause and aging, as well as religious, cultural, and other social values regarding sex. Psychological factors need to be assessed in details in the patients in terms of predisposing, precipitating and maintaining factors.

5. Medical history: Historical events related to the presence of chronic disease, use of pharmacological agents, endocrine disorders, prior surgeries and trauma is to be carefully evaluated. While evaluating women careful medical history is to be obtained about any health problem that might affect sexual anatomy, the vascular system, the neurological system, and the endocrine system. Indirect causes i.e., factors that cause chronic pain, fatigue, and malaise may also contribute to dyspareunia.

It also includes screening for depression regardless of antidepressant use as depression is most of the time related to sexual dysfunction, particularly of low sexual desire.

6. Substance use history: Evaluation of alcohol or other recreational drug use by the partners needs to be evaluated as they may also cause sexual dysfunction either by hormonal imbalance (by causing reduction in production of testosterone or by increased secretion of prolactin) or by direct effects on the penile neurovascular system.

7. Treatment/Medication history: Clinicians should also enquire about the medication intake, including prescription drugs, over the counter medications that would be associated with sexual dysfunction. While taking history, attention must be given to features which can help in distinguishing predominantly organic sexual dysfunction.

Physical Examination

Indication for physical examination are

- Recent onset of loss of desire without any apparent cause

- Female with sexual problems either during peri or post-menopause
- History of any physical illness in recent past, presence of physical symptoms other than sexual dysfunction
- History of marked menstrual irregularity and infertility
- History of abnormal puberty or endocrine disorder

Predisposing factors	• Restrictive upbringing • Disturbed family relationships • Traumatic early sexual experience • Inadequate sexual information
Precipitating factors	• Unreasonable expectations • Random failure • Discord in the relationship • Dysfunction in the partner • Infidelity • Reaction to organic disease • Pregnancy/Childbirth • Poor emotional intimacy • Expectation of negative outcome
Maintaining (perpetuating) factors	• Performance anxiety • Guilt • Poor communication • Loss of attraction between partners • Impaired self-image • Restricted foreplay • Poor emotional intimacy • Depression or anxiety • Expectation of negative outcome • Fear of intimacy • Sexual myths and misconceptions

Table No.2. Psychological factors

FEATURES	PREDOMINATELY ORGANIC	PREDOMINATELY PSYCHOGENIC
Age	Older	Younger
Onset	Gradual	Acute
Course	Progressive	Intermittent
Circumstances	Global	Situational
Partner problem	Usually secondary	Usually at onset
Organic risks	Present	Variable
Desire	Normal to start with	Decreased

Table No.4. Psychogenic & organic features

COMPONENTS	DETAILS OF HISTORY TAKING
LIBIDO/INTEREST	• Do you look forward to sex? • Do you enjoy sexual activity? • Do you fantasize about sex? • Do you have sexual dreams? • How easily are you sexually aroused (turned on)? • How strong is your sex drive?
ORGASM/SATISFACTION	• Is there adequate and acceptable stimulation with partner and/or with masturbation? • Does your vagina become sufficiently moist? • Are orgasms absent and/or very delayed and/or markedly reduced in intensity? • Is the degree of trust and safety, you feel you need, present? • What do you fear may happen that could be
DYSPAREUNIA / VAGINISMUS	• Where does it hurt? • How would you describe the pain? • When does the pain occur (with penile contact, once the penis is partially in, with full entry, after some thrusting, after deep thrusting, with the partner's ejaculation, after withdrawal, with subsequent micturition?) • Does your body become tense when your partner is attempting, or you are attempting to insert his penis? • What are your thoughts and feelings at this time? • How long does the pain last? • Does touching cause pain? • Does it hurt when you wear tight clothes? • Do other forms of penetration hurt (tampons, fingers)? • Do you recognize the feeling of pelvic floor muscle tension during sexual contact? • Do you recognize the feeling of pelvic floor muscle tension in other (non-sexual) situations? • Do you feel subjectively excited when you attempt intercourse? • Does your vagina become sufficiently moist? • Do you recognize the feeling of drying-up?

Table No.3. History taking relevant to specific sexual dysfunction [14].

To identify any disease complete physical examination is needed. Examination of entire body and genitalia should be done. A thorough inspection and palpation of external genitalia should be done including skin colour, thickness, texture, turgor and amount and distribution of pubic hair. During genital examination internal mucosa, muscle tone, any episiotomy scar or strictures, discharge in the vaginal vault should be looked for. Cultures should be taken if indicated.

Psychological Assessment

The assessment includes evaluation of psychological state of the patient at present with emphasis to any symptoms of depression or anxiety, impaired coping skills, history of any sexual abuse, any social or occupational stress, and economic state. All these factors have impact on patient`s sexual status, so they need to be assessed in each case. Another important aspect in the assessment is the status of past and present sexual relationships. Studies shown that sexual dysfunction is associated with conflicts in interpersonal relationships [15,16] .

Laboratory investigations

Basic laboratory testing is helpful to rule out treatable conditions, and includes complete blood count, lipid profiles, renal and liver function, blood glucose and thyroid function tests. follicle-stimulating hormone, luteinising hormone, oestrogens and testosterone should be measured to assess the functional integrity of the hypothalamic-pituitary-gonadal axis. When an infective etiology for dyspareunia is suspected, vaginal, cervical, and vulval discharge microscopy/ cultures should be performed.Other investigations, including imaging, will be guided by symptoms, particularly in cases of sexual pain.

FORMULATION OF FEMALE SEXUAL DYS FUNCTIONS

A formulation of the diagnoses is recommended. The formulation integrates all information obtained from the history received from the patient with and without a partner, and any relevant physical examinations, blood assays and self-report questionnaires. On the basis of the formulation, a diagnosis is established, preferably using DSM-5 diagnostic system. The clinician also continues to modify the formulation as information emerges during treatment.

CONCLUSION

Sexual dysfunction is highly prevalent among females and associated with poor quality of life. A proper and comprehensive approach to a case of female sexual dysfunction is helpful in understanding female sexual problems in a better way. By addressing all aspects of women's sexual function, healthcare providers can better diagnose and manage such cases.

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