Female Sexual Dysfunction: Indian Scenario

Navneet Magon, Monica Chauhan, Bharti Kalra

INTRODUCTION

Sexual dysfunction is common among females across the world and Indian women are no exception. Epidemiological data suggests a high prevalence of female sexual dysfunction (FSD) globally. Because of the general lack of understanding about the female sexual response cycle and the lack of standardized definitions until recently, there exists some controversy regarding the exact prevalence of FSD. In the most frequently quoted study based on the National Health and Social Life Survey of 1992, which evaluated a sample of 1,749 women aged 18–59 years, 43% reported sexual dysfunction. Female sexual dysfunction is indeed age-related, progressive, and highly prevalent, affecting 30–50% of women. US data reveals that 9.7 million American women aged 50–74 years self-report complaints of diminished vaginal lubrication, pain and discomfort with intercourse, decreased arousal, and difficulty achieving orgasm.

Earliest Indian medical literature on sexual dysfunction in males reported in modern medicine dates back to 1950s. However, as compared to male sexual dysfunction, very few Indian studies are available on FSD, and the area remains largely unexplored. Indian studies have reported findings primarily from hospital settings including outpatient departments of general medicine, OB-GYN, skin and venereal disease, psychiatry, psychosexual clinics and endocrinology as well as addictive disorder clinics and psychiatric inpatient settings. In 1970s, Agarwal first reported a study of 17 female cases of frigidity associated with ignorance regarding sexual activity, fear of pregnancy, marital disharmony, lack of emotional atmosphere, tiredness and poor precoital attention. In 2007, Kar and Koola in a postal survey among English-speaking persons from a South Indian town found orgasmic difficulties in 28.6% females. They reported almost 40% of females to have never masturbated. In another cross-sectional survey of 149 married women in a medical outpatient clinic of a tertiary care hospital, Singh and his colleagues recently reported FSD in 73.2% subjects of the sample. 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. Age above 40 years and fewer years of education were identified as contributory factors. Women attributed FSD to physical illness in participant or partner, relationship problems, and cultural taboos but none had sought professional help. In an ongoing study on a sample representative of pan-Indian population, where the lead author of this chapter is also the principal investigator, a substantial number of women have been found to have FSD.

It is important to mention here that a significant proportion of Indian women presenting to these treatment settings seek help for various other concerns related to sexual functioning. These include of headache after sexual activity, vaginal tightness, bleeding after intercourse, vaginal infection, own health problems, spouse’s health problems, conflict with spouse, and lack of privacy. While many of these concerns do not fall under a diagnosable heading, they are an important source of distress and dysfunction in these individuals.

The Diagnostic and Statistical Manual of Mental Disorders Fourth Text Revision (DSM-IV-TR) clearly states that clinical judgments related to diagnosis of sexual dysfunction should consider ethnic, cultural, religious and social backgrounds. It stands to reason, therefore, that clinical judgments related to therapy of FSD too should be made after considering psychosociocultural factors. These facts underscore the need for understanding the specific needs of Indian patients, not focusing on pharmacotherapy alone, but rather, on the soft and hard skills required for counseling patients. However, no comprehensive guidelines are available to address the issue of sexual counseling, either in India or abroad, while attempts have been made to medicalize female sexuality. In this chapter, we shall try to briefly introduce FSD and then focus on management aspects with a special focus on counseling.

DEFINITIONS AND CLASSIFICATIONS

DSM-IV-TR describes sexual dysfunction characterized by a disturbance in the processes that characterize the sexual response cycle or by pain associated with sexual intercourse (Table 1).

Female sexual dysfunction is defined as a disorder of sexual desire, arousal, orgasm or sexual pain that results in significant personal distress. In 1966, Masters and Johnson reported that the normal female sexual response cycle consists of four successive phases—excitement, plateau, orgasm and resolution. Kaplan subsequently modified this hypothesis and the excitement phase was further subdivided into desire and arousal, thereby eliminating the plateau phase. These models assume a linear progression from an initial awareness of sexual desire to one of arousal with a focus on genital swelling and lubrication, to orgasmic release and resolution. More recently, DSM-IV classified FSD into four groups (i.e. sexual desire disorder, sexual arousal disorder, orgasmic disorder and pain disorders) reflecting this linear and rather genitally focused model of sexual function. Each of these diagnoses is independent of the others, e.g. a patient with sexual desire disorder may still be arousable and capable of orgasm. Thus, relatively discrete, nonoverlapping phases of sexual response were portrayed and discrete dysfunctions defined. However, evidence to date shows that many facets of women’s sexual function are at variance with this model. Basson et al. described a nonlinear model of the sex response cycle, showing overlapping phases of the sexual response in a variable sequence that blends the responses of the mind and the body.
TABLE 1 | Sexual and gender identity disorders (DSM-IV-TR)

<table>
<thead>
<tr>
<th>Code</th>
<th>Disorder</th>
</tr>
</thead>
<tbody>
<tr>
<td>302.71</td>
<td>Hypoactive sexual desire disorder</td>
</tr>
<tr>
<td>302.72</td>
<td>Female sexual arousal disorder</td>
</tr>
<tr>
<td>302.73</td>
<td>Female organic disorder</td>
</tr>
<tr>
<td>302.74</td>
<td>Vaginismus (Not due to a general medical condition)</td>
</tr>
<tr>
<td>306.51</td>
<td>Vaginismus due to a general medical condition</td>
</tr>
<tr>
<td>625.0</td>
<td>Female dyspareunia due to: [Indicate the general medical condition]</td>
</tr>
<tr>
<td>625.8</td>
<td>Female orgasmic disorder due to: [Indicate the general medical condition]</td>
</tr>
<tr>
<td>302.70</td>
<td>Sexual dysfunction not otherwise specified</td>
</tr>
</tbody>
</table>

**ETIOPATHOGENESIS**

Throughout a woman’s life changes in sexual function occur, related to age, pregnancy, parturition, breastfeeding and menopause. Emotions for the partner and the relationship with partner during intercourse have been identified as the strongest predictors of sexual health. Women with desire disorders have anxiety issues, low self-esteem, emotional instability and neuroticism. Memories of past negative sexual experiences, including coercive or abusive relationships and expectations of negative outcome from dyspareunia or partner sexual dysfunction all adversely impact on sexual function. With advancing research on FSD it has been identified that the primary medical conditions causing FSD can be hormonal, anatomical, vascular and neural. During sexual arousal, blood flow to the clitoris and labia increases, leading to engorgement of these organs, resulting in protrusion of the glans clitoris and erosion and engorgement of the labia minora. This is associated with increased blood flow to the vagina and uterus leading to increased secretion from the uterus and Bartholin’s glands, which lubricates the vagina. As intact sensation is therefore important in arousal, poorer levels of sexual functioning may be expected in diabetic women with peripheral neuropathy. Vascular compromise may result in decreased lubrication and dyspareunia. Sexual dysfunction after pelvic surgery may be due to interruption of either the vascular supply or neurological innervations. Therefore though psychological and interpersonal factors cannot be undermined, with a better understanding of the condition it is now known that a number of illnesses can cause FSD too. Chronic diseases such as diabetes mellitus, chronic kidney disease, cancer, spinal cord injury, lupus, rheumatic diseases, Parkinson’s disease, fibromyalgia and chronic pain have all been identified to impact on sexual function adversely. A number of drugs have also been implicated in the causation of FSD. Hormonal balance is essential to maintain sexual function. There appears to be a lack of direct correlation between estrogen levels and sexual symptoms and estrogen at baseline levels is required to make vasointestinal peptides and nitric oxide (NO) effective. Generation of NO and VIPs is impaired in postmenopausal women and estrogen therapy causes up regulation of vascular estrogen receptors. Endothelial-dependent flow-mediated vasodilatation in healthy women, which is mostly mediated by these neurotransmitters, is enhanced by even short-term administration of estrogen. This is achievable with local estrogen therapy, which cannot only prevent but also reverse mild to moderate atrophy. Estrogen replacement therapy in postmenopausal women has therefore been shown to improve vaginal lubrication and sexual desire. Testosterone is the predominant androgen in women. The adrenal glands and ovaries are the major source for testosterone synthesis. Circulating androstenedione, which is also a major source of testosterone, is derived from the adrenal glands and ovaries. Decreasing levels of testosterone are associated with decreased libido, arousal, sexual response, sensation and orgasm and therefore decline after the menopause. Testosterone also influences the central nervous system and affects sexual behavior and is also believed to be beneficial in improving sexual desire in women who go through a surgical menopause. However, long-term safety data for testosterone supplementation in premenopausal women is not available.

**EVALUATION**

Occasionally, women directly present with sexual dysfunction. However, more often women present with more covert symptoms of pelvic pain, distress about menses, general dissatisfaction with a contraceptive precaution, and expression of distaste for the genital area or dissociation at the time of genital examination. A sympathetic provider will be alert to these clues and will ask open-ended questions to explore these issues. A series of screening questions as shown in Table 2 help identify women wishing further treatment for underlying dysfunction.
**Reproduction and Sexual Medicine**

Women expect their doctors to be able to discuss sexual problems but some doctors feel uncomfortable talking about sex and may not see it as part of their clinical role. Taking even a brief sexual history during a new patient visit is very effective and indicates to the patient that the discussion of sexual concerns is appropriate and is a routine component of an office visit. Urogynecological issues, menopause and depression are risks for the development of sexual problems. It can be helpful to link a woman’s current reproductive stage or presenting issue such as surgery to her sexual function. Physician’s discomfort in broaching issues of FSD may be related to a number of reasons, a few of them listed in Table 3.

When a sexual problem is identified during initial screening, it should be determined whether:

- It can be addressed during the current appointment
- A follow-up visit is needed to allow more time to address the concern adequately
- It is beyond the physician’s scope of training and the patient should be referred to a specialist.

It is always helpful to legitimize the sexual problem and to attend to patient discomfort by deferring sensitive questions to a subsequent visit or by supplying alternative terminology for patients who seem too embarrassed to provide explicit sexual details. A thorough sexual history should include medical, reproductive, surgical, psychiatric, social, and sexual information and current use of medicines. Detailed clinical examination is important to make a diagnosis and establish the cause of FSD. For professionals working in a clinical environment, time is of the essence. There may not be time to practically include questions about sexual function in a clinical encounter, thus some clinicians use validated research instruments designed to define the degree of sexual dysfunction. One such questionnaire is the female sexual function questionnaire, which assesses desire, lubrication and orgasmic potential, though there are several others routinely used in clinical practice.

When obtaining a sexual history, depending on the environment and time constraints, it is important to collect relevant information in a timely manner. Establishing a rapport and putting patients at ease helps to make the environment conducive for discussion of sexual problems as the patient is being asked the most intimate, detailed questions of private life. The patient should be clothed to eliminate the anxiety and sense of vulnerability. It is imperative that physician does not assume that the woman’s sexual behavior is limited to an identified partner or spouse. The implication that the physician does not hold preconceived notions might give patients the courage to discuss a sexual concern at a later time. The practitioner should feel comfortable using sexual terminology. The use of eye contact is vital in gaining the woman’s trust and confidence. Physicians may benefit by practicing the use of explicit sexual terminology in order to reduce embarrassment, hesitation in delivery, or other signs of discomfort. While speaking to women with FSD, it is best to mirror the patient’s sexual vocabulary so she can relate and understand the discussion. It is important to ask the patient if she would like to speak with the clinician about these issues. For some women this is not a concern, and for others it is a major life event. Giving the patient permission to discuss the issues is the first step in problem solving.

**PHILOSOPHY OF MANAGEMENT: INDIAN SCENARIO**

It is important to understand the underlying biopsychosocial underpinnings of various FSDs. Female sexual dysfunctions can be manifestations of biological (biogenic) problems or intrapsychic or interpersonal (psychogenic) conflicts or even a combination of these factors. Stress plays an important role in pathogenesis of FSDs. Female sexual dysfunction management calls for a multipronged approach and should focus on the biological, psychological and the environmental factors relevant to a particular individual seeking help.

Though a patient centered approach should be followed in every sphere of medicine, nowhere is this truer than in sexual dysfunction. While individuals suffering from FSDs share many factors, some factors such as psychological and environmental factors could be unique to an individual patient. Hence the management plans need to be individualized. Patient-centered care (PCC) has been defined as “care that is respectful of and responsive to individual patient preferences, needs, and values” and that ensures “that patient values guide all clinical decisions”.

Patient-centered care, in the context of FSD, implies understanding the patient’s background, her attitudes, beliefs, knowledge and misconceptions about sexuality, fertility and related issues. Not only that, PCC mandates an appreciation of the physical environment of the patient, such as privacy and comfort available to her and her partner. It also requires an in-depth analysis of the biological status of the patient with FSD, viz. her medical, endocrine and urogynecological health.

The concept of PCC in FSD, however, goes beyond the individual. Sexual function is not possible without a partner. Therefore, FSD counseling and management require the use of a couple-centered approach, also termed by use as couple-centered care (CCG). In this model, the couple may be taken as the basic unit for intervention. At times, the issue of sexual dysfunction takes on such importance in a young couple’s life, that the entire family gets involved in the couple’s personal life. This is especially true in traditional joint families, where the young couple has to face pressure from older family members to prove their fertility and fecundity immediately after marriage. In some selected cases, it is possible that counseling is broadened to include important family members.

Therapeutic patient education (TPE) is a concept originally used in chronic diseases. The concept states that educating and empowering patients about their illness leads to therapeutic benefits per se, and improves the benefit noted with other therapeutic modalities such as diet, physical activity and drugs. Therapeutic patient education is an integral part of sexual counseling, even though the term has not been used much in this context. Educating the patient with FSD about the anatomy, physiology, and psychology of sexuality, the possible pathophysiological mechanisms of sexual dysfunction, and available treatment modalities is in itself an important therapy. Treating FSD, without adequate patient education, whether by drugs or nonpharmacological means, runs the risk of relapse.

**TABLE 2 | Screening questions to establish female sexual dysfunction**

- Are you currently in a sexual relationship?
- Do you have any problems with desire arousal or orgasm?
- If you are not currently sexually active, are there any particular problems contributing to you lack of sexual activity?
- Do you have any concerns or questions about your sex life?
- Please feel free to ask in future.

**TABLE 3 | Reasons for reluctance to obtain a sexual history**

- Lack of training
- Lack of practice
- Lack of time
- Lack of effective treatments
- Associated stigma
- Embarrassment of doctor, patient or both
- Sensitive subject, difficult subject gender
- Age
- Culture
- Covert presentation of the problem
- Fear of "opening the flood gates"
This concept of FSD management is known as shared decision making. Shared medical decision making is a process by which patients and providers consider outcome probabilities and patient preferences and reach a healthcare decision based on mutual agreement. Shared decision making is possible only if the patient is empowered, by means of TPE.

Most patients of FSD, during the course of treatment, will undergo a change in their thoughts, attitudes, behavior and practice. These changes may be linked directly to sexuality, e.g. appreciating pornography, accepting the use of stimulatory toys, or practicing self-stimulation. At the same time, some changes might be nonsexual in nature, e.g. maintaining personal hygiene, improving physical fitness, practicing yoga, or joining confidence building classes. Any such changes will certainly be linked with some degree of discomfort. Any counseling strategy for FSD should contain inbuilt measures to help patient minimize the discomfort of change.

PREREQUISITES

External Environment
A patient friendly external environment is mandatory if counseling is to be successful. The external environment need not be luxurious, or lavishly furnished or decorated. However, it must ensure privacy, adequate but dim lighting, soundproofing, an optimal room temperature, and relaxed ambience and at the same time avoiding any interruptions. The décor should neither be “religious” or conservative nor sexually provocative.

Counselor
The counselor plays a pivotal role in the management of FSD. Counseling for FSD can be done by a single counselor of either gender, or by a couple. They may choose to interact with the counselor(s) as patient alone, or with the couple (patient and partner) as a unit. The decision to interact with the individual patient or with the couple will depend upon the comfort level of the patient, the expertise of the treating physician, the sociocultural environment, and the physical ambience of the clinical setup. Counselor must possess certain basic qualities to successfully manage FSD. While there are hundreds of adjectives to describe “humane” and “interactive” properties expected of any healthcare professional, the CARES mnemonic seems to encapsulate all of them. A person who exhibits the attributes and possesses the skill set listed in Table 4 should perform counseling in FSD.

The WATER approach represents a simple stepwise method of motivational interviewing, which can be adapted for use in FSD counseling (Table 5).

Verbal Language
Counseling must be carried out in the language that the patient is most comfortable with. The choice of euphemisms (suggestive words and phrases) to describe sexual issues will depend upon the sociocultural background and the educational level of the patient. Confident patients will approach the issue directly, while shy women may use an indirect method of asking for help. Patient may report with certain symptoms, which may be surrogate for sexual inadequacy.

Nonverbal Language
Counselors should be trained to pick up nonverbal cues of discomfort. Presence of these cues implies that discomfort allaying or confidence building measures are necessary before counseling can proceed. It also indicates that the counselor has stayed into “threatening territory” while eliciting a history or discussing sexuality, and should return to safer, less threatening ground. Some nonverbal language cues, gleaned from the patient’s body language, which suggest discomfort, are mentioned in Table 6.

HISTORY TAKING
A complete history taking should precede counseling and therapy for FSD. History taking serves multiple purposes. It not only provides an opportunity to gather information, but also helps in building the therapeutic framework. History taking in FSD follows the same pattern as a general medical history. Each relevant aspect of history should be explored in detail. The five Es of sexual history (Table 7) taking must be followed at all times.

A simple hierarchy of questioning, moving from nonthreatening to threatening, must be followed while eliciting a sexual history. This hierarchy of questioning helps put both patients and clinical at ease, minimized discomfort and shyness, helps avoid wrong or vague answer, and ensures both correctness and completeness of history. This in turn facilitates a correct diagnosis and creates optimal therapeutic outcomes. This hierarchy of questioning is mentioned, with examples, in Table 8.

<table>
<thead>
<tr>
<th>TABLE 4</th>
<th>Attributes of a counselor</th>
</tr>
</thead>
<tbody>
<tr>
<td>C</td>
<td>Confident competence</td>
</tr>
<tr>
<td>A</td>
<td>Authentic accessibility</td>
</tr>
<tr>
<td>R</td>
<td>Reciprocal respect</td>
</tr>
<tr>
<td>E</td>
<td>Expressive empathy</td>
</tr>
<tr>
<td>S</td>
<td>Straightforward simplicity</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>TABLE 5</th>
<th>WATER approach</th>
</tr>
</thead>
<tbody>
<tr>
<td>W</td>
<td>Welcome warmly</td>
</tr>
<tr>
<td>A</td>
<td>Ask and assess</td>
</tr>
<tr>
<td>T</td>
<td>Tell truthfully</td>
</tr>
<tr>
<td>E</td>
<td>Explain with empathy</td>
</tr>
<tr>
<td>R</td>
<td>Reassurance and return</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>TABLE 6</th>
<th>Nonverbal cues of discomfort</th>
</tr>
</thead>
<tbody>
<tr>
<td>Whole body:</td>
<td></td>
</tr>
<tr>
<td>• Moving away from counselor</td>
<td></td>
</tr>
<tr>
<td>• Shifting chair backward</td>
<td></td>
</tr>
<tr>
<td>• Repetitive movements</td>
<td></td>
</tr>
<tr>
<td>• Fidgeting</td>
<td></td>
</tr>
<tr>
<td>Head and face:</td>
<td></td>
</tr>
<tr>
<td>• Frowning</td>
<td></td>
</tr>
<tr>
<td>• Narrowing of eyes</td>
<td></td>
</tr>
<tr>
<td>• Sweating/perspiration</td>
<td></td>
</tr>
<tr>
<td>• Turning red in the face/ears</td>
<td></td>
</tr>
<tr>
<td>Upper limbs:</td>
<td></td>
</tr>
<tr>
<td>• Wringing of hands</td>
<td></td>
</tr>
<tr>
<td>• Frequent touching of face</td>
<td></td>
</tr>
<tr>
<td>• Covering mouth with hands</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>TABLE 7</th>
<th>The five Es of sexual counseling</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Experience</td>
<td></td>
</tr>
<tr>
<td>• Etiquette</td>
<td></td>
</tr>
<tr>
<td>• Empathy</td>
<td></td>
</tr>
<tr>
<td>• Ethnic or cultural understanding</td>
<td></td>
</tr>
<tr>
<td>• Environment conducive for relaxation</td>
<td></td>
</tr>
</tbody>
</table>
Reproduction and Sexual Medicine

**TABLE 8 | Hierarchy of questioning**

- From nonthreatening to threatening questions
- From nonintimate to intimate issues
- From nonsexual to sexual history
- From general questions to specific questions, e.g. “How is your health” to “How is your sexual health?”
- From past history to present history, e.g. “What happened during adolescence?” to “What happens now?”
- From premarital history to marital history, e.g. “Any history of premarital contact?” to “Any extramarital contact?”
- From nonsexual urogenital symptoms to sexual urogenital symptoms, e.g. “Any h/s/o skin or urinary infection” to h/s/o “sexually transmitted disease”
- From nongenital sexuality to “genital sexuality” e.g. “Which places do you like being touched at?” to “How do you like being touched on the clitoris?”
- From nonpenetrative to penetrative sex, e.g. “What about foreplay?” to “What about penetration?”
- From penovaginal sex to alternative routes, e.g. “What position do you prefer?”
- From heterosexuality to homosexuality, e.g. “Have you been attracted to other men” to “Have you ever appreciated other women?”
- From “normal” sex to perversions/fetishes, e.g. “How do you perform sex?” to “Do you enjoy any nonroutine method of intercourse?”
- From human sex to animal sex (This one is tough: authors!)

**TABLE 9 | Types of psychological therapy**

- Relaxation therapy
- Vivid imagery
- Masters and Johnson therapy
- Gradual desensitization
- Cognitive behavioral therapy
- Pelvic floor exercise
- Eclectic therapy
- Yoga

**TABLE 10 | Common antecedents of means, standard deviations**

- Related to sexuality
  - Childhood abuse
  - Puritan atmosphere at home
  - Childhood exposure to pornography
  - Unpleasant encounters in past
  - Sexually transmitted disease
  - Chance encounters
- Related to general issues
  - Martial disharmony
  - Stress at work
  - Lack of quality time
  - Financial stress
  - Physical unfitness
  - Poor personal hygiene of partner
  - Irritating tics and habits of partner
  - Inappropriate external ambience

**NONPHARMACOLOGICAL THERAPY**

A healthy diet forms part of counseling for FSD. Counselors must encourage patient with FSD to take a balanced diet, rich in vitamins and minerals, supplemented by nutraceuticals if necessary. Avoidance of smoking and moderation of alcohol intake are essential points for discussion.

**Physical Activity**

Sexual fitness will be achieved only if one is physically fit. Patients should be encouraged to indulge in moderate physical activity at least thrice a week.

**Yoga**

Yoga is an ancient Indian regime which keeps the body fit, healthy and flexible. While yoga helps ensure in general, there are specific exercises or “Asanas” which may improve sexual function by improving pelvic blood flow.

**Psychological Therapy**

Various methods of psychological therapy have been described for the management of FSD. Some of these are listed in Table 9. Most experts use an eclectic combination of these therapies.

**Cognitive Behavioral Therapy**

Cognitive behavioral therapy (CBT) follows the ABC (antecedents, behavior, consequences) approach. After identifying the C (Consequences), i.e. the specific type of dysfunction, one should focus the B (Behavior), which preceded it, and then try to analyze the A (Antecedents), which led to the behavior. The consequence (sexual dysfunction) cannot be corrected until the dysfunctional antecedents and behavior that have led to it are identified and resolved. Certain issues, which are commonly cited by patients as leading to dysfunction, are listed in Table 10.

**Coupled Centered Care**

Male patient with sexual dysfunction is part of a unit, i.e. the couple. Often, counseling of both partners is required in order to achieve desired outcomes. Each couple will have its unique challenges. The male partner’s physical, mental, emotional and social health need must be addressed in order to manage his partner’s sexual dysfunction.

Dual sex therapy, pioneered by Masters and Johnson, is an example of couple centered approach to the management of means, standard deviations. The theoretical basis of the dual-sex therapy approach is the concept of the marital unit as the object of therapy. Improved communication in sexual and nonsexual areas is a specific goal of treatment.

**Religion and Counseling**

Religion is an important aspect of life, especially in India. Religion impacts FSD in multiple manners. Some patients grow up in a puritan atmosphere, believing that sex is sin, and find it difficult to differentiate between the religious strictures against premarital sex, and sanction for marital cohabiting. Others may approach religious leaders for treatment of FSD, instead of consulting modern medical practitioners.

In all such cases, religion can be used as a means of motivation, rather than demotivation. The counselor should be able to quote examples from relevant religious texts, which encourage a proactive approach in dealing with health problems, including sexuality.

**SPECIFIC DISORDERS: PRINCIPLES OF MANAGEMENT**

Disorders of desire are difficult to treat and remain elusive since desire is a relatively complex concept that requires delineating the components for the patient and the clinician. Treatments include individual and/or couple psychotherapy/sex therapy, hormone therapy (e.g. exogenous testosterone replacement or Tibolone), and centrally acting pharmacologic agents that may have a positive
impact on sexual function. To date, there are no pharmacologic treatments that are approved for the treatment of any female sexual disorder except the testosterone patch, which has been approved and used, but only in postmenopausal women. Postmenopausal women may benefit from estrogen replacement therapy as this increases clitoral stimulation, decreases coital pain and treats vaginal atrophy. Sildenafil (Viagra), which has been of such great benefit in men with sexual dysfunction, is beneficial in only a selected group of women.

Although there has been little evidence-based research on treatment for female sexual arousal disorder, treatment generally follows the work of Masters and Johnson, who taught patients to attend adequately to sexual sensations (sensate focus) using masturbation training while working to improve communication with their partners. Estrogen therapy, systemic or local, is often an effective treatment for arousal disorder that is acquired after the menopause. Over-the-counter lubricants and/or long-acting vaginal lubricants may improve symptoms when lubrication has been diminished. Other topical pharmacologic treatments that are being studied include the use of androgens, alprostadil and L-arginine. Because physiologic and subjective arousal may be unrelated, education is a key component in the treatment of female sexual arousal disorder. Another treatment option is the Eros Clitoral Therapy Device, made by UroMetrics. The device is FDA-approved and is designed to improve arousal by increasing blood flow to the clitoris with gentle suction.

Disorders of orgasm are often “situational”. These women can achieve orgasm readily and reliably with some specific forms of stimulation. For example, women are often reliably orgasmic with manual stimulation, but not with intercourse. In fact, intercourse is not a particularly reliable method for many women to achieve an orgasm. The most effective treatment is a cognitive-behavioral approach in which a woman learns to be comfortable with her body and then her own sexuality by altering negative attitudes and decreasing anxiety. The behavioral treatments include directed masturbation, sensate focus exercises, and systematic desensitization. Eliminating myths that masturbation is bad is an important theme in treatment. Masturbation is an extremely effective way for the woman who has never achieved orgasm to experience her first climax. In privacy, without the pressure of performing for, or pleasing a partner, the woman is free to explore her own body and responsiveness. Vibrators may be used in this condition. Another effective component of treatment is permission given by a clinician. Dyspareunia can be described as involving pain on entry or deep pain. Painful entry is most typical of vulvodynia, inadequate lubrication and vaginismus. The psychobiology of sexual pain should be addressed with a comprehensive, integrated, and patient-centered perspective. For vaginismus, the most effective treatment is a combination of cognitive and behavioral psychotherapeutic approaches. The goal is to desensitize a woman to her panic and help achieve a sense of control over a sexual encounter or a pelvic examination and an understanding that she is in no danger of expelling her partner, thereby feeling helpful and calm. One of the most commonly used treatment techniques is systematic desensitization. In this case, women are first taught deep muscle relaxation and then to very gradually insert objects (usually dilators) of increasing diameter into the vagina. Refractory vaginismus may respond to botox injections into the puborectals.

The management of persistent sexual arousal disorder is unclear though there are anecdotal reports of treatment with high dose selective serotonin reuptake inhibitors.

COMMUNITY AWARENESS

Female sexual dysfunction may seem superficially to be an individual’s problem, or at the most, a couple’s concern. In reality, the impact of FSD goes for beyond this. Such patients are often subjected to ridicule, by spouse, family members or friends, and this only serves to aggravate the illness.

The community must be sensitized to treat the women with sexual dysfunction in a human and supportive manner, and not to act as barriers or hurdles in their sexual rehabilitation process. The onus of spearheading this public health campaign lies with healthcare professionals, who should actively involve themselves in FSD patient advocacy. Public awareness must also be raised about the lack of evidence, and potential risk, discomfort and harm of untested treatments offered by unqualified practitioners of complementary and alternative therapy. Every window of opportunity should be utilized to spread awareness about the utility and benefits of modern nonpharmacological, medical and surgical strategies for FSD.

CONCLUSION

Human sexuality has numerous symbolic meanings to an individual, and it is important for the clinicians to understand human sexuality. Despite advances in the treatment of human sexual problems, various lacunae remain in our knowledge of human sexuality. In particular, our knowledge of female sexuality has consistently lagged behind that of male sexuality. In fact, relatively little is known about the relationship among sexual behavior, sexual attitudes, sexual fantasies, and marital functioning of women. In India, sexuality was considered a taboo, and sexual matters were generally not discussed in the family till 1960s, as reported in literature. Indian women were lacking the independent authority for the control of their sexuality or reproduction. However, in last quarter century, there has been an apparent transition in the attitude of people toward sexuality. Expressions and feelings that would have otherwise been termed as scandalous and in the need of being tamed to adhere to socially accepted rules, values, and practices, are now accepted as natural. More people are accepting the fact that sexuality plays a crucial role not only in procreation but also for pleasure. It is important to realize that in the last four decades, sizeable scientific work has been conducted on human sexuality worldwide. However, scientific research in the area of sexuality in India is still scant and, if studied, most have almost exclusively focused on male sexual disorders. This has been a limitation to better understand sexuality of Indian women. Nevertheless, Indian women appear to be rejecting the traditional Indian repressive standards of sexual functioning. Most young Indian women now have liberal attitudes toward varied sexual behaviors, which could be regarded as the components of their usual sexual practice. Further studies on Indian female sexual attitudes and behavior, and their association with sexual dysfunction are much needed. The problem is sexuality is not addressed by a women healthcare professional in India yet as an issue, which actually needs to be discussed with women sailing through crisis of self-identity and self-disapproval.

BIBLIOGRAPHY