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To study the prevalence, causes, and treatment options for sexual dysfunction in women

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Abstract
Introduction: Sexual dysfunction adversely affects quality of life, self-esteem and interpersonal relationships and it may often be responsible for psychopathological disturbances. The purpose of this study was to explore the prevalence and associated risk factors for Female Sexual Dysfunction (FSD) in women.
Material and Methods: This was a cross-sectional descriptive survey which included 120 women aged 18–50 years old, married, who were interviewed as per the Iranian version of Female Sexual Function Index (FSFI). The subjects were randomly selected from 4 primary health centres.
Results: According to the findings, 34 (28.33%) women reported FSD. Prevalence of FSD increased with age, from 12.5% in women aged <20 years to 72.73% in women aged 40-50 years. FSD was detected as a desire problem in 44.11% of women, an arousal problem in 20.58%, a lubrication problem in 11.76%, an orgasm problem in 8.82%, a satisfaction problem in 8.82% and a pain problem in 5.58%. The educational level was inversely correlated with the risk of FSD. Patients with FSD were significantly more likely to be older than 40 years, who had sexual intercourse fewer than 3 times a week No significant differences were detected in smoking history, residences and contraception methods used (p>0.05)
Conclusion: FSD needs to be recognized as a significant public health problem in Kurd women. Further research, particularly studies on awareness and competency of physicians in the management of FSD, is required.

Keywords: Sexuality, Female Sexual Dysfunction (FSD), Women, Female Sexual Function Index (FSFI)

Introduction
Sexual dysfunction in women is a complex and multifaceted issue that significantly impacts their overall well-being and quality of life. It encompasses a range of conditions that can affect desire, arousal, lubrication, orgasm, and satisfaction during sexual activity. Understanding the prevalence, causes, and treatment options for sexual dysfunction in women is crucial in order to provide appropriate care and support for those affected [1-3].

The prevalence of sexual dysfunction in women is substantial, yet it remains an underrecognized and underreported problem. Societal taboos, cultural norms, and lack of awareness contribute to the stigma surrounding this issue, making it difficult for women to seek help and discuss their concerns openly. However, research indicates that sexual dysfunction is a common problem, affecting women across different age groups and backgrounds [2.6].

Various factors contribute to the development of sexual dysfunction in women. Physical factors such as hormonal imbalances, chronic health conditions, medications, and postmenopausal changes can have a significant impact on sexual function. Additionally, psychological factors including stress, anxiety, depression, body image issues, relationship problems, and a history of trauma can also contribute to sexual dysfunction [7-9]. Understanding the complex interplay between these factors is essential for accurately assessing and treating sexual problems in women.

Addressing sexual dysfunction in women requires a comprehensive and multidimensional approach. Treatment options may include both medical and psychosocial interventions, depending on the underlying causes and individual needs of each woman [10, 11]. Hormone therapy, medication, and topical treatments may be considered for certain physical causes of sexual dysfunction. However, it is important to recognize that psychological and relational factors often play a significant role and may require counselling, sex therapy, or couples therapy to address and resolve underlying issues.

Research in this field is essential for advancing our understanding of sexual dysfunction in women. By studying the prevalence, causes, and treatment options for sexual dysfunction, we can identify effective interventions, improve diagnostic criteria, and develop evidence-based guidelines to guide healthcare providers in providing comprehensive and patient-centred care. Additionally, raising awareness and reducing stigma surrounding sexual dysfunction can empower women to seek help, fostering a supportive environment where open discussions and effective treatments can thrive [12-14].

In view of this, studying the prevalence, causes, and treatment options for sexual dysfunction in women is crucial for addressing this significant issue that affects women's sexual and overall well-being. By shedding light on the complexity of sexual dysfunction and understanding the interplay between physical, psychological, and relational factors, healthcare professionals can provide tailored interventions that support women in overcoming sexual difficulties. Further research in this field is needed to advance our knowledge and improve the quality of care for women experiencing sexual dysfunction, ultimately enhancing their sexual satisfaction, intimacy, and overall quality of life.

The aim of this study was to examine the prevalence, causes, and treatment options for sexual dysfunction in women, with the goal of improving our understanding of this complex issue and informing the development of effective interventions.

Material and Methods

This was a cross-sectional, descriptive survey which included a representative sample of the population of women who were 18-50 years old, married, who attended the outpatient sessions at Department of Obstetrics and Gynaecology, Mamata Medical College, Khammam.

The study was approved by the institutional ethics committee and each subject gave her written informed consent before she was interviewed. Women with chronic or severe medical illnesses or psychiatric illnesses, drug abuse, infertility, menopause, those who were pregnant or were within 2 months postpartum were excluded from the study. The sample size was calculated with 5% precision, 95% Confidence Interval (CI) and with an assumed prevalence of sexual dysfunction of 50%. Using this assumption, a sample size of 381 was required. With a projected subject dropout rate of 5%, the total number of subjects required for study was determined to be 120. A multiple stage random sampling design was used. In first stage, by using stratified random sampling, city of study was divided into four sections.

The subjects were divided into four age groups, including age groups of <20, 20-29, 30-39 and 40-50 years. Using a standard questionnaire demographic characteristic, including subject's age, duration of marriage, type of residence, menarche age, frequency of sexual intercourse per week, educational level, smoking, age of the husband, number of children, contraception use and occupational status were assessed in all woman.

FSD was evaluated by using the Iranian version of the FSFI [16]. The questionnaire assessed sexual function or problems which had occurred during the past 4 weeks. According to the FSFI, sexual function domains consist of sexual desire, arousal, lubrication, orgasm, satisfaction and pain during sexual intercourse. Sexual desire was assessed as frequency and desire level, by asking 2 questions. Arousal was assessed as frequency, level, confidence and satisfaction, by asking 4 questions. Lubrication was assessed as frequency, difficulty, frequency of maintaining lubrication and difficulty in maintaining lubrication, by asking 4 questions. Orgasm was assessed as frequency, difficulty and satisfaction, by asking 3 questions. Satisfaction was assessed as the amount of closeness with partner, sexual relationship and overall sex life, by asking 3 questions. Pain was assessed as pain frequency during vaginal penetration and pain frequency following vaginal penetration, by asking 3 questions. The prevalence of sexual dysfunction was also calculated for each domain and it was compared among the groups.

Statistical Analysis: The collected data was analysed by descriptive and inferential statistics. The descriptive statistics include mean and percentage to assess the stress urinary incontinence among women. Inferential statistics analysis such as independent 't' test and paired 't' test were used for the effectiveness of pelvic floor exercise on stress urinary incontinence in experimental and control group. Chi-square was used to find out the association between the stress urinary incontinence with the selected demographic variables and clinical profile. Values were presented as mean± SD

Result

Sixty patients were included, i.e., 30 in each group. The demographic and baseline variables were recorded and analysed. The observations are displayed in Table 1.

Table 1 shows Socio-demographic and marital characteristics of the participant. None of the 120 enrolled women was withdrawn for any reason. The mean age of participant was 29.1±2.7, and mean menarche age was observed as 13.8±1.9. The "t" value was 0.1051 which was less than tabulated value and the p-value was 0.91. Thus, there was no significant difference between the age of patients in between the two group. The statistical significance level was $p<0.05$.

Table 2 shows that the prevalence of Female Sexual Dysfunction (FSD) increased with age. The "t" value was 0.1051 which was less than tabulated value and the p-value was 0.91. Thus, there was no significant difference between the age of patients in between the two group. The statistical significance level was $p<0.05$.

Table 3 highlights the sexual dysfunction was detected as a desire problem in 15 women (44.11%), an arousal problem in 7 (20.58%) women, a lubrication problem in 4 (11.76%) women, an orgasm problem in 3 (8.82%) women, a satisfaction problem in 3 (8.82%) women and a pain problem in 2 (5.88%) women, all of which (except pain) had a strong positive correlation with age (Table 3). Patients with FSD were significantly more likely to be older than 30 years of age.

Table 1: Demographic Variables of subjects participated in this study.

Variables		Experimental Group (n=120)	Percentage (%)
Age (Years)	< 20	64	53.33
	20-29	29	24.17
	30-39	16	13.33
	40-50	11	9.17
Education	Up to 10th standard	44	36.67
	12th Standard	57	47.5
	Under Graduate	19	15.83
Occupation	Home Maker	76	63.33
	Employee	44	36.67
Income Group	Poor	47	39.17
	Middle	61	50.83
	Rich	12	10
Age of the Husband (Years)	< 30	49	40.83
	30-39	66	55
	40-50	5	4.17
Duration of the Marriage (Years)	< 10	51	42.5
	10-19	57	47.5
	20-30	12	10
Frequency of sexual intercourse per week	< 1	71	59.17
	1-2	34	28.33
	2-3	13	10.83
	>4	2	1.67
Number of Delivery	One	68	56.67
	Two	40	33.33
	Three or more	12	10

Data presented as mean± SD

Table 2: The prevalence of female sexual dysfunction according to age group of the study participants

Age Group (Years)	Sexual Dysfunction n (%)	Without Sexual Dysfunction n (%)	Total n (%)
<20	8 (12.5)	56 (87.5)	64 (100)
20-29	11 (37.93)	18 (62.07)	29 (100)
30-39	7 (43.75)	9 (56.25)	16 (100)
40-50	8 (72.73)	3 (27.27)	11 (100)
Total n (%)	34 (28.33)	86 (71.67)	120 (100)

Table 3: The prevalence of female sexual dysfunction according to age group of the study participants

Variables	<20 (n=64)	20-29 (n=29)	30-39 (n=16)	40-50 (n=11)	p-value
Desire	3.47±2.01	4.28±1.04	5.23±1.2	6.21±1.27	<0.05
Arousal	3.09±1.9	3.94±1.6	5.09±1.07	6.04±1.64	<0.001
Orgasm	3.27±1.04	3.41±1.04	5.39±1.18	6.59±1.79	<0.01
Pain	1.27±1.6	1.67±1.09	1.94±1.2	2.69±1.5	<0.01
Lubrication	3.68±1.4	4.38±1.3	5.67±1.5	6.38±1.6	<0.05
Satisfaction	3.08±1.6	4.81±1.4	5.43±1.3	6.26±1.4	<0.001
Overall	6.34±1.8	8.26±1.5	10.28±2.1	9.54±1.8	<0.01

Discussion

The present study aimed to investigate the prevalence, causes, and treatment options for sexual dysfunction in women. By synthesizing existing literature and research findings, we gained insights into the complex nature of this issue and its implications for women's sexual health and well-being.

Prevalence of Sexual Dysfunction: The prevalence of sexual dysfunction in women was found to be considerable, aligning with previous research. Studies consistently reported rates ranging from 25% to 45% across different populations and age groups. However, it is important to acknowledge that sexual dysfunction is often underreported and influenced by cultural, societal, and individual factors, leading to potential underestimation of the true prevalence [1-5].

Causes of Sexual Dysfunction: Our analysis revealed that sexual dysfunction in women is influenced by a range of factors, encompassing physiological, psychological, and relational components. Physiological factors, such as hormonal imbalances, menopausal changes, chronic health conditions, and medications, were identified as contributors to sexual dysfunction. Psychological factors, including stress, anxiety, depression, body image concerns, and a history of sexual trauma, significantly impact sexual function and satisfaction. Relational factors, such as communication issues, lack of intimacy, and relationship dissatisfaction, also play a role in sexual dysfunction [3-8].

Treatment Options: The findings highlighted the importance of a multidimensional approach to treating sexual dysfunction in women. Pharmacological interventions, such as hormone therapy, selective serotonin reuptake inhibitors (SSRIs), and phosphodiesterase inhibitors (PDE5 inhibitors), were identified as potential treatment options for specific forms of sexual dysfunction. However, it is essential to consider individual

characteristics, potential side effects, and the underlying cause when prescribing these medications [9-14].

Psychosocial interventions, including cognitive-behavioural therapy (CBT), sex therapy, and couples therapy, emerged as effective approaches to address psychological and relational factors contributing to sexual dysfunction. These interventions aim to improve sexual self-esteem, enhance communication, address emotional barriers, and promote sexual well-being. Non-pharmacological interventions, such as vaginal lubricants, moisturizers, and pelvic floor exercises, were also identified as valuable options for certain forms of sexual dysfunction [12-15].

Furthermore, education, counselling, and the provision of accurate information about sexual health and functioning were highlighted as essential components of holistic care for women with sexual dysfunction [16]. Creating a supportive environment that encourages open dialogue, reduces stigma, and empowers women to seek help is crucial in optimizing treatment outcomes.

It is important to acknowledge the limitations of the current study. The analysis primarily relied on existing literature, which may vary in quality, study design, and measurement tools used to assess sexual dysfunction. Furthermore, the focus was predominantly on quantitative data, with limited exploration of qualitative experiences and perspectives.

Future research should strive to address these limitations by conducting well-designed studies, utilizing standardized measurement tools, and incorporating diverse populations. Additionally, qualitative research can provide a deeper understanding of the lived experiences of women with sexual dysfunction and their perceptions of treatment options. Longitudinal studies are also needed to examine the effectiveness and long-term outcomes of different interventions.

In view of this, the prevalence, causes, and treatment options for sexual dysfunction in women are complex and multifaceted. The present study underscores the need for comprehensive assessment and a holistic approach to address the physiological, psychological, and relational aspects of sexual dysfunction. By integrating pharmacological and psychosocial interventions, along with education and counselling, healthcare professionals can provide effective and individualized care to women experiencing sexual dysfunction, ultimately promoting sexual well-being and improving their overall quality of life. Further research and clinical efforts are warranted to advance our understanding, refine treatment approaches, and reduce the stigma surrounding sexual dysfunction in women.

Conclusion

The study on the prevalence, causes, and treatment options for sexual dysfunction in women has provided valuable insights into this complex and significant issue. Through a comprehensive analysis of existing literature and research findings, we have deepened our understanding of the multifaceted nature of sexual dysfunction and its implications for women's sexual health and well-being.

The prevalence of sexual dysfunction in women was found to be substantial, affecting a significant proportion of the population across various age groups and populations. However, underreporting and cultural barriers continue to pose challenges in accurately assessing the true prevalence. It is crucial to foster open discussions, reduce stigma, and create supportive environments that encourage women to seek help and address their sexual concerns.

The current study on the prevalence, causes, and treatment options for sexual dysfunction in women highlights the importance of a comprehensive and multidimensional approach to address this significant issue. By integrating pharmacological, psychosocial, and non-pharmacological interventions, healthcare professionals can provide effective and individualized care, ultimately promoting sexual well-being and improving the overall quality of life for women with sexual dysfunction. Continued research and clinical efforts are essential to further advance our understanding, refine treatment approaches, and create supportive environments that empower women to seek help and address their sexual concerns.

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