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FEMALE SEXUAL DYSFUNCTION AND GYNAECOLOGICAL PRACTICE: REPORT OF SIX CASES

V.M. Lema, MBChB, MMed, Professor of Obstetrics & Gynaecology, Honorary Lecturer, Faculty of Medicine, The Aga Khan University, P. O. Box 30270-00100, Nairobi, Kenya

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V.M. LEMA

SUMMARY

Sexuality is a complex phenomenon, yet an essential part of a healthy life, influenced by biological, psychological and socio-economic factors. Current re-conceptualisation of women's sexual response acknowledges that they have many reasons for engaging in sex beyond sexual desire. Women are increasingly becoming aware of their sexuality and demand sexual fulfilment more than ever before and when that is not realised there may be personal distress.

Female sexual dysfunction is prevalent in all populations and cultures globally. However, very few women seek medical help due to belief that the problem is not serious, challenges with access to or affordability of care and lack of awareness of available treatments. It's also infrequently diagnosed, due to lack of awareness among health care providers.

Case scenarios on female sexual dysfunction managed by the author are presented with the aim of raising awareness among health professionals. Possible strategies to address the problems are proposed.

INTRODUCTION

In defining reproductive health, the ICPD (Cairo 1994), stated that it includes sexual health, the purpose of which is the enhancement of life and personal relations. It also indicated that reproductive health implies "people are able to have satisfying and safe sex.....". It went further by stating that "fundamental to this concept are the right to sexual information and right to pleasure (1). The definition of sexual health has evolved a great deal from the earliest WHO definition in 1975 to the 2022 one, which states "sexual health is a state of physical, emotional, mental and social well-being related to sexuality; it is not merely the absence of disease, dysfunction or infirmity" (2). These are fundamental statements. The topic of reproductive health is not a new concept; several of the papyrus discovered in the ancient tombs of Egypt, thought to be nearly 4000 years old, relate to the improvement of sexual health, mainly in women (3).

Human sexuality is a basic human right and an essential part of healthy life (4). It is a complex phenomenon especially in the woman, influenced by an interplay of the individual's physical, mental, psychological well-being, socio-cultural context, interpersonal relationships, and previous sexual experiences (5, 6).

There is an increasing openness in discussing female sexuality and women are now more aware of

their sexuality and sexual health. Surveys conducted across a range of cultures demonstrate that the vast majority of women believe sexual activity to be important. It has been shown that higher levels of physical pleasure in sex are significantly associated with higher levels of emotional satisfaction. Many appreciate the need for sexual satisfaction, defined as "the individual's subjective evaluation of the positive and negative aspects of one's sexual relationship and her subsequent affective response to the evaluation (7, 8), and its positive impact on relationship (9).

Women's motivations and desire to engage in or initiate sex vary greatly amongst individuals and even in the same individual from one time or partner to another (10). Likewise the response to sexual stimulation varies a great deal. To understand why sexual problems occur, it is important to understand the sexual response cycle. The first account of female sexual response was by Masters and Johnson in their epic research work, which reported a four-phase linear progression from excitation and arousal, reaching a plateau-stage, orgasm and resolution (11). Kaplan's introduced the concept of desire bringing about arousal but kept the linear model (12). More recently, Basson proposed a non-linear model, and opined that subjective sexual arousal experienced by women, where recognised, will in favourable circumstances bring about a desire for sexual activity and behaviour, especially when this is focused on enhancing intimacy and pleasurable outcome (13). The non-linear model

of female sexual response incorporates an intimacy-based motivation affecting sexual stimuli and co-influencing biological and psychological factors and satisfaction.

Sexuality for a woman encompasses a very broad range of physical activities and psychological experiences, which fulfil physical and emotional need for closeness and intimacy. Although most women's sexual responsiveness peaks in the late 30s and early 40s, a woman can have satisfying sexual experiences throughout her adult life. The quality of her experiences is affected by individual differences, by life situation, by age and hormonal levels, and overall health and well-being (10).

Sexual dysfunctions are characterised by persistent disturbances in the processes of a normal sexual response cycle and by pain associated with sexual intercourse (14, 15). Particularly in women, any one or more of the domains that include sexual interest/desire, sexual arousal (and lubrication), and orgasm could be affected (15). Female sexual dysfunction (FSD) is a multifactorial condition with anatomical, physiological, medical, psychological, and social components (16). Cultural and religious factors also play an important role in the development and progression of FSD (17). FSD may lead to interpersonal difficulties, marital discord and divorce, reproductive difficulties, as well as reduced quality of life (18).

Although sexual problems among women have started to receive due attention in Western countries, it is not the case in Africa and other developing parts of the World. There is also paucity of publications from the developing world more so Africa. Some of plausible explanation to that is lack of awareness among the public as well as health professionals on the problems and available treatment options.

This article presents case scenarios of a selection of women with FSD managed by the author over the past ten years in two different countries in Eastern and Southern Africa. It highlights the effects of FSD on the women's lives and the presentations thereof. It aims at raising awareness of gynaecologists in the region on FSD, stimulate their interest in diagnosing and managing it including appropriate referral.

CASES

No. 1

Ms M.S.W, a 34 year old single lady, a lawyer in a local legal firm, presented with long-standing history of fear of intimacy and sexual intercourse. She had had several boyfriends since age 20, when in the University, but was still a virgin. She could not bring herself to be alone with a man even in public, always taking a friend along when invited for a date for "safety precautions". She dearly wanted to be able to

overcome her fears and enjoy life like her peers.

She reported that when she was young and in primary school her biological father used to abuse her mother both verbally and physically. She was not sure if there was any sexual abuse but she suspected there was, as she often heard her mother crying at night in the parent's bedroom. The mother finally left the home when she was in secondary school and committed suicide soon thereafter. She therefore grew up fearing and not trusting any man.

She had not experienced any form of abuse herself – physical or sexual. She had no sexual attractions to the same gender, had not even kissed a man, nor masturbated. She considered herself normal otherwise as she often became very sexually aroused watching movie with sexual contents. She had attained menarche at age 14 and her menstrual cycles had been fairly regular bleeding for four days every 28-30 days. The flow was modest and she did not have dysmenorrhoea.

She currently had a boyfriend who was quite understanding, loving and caring, who had proposed marriage but she had turned him down.

Physical examination revealed a normal healthy young woman, with fully developed feminine features. She had several counselling sessions over a six months period and was encouraged to explore her own body. After the first four months she was confident enough to go on a date alone with her boyfriend, and had kissed a few times, which she found exciting and enjoyable. By the end of six months she had attempted sexual intercourse twice but pulled out before penetration. She was encouraged to try self masturbation and given some guidance on it. There was steady improvement over the ensuing months and exactly a year after she was first seen they announced their engagement and got married four months later. I had the privilege of taking care of her first pregnancy and delivering her baby. She and her husband are very happy and grateful as they now have a very satisfying sexual relationship.

No. 2

Ms VLN, a 32 year old business woman – high school graduate, married for 5 years presented with failure to conceive. She had attained menarche at age 13 and her menstrual cycles had been fairly normal and regular, with no dysmenorrhoea. Her husband, a 35 year old college graduate was her first and only sexual partner. She was a virgin when she got married.

On sexual history, she reported that they had intercourse very infrequently, never more than once per week. At times they could stay for up to three weeks without sex. They both worked at a family business in the city and her husband would often leave the house ahead of her at about 5 am and return much later than her at about 9 – 10.00 pm Monday

to Saturday. The only free day they had was Sunday when they would go to church and then visit relatives and friends. By the time he came home from work he would be so tired and soon after dinner he'd "drop dead". He did not have another woman. She often felt very frustrated sexually because of that as well as the fact that even when they did it was so rushed, she would not get adequately aroused before he reached orgasm. She had never experienced orgasm herself, a fact which distressed her as her women friends would often tell her of their own experiences – that they would have up to three orgasms in one night. Neither she nor her husband imbibed alcoholic beverages or smoked cigarettes.

Physical examination did not reveal any abnormalities. She had normal external and internal genitalia.

She was given sexual health talk, and had several counselling sessions on a weekly basis initially. She was also advised on fertile days and how to maximise on the potential of conception considering their nature of work and life style. Her husband was invited for a counselling session but could not make it due to work. She was advised to share the information she was been given with her husband. After three months she reported a great improvement in their sexual relations and on the fourth month she was confirmed to be pregnant. She eventually went on to deliver a healthy baby boy at term.

No. 3

Ms R.N., a 29 year old health worker, para 2+0, both normal deliveries, presented a year after her last delivery with history of having sustained a perineal tear during that delivery at a University teaching hospital, which was not repaired. Her complaint was that she was not enjoying sexual intercourse with her husband as she used to before the delivery. She felt the vaginal introitus was more patulous with poor penile grip. Whereas her desire had remained unchanged, genital arousal was a problem and she was having great difficulties achieving orgasm, something she never worried about before. The only times she was able to achieve orgasm was with oral sex and what she termed "finger fucking"! She had tried Kegel's exercises to no avail. Her husband had not noticed any difference though. She was unhappy with the situation and wanted help.

Upon physical examination, she was found to be in good general health. Had a small perineal tear which had healed well without much scarification. She was counselled on the vaginal-perineal repair and potential sequelae.

A colpo-perineorrhaphy was performed successfully five days later and she healed very well. The couple

was advised to abstain from penetrative sexual intercourse for at least eight weeks to allow tissues to heal well. They resumed sexual intercourse after ten weeks and although there was minimal discomfort initially, she was able to enjoy normal and satisfying sexual relations by the twelfth week after surgery. She is happy with the results.

No. 4

Ms J.M., a 28 year old secretary, married for two years to a 35 year old sales executive in a multinational company, was expecting their first child. Her husband was the third sexual partner she had had in her life, but he was her first husband. They had regular and satisfying sexual relations, which she often looked forward to with anticipation. She often would have two or more orgasms in one night and she felt "thoroughly satiated".

Her sexual response had declined somewhat in the first two months of her pregnancy, but improved by the fourth. This remained so until towards the end of the sixth month when during routine antenatal visit she complained of total lack of sexual desire and severe dyspareunia. She had explained the situation to her husband but he had ignored her insisting of having "his conjugal rights", which was almost daily with a frequency of two to three times a night. Whenever she complained he would threaten her that he would look for another woman. She opted to endure the pain, pretending to be enjoying it and at times faking orgasm.

She was advised to use a lubricant to aid penetration and ease the pain at least. Her husband was invited for a counselling session but refused saying he did not have a sexual problem. They continued like that till delivery. I did not see her again after the six week postnatal check up.

No. 5

Ms M.O.A., a 30 year old high school teacher, para 2+0, had been on injectable contraceptive (DMPA) for a year from about four months after her last delivery at a University teaching Hospital. Prior to the last conception her menstrual cycles had been quite regular bleeding for five days every 29 to 32 days, with a normal flow. She was married to a 36 year old University lecturer, who had no history of health problems, neither smoked nor imbibed alcoholic beverages. He was her second sexual partner but currently the only one. They enjoyed each others company and had regular satisfying sexual relations. After the last delivery they had resumed sexual relations after about three months and it had been okay.

Following the use of DMPA her sexual desire had plummeted considerably. She had great difficult

with arousal and had not experienced orgasm since then, something she used to regularly before. She however did not have dyspareunia. Both she and her husband were very concerned by the turn of events. They wanted to change to another method.

On physical examination, she was noted to be in very good general health.

She was counselled on various contraceptive methods, their modes of action, advantages and side effects. She opted for the intrauterine device. She was put on combined oral contraceptives for three cycles to regularise her menstrual cycles after which a copper T 380A IUCD was inserted. There was dramatic improvement in her sexual response by the third month. The couple was happy with the results.

No. 6

Ms P.N.K., a 29 year old insurance executive, had been my patient for close to two years. She was married to a 40 year old business executive, who was her third sexual partner. They had been married for just over a year but had been together for about three years. I had taken care of her during their first pregnancy, which ended in a preterm intrauterine death due to a cord accident. She had insisted on being delivered through caesarean section then despite intense counselling. The postoperative period was uneventful and she and her husband were given a lot of counselling to cope with the loss. They had been advised to rest for at least a year before conceiving again for the uterus to heal well and was put on combined oral contraceptive pills. She deliberately stopped using the oral pill after five months and conceived soon thereafter.

I continued seeing her during the second pregnancy from about six weeks. She had no problems, until about sixteen weeks into the pregnancy, during routine antenatal visit when she complained of lack of sexual desire. On probing further she intimated that she had never really enjoyed sex with her husband from the beginning. She used to compare his performance to that of her previous lover who according to her "would take to cloud nine"! Her husband's foreplay was often lacklustre. She enjoyed oral sex which she found very stimulating but he was not a great fan thereof. He preferred the missionary position while she liked adventure and exploration. She had tried explaining this to him but he ignored her. This had frustrated her a great deal and was contemplating responding to her ex-boyfriend's overtures with whom they were still communicating by phone. She often found herself so aroused during these telephone conversations, that she would often masturbate. At one time she reached climax just talking with him on the phone.

Much as she wanted to be faithful and keep her marriage vows, she found it increasingly difficult to

cut off communication with him. She even looked forward to his telephone calls as then she "felt alive".

She was taken through several counselling sessions and was asked to bring her husband, but she did not. She went on to deliver a healthy baby at full term, but the sexual problem has persisted. The last time I saw her she was thinking of separation with an option of divorce!

DISCUSSION

The presented six cases represent a very small proportion of women seen and managed by the author over the past ten or so years, but a fair spectrum of the sexual dysfunction thereof. They underlie the fact that female sexual dysfunction is prevalent among women seeking routine gynaecological care as reported by Nussbaum et al (2000) (19). Over the said period I have attended to close to 200 women and men with one form of sexual dysfunction or the other. The main complaints among women are lack of desire and orgasm while amongst the men it is erectile dysfunction (ED) and premature ejaculation (PE). Their ages range from as low as 20 to 50 years. Some have had very good results following treatment, while some not so good and a few no improvement at all basically because the main operational factors were not resolved.

My professional interest in sexual dysfunction was triggered by the number of young married women, often in their late 20's, who presented in my clinic with ill-timed pregnancy resulting from extramarital liaisons requesting termination. On enquiring into the circumstances a good majority cited poor and unsatisfactory partner sexual performance and a few indicated that they could not resist the temptations from their ex-boyfriends! Secondly I was also seeing quite a number of patients with HIV/AIDS who during the acute illness stages had no sexual desire at all, but when the condition improved after being started on ARVT and other supportive treatments the situation changed drastically. I then started taking more in depth sexual histories from almost all my gynaecological and obstetric patients and read extensively on the subject of human sexuality and associated problems. I currently run a weekly sexual medicine clinic at a university teaching hospital in Nairobi and a personal gynaecological/obstetric clinic where I see between two and three patients with sexual dysfunction weekly. Majority of them are women, may be because I am a gynaecologist.

Population based studies mainly in the developed world, have shown that at least 40% of women have one or more SD in their adult life (20). The prevalence varies from one study to another chiefly because of the criteria used in diagnosis and the study population itself. There is a great paucity

of research work and publication on SD from Africa, but that does not mean it does not exist. Studies by Fajewoyami *et al* (2007) in Nigeria and Amidu *et al* (2010) in Ghana reported FSD prevalence rates of 63% and 73% respectively (21-22), higher than the average globally. Odar *et al* (2011) in their study on postnatal women in Uganda, found that of those who had resumed sex within six months after delivery 22% had sexual problems (23).

The American Psychiatric Association in its DSM IV-TR defined six female dysfunctions, namely hypoactive sexual desire disorder (HSDD), sexual aversion disorder, arousal disorder, orgasm disorder, dyspareunia and vaginismus (14). Basson (2005) in her expanded definitions of FSD categorised arousal disorder into subjective, genital and a combination of the subjective and genital arousal disorder (24). FSD may be primary, secondary or situational based on occurrence. Cognisant of the foregoing, of the presented cases, MSW had primary sexual aversion disorder, VLN had situational orgasm disorder; RN had secondary genital arousal disorder complicated by orgasm disorder; JM had secondary hypoactive sexual desire disorder complicated by arousal and orgasm disorder and dyspareunia, MOA had secondary HSDD, while PNK had situational secondary HSDD.

Sexual desire disorders are reportedly the most frequent FSD, accounting for 64%, followed by orgasm disorder (35%), then arousal (31%) and finally pain disorders (26%) (25). Half of the presented cases had desire disorders. As seen from the presented cases one FSD may be complicated or lead to another, e.g., desire disorder will almost invariably lead to arousal and orgasm disorders; dyspareunia may lead to genital arousal and orgasm disorders; orgasm disorders may lead to desire and arousal disorders and so on. It is therefore critical when managing FSD to establish the primary disorder and address it. I see a good number of situational HSDD among young married women often in their second year of marriage and after first childbirth. They suddenly lose desire in as far as their spouses are concerned. Some have drifted back to their ex-boyfriends or sought new relations for sexual gratification and have a lot of guilt conscious. They almost always blame poor husband sexual performance when compared with their former lovers. This situation is becoming increasingly common in our societies. It is even more worrying cognisant of the reports indicating high HIV infection rates among young and married women in SSA (26). It is also very possible that the main root cause of a number of cases of husband assaults being reported in the media lately could be sexual dysfunction as many women when asked say the husbands are not responsible!

The aetiology of FSD is very varied and

results from a complex interaction of biological, psychological and social factors (27). The type and quality of relationship one is in and partner's sexual performance and/or dysfunction have been cited as the major reasons for dysfunction in women (28). Two of the presented cases (VLN and PNK), gave their partners' performance as the reason. As mentioned earlier women are demanding sexual satisfaction from their partners now more than ever before. At the same time young married men are caught in a complex web to satisfy their young wives sexually, while at same time providing adequate social and economic security in an ever challenging and competitive economic environment! A good number are not able to fulfil all these demands. There are stories in the media of married women paying young men for sexual favours as their husbands are not meeting the challenge!

Sexuality changes in pregnancy and postnatal periods are well documented, and include diminished sexual desire (23, 29) as in the case of JM. Other causes are genital trauma (30) such as obstetric injury which may either cause scarification leading to dyspareunia or a gaping introitus leading to diminished genital arousal as in the presented case. Over the past one year alone I have had to reconstruct the introitus (colpo-perineorrhaphy) in six patients who had similar complaints as RN. Although significant reduction in sexual desire is not mentioned in literature on side effects of medroxy-progesterone acetate (DMPA) contraceptive, I see quite a few women who are using it complaining of HSDD and asking for a change of method.

As has been reported in other studies there is a global trend in delaying first age at marriage without concomitant delay in sexual debut. It is therefore not unusual for a young woman to have had a number of sexual partners before marriage. Secondly as some marry due to peer, family or personal pressures, social and or economic reasons and not necessarily for love, there are always chances of drifting back to old love or seeking new ones!

Sexual dysfunction is an important health concern and prevalent in all cultures and populations globally. It can have serious psychological, social, and even biological impact on the victim and her spouse/partner. With the broadening of democratic dispensation and increased awareness amongst the majority of the population of their basic human rights including sexual pleasure and satisfaction, as well more openness in discussing human sexuality, we are likely to have more individuals presenting with SD. It is important therefore for health care professionals especially gynaecologists to be aware of its existence, causes, predisposing factors, preventive and treatment strategies. Revision of relevant curricula to incorporate sexual health could be a starting point. Secondly gynaecologists should be

encouraged to take more in-depth sexual histories in all their patients even those with no obvious complaints thereof and either manage those with problems or refer as appropriate.

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