

Prevalence of Sexual Dysfunction among Different Female Psychiatric Patients

Monica Shringirishi¹, KC Gurnani²

¹Assistant Professor Department of Psychiatry Chirayu Medical College and Hospital
Bhopal Madhya Pradesh

²Professor Department of Psychiatry Sarojini Naidu Medical College, Agra Uttar
Pradesh

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Corresponding author: Dr. Monica Shringirishi

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Abstract

Objective: Female sexual dysfunction is a common, condition that significantly reduces the quality of life of the affected persons. Unfortunately, because of the veil of secrecy that shrouds discussions on human sexuality, there has been limited research on this topic in some sociocultural settings. The aim of this study was to study sexual dysfunctions and factors that may be associated with them in female psychiatric patients.

Methods: The study had a cross-sectional design and the sample was recruited by purposive sampling. Psychiatric cases were taken both from OPD and IPD of People's Hospital Bhopal, Data from control population was collected from the married females who came along as informant with the psychiatric patient to our hospital.

Results: Comparison of mean FSFI Domain score and Total FSFI Scale Score between Different Psychiatric Illness patients and Healthy Control. Total FFSI Score was highest in migraine followed by borderline disorder and bipolar or dissociative disorder. It was least in insomnia cases. It was 26.00 ± 3.46 in migraine, 23.66 ± 4.82 in dissociative disorder and 18.60 ± 11.73 in insomnia cases. There was statistically highly significant difference in FSFI score among different Psychiatric patients.

Conclusion: Ascertaining and attending to sexual dysfunctions not only enhance the therapeutic bond between psychiatrist and patients but also will have several positive spinoffs out of which sense of wellness and competence in the patients can be considered as most important.

Keywords: Sexual Dysfunctions, Therapeutic Bond, Psychiatrist

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Introduction

In a survey of the US general population, sexual dysfunction was more prevalent in women (43%) than men (31%) and was associated with various sociodemographic characteristics including educational attainment and age. Women of different social groups demonstrate a different pattern of sexual dysfunction. The experience of sexual dysfunction is more likely among women with poor physical and emotional health. [1-2]

The most common problems were a lack of desire, vaginal dryness, and infrequent orgasm. Problems with desire were found with 45%, arousal problems in 37%, the lubrication problem in 41%, the orgasmic problem in 42% and pain problem in 42%. Important associated etiological factors were older age, infrequent sexual activity, more than 10 years of marriage, more than three kids and husbands more than 40 years. We may consider that the female sexual dysfunction is a significant public health problem of women in that nation. The literature on etiological factors associated with sexual dysfunction infers that in women, the predominant association with arousal, orgasmic, and enjoyment problems was marital difficulties. Vaginal dryness increase with age after menopause. In general, sexual dysfunction in women was commonly associated with social problems. [3-5]

Female sexual dysfunction has traditionally included disorders of desire, arousal, pain/discomfort, and inhibited orgasm. As epidemiologic data are limited, the available estimates are that 43% of women complain of at least one sexual problem, while 11–33% of survey and clinical samples fall within a specific problem category. Psychiatric patients lose the sense of competency due to diminished functioning in many areas of life. Impaired sexual functioning can add further burden to inter-personal relationships that are already stressed by psychiatric illness [2-4]

In spite of the high prevalence of female sexual dysfunction less attention has been paid to the sexual problems of women which appears to surpass that of male sexual dysfunction. Few studies have investigated the psychological and physiological underpinnings of female sexual dysfunction and fewer treatments are available than for comparable conditions in the male. In general, there has been an acute dearth of valid or reliable statistical data on the epidemiology of female sexual disorders. [2-6]

This study aims to explore sexual dysfunction among female psychiatric patients and healthy controls. Ascertaining and attending to sexual dysfunctions not only enhance the therapeutic bond between psychiatrist and patients but also will have several positive spinoffs out of which sense of wellness and competence in the patients can be considered as most important. An explorative study of this nature is likely to add impetus to research in this very important area.

Materials and Methods

The study was conducted in a tertiary care teaching hospital in Bhopal (M.P). For our study we took 100 Psychiatric patients and 100 controls. The study had a cross-sectional design and the sample was recruited by purposive sampling. Psychiatric cases were taken both from OPD and IPD of Peoples Hospital Bhopal, who were between the age group of 18-45 years, married and those who were having some psychiatric illness. And data from control population was collected from the married females between age group of 18-45 years who came along as informant with the psychiatric patient to our hospital. Female patients outside the age range for inclusion, those who had significant cognitive impairment, major medical conditions and those who were not willing to participate in the study were excluded. Patients from both Urban and Rural areas are included in the study.

The purpose of the study was explained to every individual included in the study. They were given freedom of choice, to accept or refuse to participate in the study. Those who provided written informed consent were included in the study. They were told that less objective information was available regarding sexual experiences of women.

So we wanted to collect reliable data in this area so that sexual and marital problems could be effectively treated. They were assured that the information will be kept confidential. We did not interview the husband because it was felt that if both partners are interviewed than the chances are that more subjects may give socially acceptable answers. Most of the subjects cooperated in this endeavor.

Observation Chart

Table 1: Demographic Distribution of Psychiatric Cases and Healthy Controls

Demographic		Psychiatric cases (N=100)	Healthy controls (N=100)	Total	X ² Value	P Value
Age	18-23	7	10	17	1.33	0.857(NS)
	24-29	16	18	34		
	30-35	41	36	77		
	36-40	28	30	58		
	41-45	8	6	14		
	Mean age	33.57 year	32.73 year	33.15		
Locality	Rural	21	30	51	2.13	0.144(NS)
	Urban	79	70	149		
Education	Illiterate	22	20	42	0.892	0.989(NS)
	Primary education	9	10	19		
	Secondary Education	14	15	29		
	High school	16	18	34		
	Higher secondary	12	14	26		
	Graduate	20	18	38		
Occupation	Working	12	20	32	2.38	0.123(NS)
	Non- working	88	80	168		
Years of Marriage	0-10	31	32	63	0.660	0.719(NS)
	11-20	50	45	95		
	21-30	19	23	42		
Number of Child	0	7	9	16	5.58	0.233(NS)
	1	18	26	44		
	2	41	44	85		

	3	24	17	41		
	4	10	4	14		
Type of Contraception	Nil 0	17	11	28	13.5	0.036(S)
	Condom	28	48	76		
	Tubectomy	43	25	68		
	Coitus Interruptus	5	5	10		
	OC Pills	2	4	6		
	IUD	2	5	7		
	Hysterectomy	3	2	5		

Table 2: Comparison of Prevalence of Sexual Dysfunction among Different Psychiatric Illness Patients and Healthy Control

Groups	N	Sexual Dysfunction				Chi Square	P Value
		Present		Absent			
		Number	%	Number	%		
Anxiety Disorder	27	23	85.18%	04	14.82%	19.0	0.001 (HS)
Healthy Control	100	38	38%	62	62%		
Depression	25	20	80.0%	05	20%	14.2	0.001 (HS)
Healthy Control	100	38	38%	62	62%		
Somatic symptom Disorder	14	12	85.71%	02	14.29%	11.4	0.001 (HS)
Healthy Control	100	38	38%	62	62%		
Dissociative Conversion Disorder	9	6	66.66%	03	33.37%	2.82	0.093 (NS)
Healthy Control	100	38	38%	62	62%		
Schizophrenia	7	6	85.71%	01	14.29%	6.15	0.013 (HS)
Healthy Control	100	38	38%	62	62%		
OCD	5	5	100%	00	0.0%	7.57	0.006 (HS)
Healthy Control	100	38	38%	62	62%		
Migraine	4	1	25%	03	75%	0.277	0.598 (NS)
Healthy Control	100	38	38%	62	62%		
Bipolar Disorder	2	2	100%	00	0.0%	3.16	0.075 (NS)
Healthy Control	100	38	38%	62	62%		
Borderline Dis.	2	1	50%	01	50%	0.120	0.730 (NS)
Healthy Control	100	38	38%	62	62%		
Insomnia	5	4	80%	01	20%	3.50	0.061 (NS)
Healthy Control	100	38	38%	62	62%		

Table 3: Mean Fsf Domain Score and Total Fsf Scale Score Between Different Psychiatric Illness Patients and Healthy Control

Groups	N	Desire	Arousal	Lubricatio n	Orgasm	Satisfactio n	Pain	FSFI Score
		Mean±SD	Mean±SD	Mean±SD	Mean±SD	Mean±SD	Mean±SD	Mean±SD
Anxiety Disorder	27	2.51±0.97	3.48±0.80	4.00±0.87	3.44±0.97	3.88±0.80	5.33±0.83	22.55±3.37
Healthy Control	100	3.50±0.67	3.77±0.61	4.45±0.74	4.250.63	4.53±0.59	5.74±0.45	26.26±3.05
Significance 'P Value		0.001(HS)	0.040(S)	0.008(S)	0.001(HS)	0.001(HS)	0.001(HS)	0.001(HS)
Depression	25	2.56±1.26	3.08±1.11	3.52±1.32	3.24±1.01	3.84±0.80	5.64±1.15	21.96±4.84
Healthy Control	100	3.50±0.67	3.77±0.61	4.45±0.74	4.250.63	4.53±0.59	5.74±0.45	26.26±3.05
Significance 'P Value		0.001(HS)	0.001(HS)	0.001(HS)	0.001(HS)	0.001(HS)	0.460(NS)	0.001(HS)
Somatic symptom Disorder	14	2.71±1.20	2.71±1.13	3.35±1.49	2.71±1.20	3.71±0.99	4.35±1.82	19.57±6.40
Healthy Control	100	3.50±0.67	3.77±0.61	4.45±0.74	4.250.63	4.53±0.59	5.74±0.45	26.26±3.05
Significance 'P Value		0.001(HS)	0.001(HS)	0.001(HS)	0.001(HS)	0.001(HS)	0.001(HS)	0.001(HS)
Dissociative conversion Disorder	9	2.88±1.16	3.33±1.11	4.22±1.39	3.33±1.22	4.44±0.52	5.33±1.32	23.66±4.82
Healthy Control	100	3.50±0.67	3.77±0.61	4.45±0.74	4.250.63	4.53±0.59	5.74±0.45	26.26±3.05
Significance 'P Value		0.016(S)	0.05(S)	0.422(NS)	0.001(HS)	0.645(NS)	0.038(S)	0.022(S)
Schizophrenia	7	2.14±0.89	2.71±0.95	3.42±1.51	2.71±0.95	3.57±0.78	5.28±1.11	20.14±4.74
Healthy Control	100	3.50±0.67	3.77±0.61	4.45±0.74	4.250.63	4.53±0.59	5.74±0.45	26.26±3.05
Significance 'P Value		0.001(HS)	0.001(HS)	0.002(HS)	0.001(HS)	0.001(HS)	0.024(S)	0.001(HS)
OCD	5	2.60±0.89	3.00±1.00	3.40±0.54	3.40±1.51	3.80±1.09	5.20±0.83	21.40±2.88
Healthy Control	100	3.50±0.67	3.77±0.61	4.45±0.74	4.250.63	4.53±0.59	5.74±0.45	26.26±3.05
Significance 'P Value		0.005(HS)	0.009(S)	0.003(HS)	0.008(S)	0.012(S)	0.013(S)	0.001(HS)
Migraine	4	3.50±1.00	4.00±0.81	4.75±1.25	4.25±0.95	4.50±0.57	5.00±0.81	26.00±3.46
Healthy Control	100	3.50±0.67	3.77±0.61	4.45±0.74	4.250.63	4.53±0.59	5.74±0.45	26.26±3.05
Significance 'P Value		0.991(NS)	0.483(NS)	0.444(NS)	0.995(NS)	0.911(NS)	0.002(HS)	0.865(NS)
Bipolar Disorder	2	3.00±2.82	4.00±1.41	4.00±1.41	2.50±0.70	3.50±0.70	6.00±0.00	23.00±5.65
Healthy Control	100	3.50±0.67	3.77±0.61	4.45±0.74	4.250.63	4.53±0.59	5.74±0.45	26.26±3.05
Significance 'P Value		0.335(NS)	0.619(NS)	0.406(NS)	0.001(HS)	0.017(S)	0.436(NS)	0.142(NS)
Borderline Disorder	2	3.00±1.41	4.00±1.41	5.00±1.41	4.00±1.41	3.00±1.41	5.50±3.53	25.00±9.89
Healthy Control	100	3.50±0.67	3.77±0.61	4.45±0.74	4.250.63	4.53±0.59	5.74±0.45	26.26±3.05

Significance 'P Value		0.307(NS)	0.619(NS)	0.311(NS)	0.585(NS)	0.001(HS)	0.546(NS)	0.580(NS)
Insomnia	5	2.20±1.78	2.60±1.67	3.20±2.48	3.00±2.00	3.40±2.07	4.60±2.60	18.60±11.73
Healthy Control	100	3.50±0.67	3.77±0.61	4.45±0.74	4.250.63	4.53±0.59	5.74±0.45	26.26±3.05
Significance 'P Value		0.001(HS)	0.001(HS)	0.003(HS)	0.001(HS)	0.001(HS)	0.001(HS)	0.001(HS)

Results

Table reveals demographic distribution of Psychiatric cases and healthy controls. Out of 200 study subject, 100 were of different Psychiatric illness like anxiety, depression, OCD, Bipolar disorder etc and 100 were of healthy control for comparison. Out of 200, maximum 77 were 30-35 year old and maximum 149 were from urban locality. Maximum 49 were illiterate and 38 were graduates. Out of 200, 168 were nonworking and 85 were having two child. Out of 200, maximum 76 were using condom and 68 were tubectomy. There was statistically no significant difference in the distribution of Psychiatric cases and healthy controls according to various demographic factor ($P > 0.05$), except according to methods of contraception. ($P = 0.036$)

Table shows the comparison of the prevalence of sexual dysfunction among different Psychiatric illnesses patients and Healthy controls. There is a highly significant difference between Anxiety disorder, Depression, somatic symptom disorder, Schizophrenia, OCD patients and healthy controls ($P = 0.001$). No statistically significant difference was found between patients of Dissociative conversion disorder, Migraine, Bipolar disorder, Insomnia, Borderline personality disorder and healthy controls ($P > 0.05$)

Table reveals comparison of Mean FSFI Domain score and Total FSFI Scale Score between Different Psychiatric Illness patients and Healthy Control. Total FFSI Score was highest in migraine followed by borderline disorder and bipolar or dissociative disorder. It

was least in insomnia cases. It was 26.00 ± 3.46 in migraine, 23.66 ± 4.82 in dissociative disorder and 18.60 ± 11.73 in insomnia cases. There was statistically highly significant difference in FSFI score among different Psychiatric patients. ($P < 0.001$).

Statistical Analysis:

The data obtained was subjected to statistical analysis with the consult of a statistician. The data so obtained was compiled systematically. A master table was prepared and the total data was subdivided and distributed meaningfully and presented as individual tables along with graphs.

Statistical analysis was done using Statistical Package of Social Science (SPSS Version 20; IBM; Chicago Inc., USA). Data comparison was done by applying specific statistical tests to find out the statistical significance of the comparisons. Quantitative variables were compared using mean values and qualitative variables using proportions. Significance level was fixed at $P \leq 0.05$.

Statistical tests employed for the obtained data in our study were:

1. Chi-Square (χ^2) Test
2. Student's t-test:
3. Analysis of Variance (ANOVA):
Pearson's Correlation:
4. Multiple regression analysis:
5. Step wise multiple linear regression analysis:
6. P Value denotes level of significance:
 $P > 0.05$ Not significant
 $P < 0.05$ Significant (significant at 95%)

confidence level)

p <0.01 Highly Significant (significant at 99% confidence level)

p <0.001 Very Highly significant (significant at 99.9% confidence level)

Discussion

In our study none of our female psychiatric patients and apparently healthy females reported to the psychiatric OPD voluntarily for sexual dysfunction. As sexual activity requires participation of both the partners equally and even sexual dysfunction in either of the partners would cause impairment in multiple areas of functioning in both. Despite such a high prevalence of sexual dysfunction in both the group even the male partners did not report such problem to the treating psychiatrist or did not bring their apparently healthy partners to psychiatry OPD for treatment of sexual dysfunction. Although in our daily OPD of teaching hospital percentage of males seeking consultation for their own sexual problem is very high (pre mature ejaculation, erectile dysfunction, Dhat syndrome). [2-4]

Epidemiology of female sexual dysfunction was evaluated by undertaking a Medline (1969–2008) literature review by Palacios S et al. The effect of concomitant diseases and drug therapies was also studied. It is difficult to distinguish between various types of sexual dysfunction and possible co-morbidities. In general, 40% of women will experience some form of sexual problem. The diseases which cause sexual dysfunction are those which affect mobility and activity, as well as body image and feeling attractive. It was concluded that the prevalence of female sexual problems is high and personal distress is less common but is an important factor. However, more research is necessary in order to determine the prevalence of each sexual dysfunction in different populations and the relation these dysfunctions have with respect to different diseases and drug therapies. Sexual

dysfunction is often one of the first symptoms of a disease or an adverse drug reaction. [1]

Osborn M et al in a community survey of women aged 35-59 found that one third of these women had operationally defined sexual dysfunction. Sexual dysfunctions were statistically significantly associated with increasing age and also with psychiatric disorder, neuroticism, and marital disharmony. Nevertheless, they differed from the rest of the sample in having more psychiatric disorder, neuroticism, marital disharmony, and (in women still menstruating) psychological symptoms of the premenstrual syndrome. To conclude, the prevalence of sexual dysfunction in this series of women suggests that general practitioners should increase their alertness to the problem in their patients. [2]

Basson R, Berman J et al in 2000 prepared a report of the international consensus development conference on female sexual dysfunction -definitions and classifications. An interdisciplinary consensus conference panel consisting of 19 experts in female sexual dysfunction selected from 5 countries was convened. Classifications were expanded to include psychogenic and organic causes of desire, arousal, orgasm and sexual pain disorders. An essential element of the new diagnostic system is the “personal distress” criterion. In particular, new definitions of sexual arousal and hypoactive sexual desire disorders were developed. They recommend use of the new female sexual dysfunction diagnostic and classification system based on physiological as well as psychological pathophysiologies, and a personal distress criterion for most diagnostic categories. [3,4]

Fajewonyomi BA et al in a similar study like us studied sexual dysfunction among female patients of reproductive age in a hospital setting in Nigeria. This cross-sectional study was conducted to determine the prevalence of sexual dysfunction and their correlates among female patients of reproductive age using a questionnaire. The peak age of sexual

dysfunction was observed among the age-group of 26–30 years. Women with higher educational status were mostly affected. The reasons for unsatisfactory sexual life mainly included psychosexual factors and medical illnesses. The culture of male dominance in the local environment which makes women afraid of rejection and threats of divorce if they ever complain about sexually-related matters might perpetrate sexual dysfunction among the affected individuals. Sexual dysfunction is a real social and psychological problem in the local environment demanding urgent attention. It is imperative to carry out further research in society at large so that the health and lifestyles of affected women and their partners could be improved. [5,6]

In recent years female sexual dysfunction (FSD) is increasingly being recognised. Many authors like Laumann EO et al, Lewis RW et al and Jha S et al studied extensively on FSD. It has a detrimental effect on a woman's quality of life and includes a range of disorders, and therefore adequate screening and diagnosis of patients are necessary before appropriate treatment can be commenced. As the etiology of FSD is often multi-factorial, arising from a multitude of organic pathologies in addition to having an underlying psychological basis, the treatment is often multidisciplinary. An understanding of the etiopathogenesis is therefore imperative to management. In the past 20 years major changes have occurred in our understanding, conceptualization and treatment of sexual dysfunction. In this article we look at the prevalence, classification, etiology and management of FSD. [7-9]

Clayton AH did a review on the literature regarding the epidemiology and neurobiology of FSD. Although several conceptual frameworks for female sexual dysfunction (FSD) have been advanced, there still is considerable disagreement over what constitutes a normal vs. abnormal response. Sexual dysfunction is a disturbance in sexual functioning involving one or multiple phases

of the sexual response cycle or pain associated with sexual activity, while a sexual disorder includes both dysfunction and marked distress. It is becoming clear that good sexual health is associated with good physical and mental health as well as compatible relationships with one's sexual partner. Central nervous system (CNS) control of the sexual response is a relatively new area of scientific exploration. To conclude, we need to improve our understanding of the contributions of the CNS neuroendocrine and neurotransmitter systems that modulate sexual behavior. [10]

Diabetes Mellitus (DM) is considered to play a principle role in the etiopathogenesis of sexual dysfunction both in men and women. The aim of the study by Erol B et al was to evaluate sexual function in Type II diabetic women. Lack of libido was the most common symptom in diabetics and was observed in 77% of the women. Diminished clitoral sensation was observed in 62.5% of the women, 37.5% complained of vaginal dryness and 41.6% had vaginal discomfort. Orgasmic dysfunction was found in 49% of the women. The incidence of all these related symptoms were significantly higher when compared to controls. The authors concluded that significant percentage of diabetic women that we observed experience sexual dysfunction of varying degrees that diminishes their quality of life. [11]

Nwagha UI et al study aim was to determine the prevalence and some sociodemographic factors associated with sexual dysfunction in females in a university community at the University of Nigeria, Enugu Campus, Enugu State, Nigeria. This was a cross-sectional study, a self-administered structured pretested questionnaire on sexual activity was administered (the Female Sexual Function Index [FSFI]). Statistical analysis was performed using SPSS software package. Multiple logistic regression was used to determine the relationship between the sociodemographic factors, and the total FSFI scores dichotomized as normal and reduced sexual function. For all, calculations, $P < 0.05$

was considered as statistically significant at 95% confidence interval (CI). The prevalence of female sexual dysfunction (FSFI score \leq 26.50) was 53.3%. Marital status, religion, ethnic group, and educational qualification had no significant effect ($P < 0.05$). The total FSFI significantly increase as desire increases. It was concluded that female sexual dysfunction is common in the university environment, with the highest prevalence occurring in 41-50 years age group. [12]

Tehrani FR et al did a population based study in Iranian reproductive age women on factors associated with sexual dysfunction. This study aimed to determine the prevalence of sexual dysfunction and the related factors among reproductive age women in Iran. Female sexual function was assessed using the Female sexual function index questionnaire. Data was analyzed using Spearman and logistic regression tests. Among the participants, 15.2% were unsatisfied with their sexual life. There was a statistically significant relationship between sexual dysfunction and duration of married life, perceived attraction of spouse, overall satisfaction with routine life and the women's ability to express their sexual desires. This study concluded that sexual dysfunction is prevalent among Iranian women. A comprehensive service including counseling programs for sexual dysfunction at primary health care is highly recommended. [13]

Heiman JR studied psychologic treatments for female sexual dysfunction. They gave answers to questions like- Are they effective and do we need them. Most successful treatments for sexual dysfunction are psychophysiological, in that physiological change circularly interacts with a psychological change. The review shows there to be limited controlled research, with only orgasmic disorders meeting the more stringent "well established" criteria, promising but uncontrolled results for vaginismus and dyspareunia, minimal effectiveness data for hypoactive sexual desire disorder, and no available efficacy data on female sexual

arousal disorder and sexual aversion. It was concluded that (a) since a psychologic treatment can and does impact sexual physiology, we need to continue to develop and test psychologic approaches both out of intellectual interest and out of respect for the choices patients require or prefer, (b) the prescription of a physiologic treatment which ignores the fact that human sexuality is infused with individual meaning may invite further interference with sexual functioning, and (c) future research would do well to test the efficacy of the psychologic and physiologic treatments, both separately and in combination, for female sexual dysfunction. [14]

Nappi RE et al worked on advances in pharmacotherapy for treating female sexual dysfunction. The paper reports the most recent advances in pharmacotherapy for women taking into account the biopsychosocial model. Hormone therapy, including estrogens, testosterone, tibolone and dehydroepiandrosterone, are discussed in term of efficacy and safety in postmenopausal women both for female sexual interest/arousal disorder (FSIAD) and genito-pelvic pain/penetration disorder. Ospemifene, a selective estrogen receptor modulator, approved to treat dyspareunia at menopause, is also discussed. Data on psychoactive agents for treatment of FSIAD in premenopausal women are discussed, including the potential use of on-demand combined hormonal (testosterone) and non-hormonal (buspirone or sildenafil) treatments to address possible neurophysiological profiles of women. [15,16]

From our survey we concluded that for females coming to the gynecology OPD sexual complaint was never a chief complaint. Patients attending infertility clinics rarely had any query regarding sexual problems. We also found that females do consult for dyspareunia and PID and report of pain during coitus but they reveal this information only when gynecologists ask for it and not voluntarily. Also white discharge is a frequently reported

problem but it is not related to sexual dysfunction. For adolescent girls special clinics are run by both the departments independently but the most frequent discussion in those clinics is about the menstrual problem and no queries are raised regarding sexual concern. Although in our psychiatry OPD we do enquire about the sexual health of our patients.

Conclusion

The study concludes that the prevalence of sexual dysfunction in female Psychiatric patients is alarmingly high and demands immediate attention. Various Psychiatric disorders such as Anxiety disorder, Depression, somatic symptom disorder, Schizophrenia, Bipolar disorder, Personality disorders, Migraine and Insomnia not only affect the mental wellbeing but also the sexual health of the patients. Thus the treating psychiatrist will have to be more vigilant in enquiring about the sexual functioning of the patient not only from the patient but also from their spouses, so that the comprehensive management can be provided to the patients.

Declarations:

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Availability of data and material: Department of Psychiatry Peoples Medical College.

Code availability: Not applicable.

Consent to participate: Consent taken.

Ethical Consideration: There are no ethical conflicts related to this study.

Consent for publication: Consent taken

Limitation: In our study sample size of some of the disorders were very less (eg: n=2 in bipolar disorder, n=2 in borderline personality disorder, n=4 in Migraine), so it was difficult to draw a comprehensive interpretation on the basis of such a small sample size. The majority of the total sample comprise of categories having higher prevalence i.e. Anxiety disorder,

Depressive disorder, Somatic symptom disorder or diseases which present very commonly in OPD setup i.e. Psychosis (Schizophrenia). It would have been better if we had decided fixed sample size of each category before the start of the study. We did not do so because of time constraints and limitation of the resources. FSFI is not an Indian scale so because of cultural differences we do not have a cutoff score for individual domain. We did not interview the husband though male sexual dysfunction also plays an important role in the sexual life of the partner

Strength Less of Indian studies are there on female sexual dysfunction in Psychiatry patients. We covered almost all of the major Psychiatric Illnesses prevalent in our country.

Future Recommendation There is a need to develop Indian scales for evaluation of female sexual dysfunction which would also have cutoff scores for individual domains. Spouses should be actively involved in the evaluation of female sexual dysfunction. Study should include large sample size and long term follow up should be done.

Contribution by Different Authors

First and Corresponding Author Dr Monica Shringirishi Assistant Professor Department of Psychiatry Chirayu medical college Data collection ,statistical analysis and Discussion

Second author Dr. KC Gurnani Professor Dept of Psychiatry Sarojini Naidu medical College Agra Uttar Pradesh Concept and Guidance

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