ORIGINAL ARTICLE

Profile of Patients Seen at a Psychosexual Clinic in a Gynaecological Teaching Hospital - The Singapore Experience

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Summary

Ignorance is not bliss when it comes to sexuality. Psychosexual problems lead to shame, fumbling, needless fears, low-self esteem and even subfertility. The demands for help appears to be increasing; as the general population become more aware of its presence and the treatment options available through the mass media and better health education. Sex therapy has traditionally been the realm of the psychiatrist[1] but with the gynaecologist as the first contact for most women, the number of women seeking advice directly from their doctors will only increase with time[2,3].

A total of 243 new cases of sexual dysfunction were treated at the sexual problem clinic in Kandang Kerbau Hospital between January 1994 and November 1996; majority of which were self-referrals (48.5%). The patient pool consisted of more males than females although the clinical setting is in an obstetrics and gynaecology teaching institute. Vaginismus and erectile problems constituted the main complaints. Erectile problems are more common in the patients above 40 years old ($p<0.001$).

We report here our experience of such a sexual problem clinic and hope to provide insight into this area of medicine from the perspective of a practising gynaecologist.

Key Words: Sexual dysfunction clinic, Vaginismus, Erectile dysfunction

Introduction

Gynaecologists are women's front-line sexual consultants and have been since the formation of the specialty. The demand for help with sexual problems appears to be increasing, as our cosmopolitan society becomes more sophisticated. Indeed, sexual dysfunction may exist in an estimated 50% of marriages[2] and even happily married women have reported a rather high rate of sexual dysfunction (63% in one study)[3]. However, there appears to be paucity in the number of clinics that deal specifically with such problems. We report here our experience of such a clinic in Kandang Kerbau Hospital, a tertiary referral centre for obstetrics and gynaecology as well as a teaching hospital. We hope that from this review, some guidance about the workload and other problems can be highlighted.

Materials and Methods

The clinic is organised by a senior consultant gynaecologist with a special interest in sexual problems. The clinic takes up one session a week at which the staff sees three to four new patients and provide continuing treatment for other patients.

The authors carried out a retrospective analysis noting demographic details, diagnosis, treatment and follow-up of the cases that attended the clinic between January 1994 and November 1996.

All statistical analysis were done using the independent t test and non parametric tests of statistical significance e.g. Fishers' exact test.

Results

1. The patient population

There were a total of 243 patients assessed in the clinic between January 1994 and November 1996. There were 155 male patients (63.8%) and 88 female patients (36.2%) seen. Although the first visit may involve the attendance of only one partner, the couple is encouraged to attend the subsequent sessions together to facilitate proper counseling and treatment. (In the case of a couple, the sex of the partner with the initial appointment was recorded.) The mean age of the male patients reviewed was 39.96 years old (age range 21-77 years old), while the mean age for female was 32.26 years old (age range 20-48 years old). This age difference was statistically significant ($p<0.001$) (graph 1 and 2)

The sources of referrals are shown in Table I and this is sub-classified according to their job status.

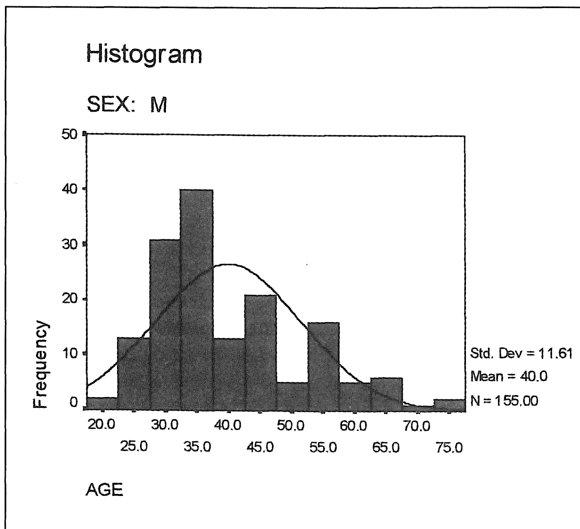

Fig. 1: Age distribution of male patients

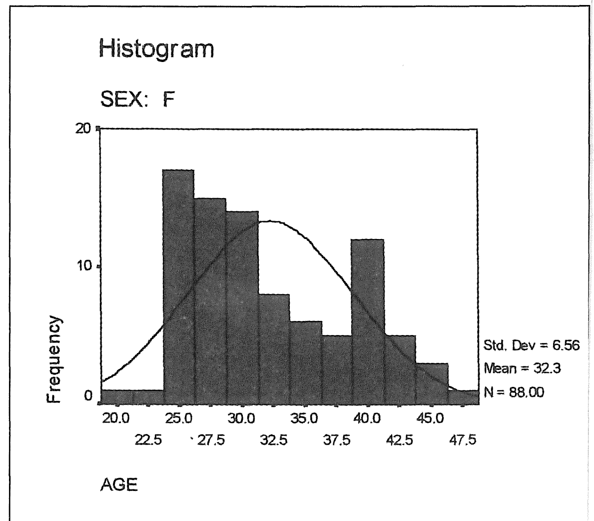

Fig. 2: Age distribution of female patients

Table I
Sources of referrals and the job status

	Frequency	Professionals	Non-Professionals
Self referral	118 (48.5%)	47 (53.4%)	71 (45.8%)
General Practitioner / OPD	83 (34.2%)	27 (30.7%)	56 (36.1%)
Specialist	42 (17.3%)	14 (15.9%)	28 (18.1%)
Total	**243**	**88**	**155**

We find no statistical difference between the occupational status of our patients and the method of referral (p>0.5). This trend may indicate that neither group is more likely to seek other specialists help directly and appears to be well informed of the venues of treatment regardless of job status. This may reflect maturity and increasing openness in the general social and cultural makeup of the population in dealing with sexual dysfunction.

The distribution of race and marital status are shown in Table II.

There are more Chinese in our cohort of patients (80.6%) which is not surprising as this fit the demographic pattern of Singapore's ethnic composition.

2. Types of Sexual Problems

Twenty eight out of 155 (18%) male patients who

Table II
Distribution of race and marital status

	No.	Male	Female	Married	Single	Divorced	Separated
Chinese	173 (17.1%)	112 (72.2%)	61 (69.3%)	135 (68.8%)	31 (79.4%)	5 (83.3%)	2 (100%)
Malay	18 (7.4%)	10 (6.4%)	8 (9.0%)	17 (8.6%)	1 (2.5%)	0	0
Indian	35 (14.4%)	22 (14.2%)	13 (14.8%)	30 (15.3%)	4 (10.3%)	1 (16.7%)	0
Others	17 (7.1%)	11 (7.2%)	6 (6.9%)	14 (7.3%)	3 (7.8%)	0	0
Total	**243**	**155**	**88**	**196**	**39**	**6**	**2**

Table III
Breakdown of Diagnosis (Female)

Female	Number	Frequency
1. Vaginismus / Non consummation	30	27.8%
2. Vaginismus	21	19.4%
3. Dyspareunia	4	3.7%
4. Infertility	26	24.0%
5. Non consummation	8	7.4%
6. Low desire	5	4.6%
7. Anorgasmia	3	2.9%
8. Others	11	10.2%
Total	**108**	**100.0%**

presented at the sexual dysfunction clinic had the final diagnosis attributed to a female sexual dysfunction compared with 11 out of 88 (12.5%) female patients who first presented at the sexual dysfunction clinic and later had the final diagnosis attributed to male sexual dysfunction (p=0.28). This is not statistically significant.

Six couples (2.5%) had both male and female sexual dysfunction.

Others

4 Urinary tract infection
3 Lower genital tract infection
3 Relationship problems
1 Post coital bleeding

The range of sexual problems seen at the clinic are varied, with vaginismus contributing a big proportion. Compared to the western studies, we see less of the sexual arousal and orgasmic disorders[4].

Impotence predominates the type of cases seen (more than 50%). Although the mean age of the studied group is less than 40 years old.

Others

6 male wanted to test HSA (sperm)
4 patients - misconception about penis size
3 psychiatric patients
2 surgical problems: Anal polyp / Diverticulitis
2 Phimosis
1 Hydrocele
1 urinary tract infection / urethral discharge

Statistically not significant.

Table IV
Breakdown of Diagnosis (Male)

Male		Number	Frequency
1.	Erectile failure	80	56.7%
2.	Premature Ejaculation	33	23.4%
3.	Non Ejaculate	3	2.1%
4.	Low desire	6	4.3%
5.	Others *	19	13.5%
	Total	**141**	**100.0%**

Table V
Incidence of vaginismus vs race

	Chinese	Indian	Malay
Vaginismus	14	6	0
Vaginismus + Non-consummation	21	5	5
Total	**35**	**11**	**5**

Total Number of Visits

The number of visits attended by the patients ranged from one to 12. The average number of visits was 2.39. There were a total of 82 patients who defaulted their appointment despite telephone reminders.

Discussion

The age-old cloak of ignorance and mystery around female and male sexuality has yielded to scientific study. Sexual dysfunction can be understood and treated by informed physicians today. Since the time of Robert Dickinson and Alfred Kinsey, sexual research has come a long way and William Masters, a gynaecologist from St. Louis has further strengthened the role of gynaecologist as the front line advisors and care-givers to couples with sexual dysfunction[2]. He first studied his own theories about the cause of sexual symptoms by careful laboratory observations. Then, for over five years he documented on film the sexual performance of 135 couples (men and women aged 19 to 50) in solo and coital sexual activity. Using these findings, Masters developed these findings into a successful technique of brief (2 week) treatment of sexual dysfunction of both men and women[4].

How widespread are sexual doubts or symptoms? Sexual problems perplex every boy, girl, teen and adult. Population studies by Kinsey et al [5,6] has found that more than 50% of the 5900 women interviewed had not experienced orgasm in their late teens and that male sexual function tended to deteriorate with age up to 38% of women report anxiety and inhibition during sexual activity, 16% complain of the lack of pleasure and 15 % have difficulties reaching orgasm[7]. Another study[8], showed that up to 40% of middle aged men reported some kind of sexual dysfunction and that this dysfunction may be purely psychological or physical but usually a mixture of both[9]. In all, 1.6% of men had more or less permanent problems achieving erections and this figure rose to 27% by the age of 70. However, such studies are invariably biased by social and cultural factors and are not reflective of every society. Our own figures show a wide age range in the patients seen and treated. Besides our study population reflects only the patients that seek medical advice and may not be representative of the population as a whole. Other confounding variables in the epidemiological study of sexual dysfunction lies in each individual's sexual responsiveness being determined by the interaction of physical, psychological and relationship factors.

Sexual dysfunction are impaired, incomplete or absent expressions of normally recurrent sexual desires and responses. When difficulties with pleasurable climatic resolution of appropriate sexual arousal occur, dysfunction may be accepted as transient or, when there is subjective concern or discomfort, they become problematic. From our results, the majority of patients suffer from conditions like non-consummation, vaginismus, subfertility, impotence and premature ejaculation occupy the bulk of cases seen. It is obvious that partner dissatisfaction may have precipitated awareness of a dysfunction and subsequently been seen at our clinic e.g. premature ejaculation, anorgasmia.

Although our clinic has not dealt with all patients with sexual problems in our country, it has certainly seen most of the referrals referred for specialist help. A difficulty in establishing the number of sexual problem in any given population is that there is a very wide range of severity of such problems and indeed few sexual relationships do not have scope for some improvement with better awareness and communications. As elucidated earlier, the mere definition of sexual dysfunction is at best subjective in many ways, various factors will determine whether a couple considers a problem sufficiently important to seek professional help, in particular referral to a specialist clinic. Severity is one factor, social implication of referral is another and the efficacy and acceptability of the help offered is a third[10]. We find that close to half the patients (48.5%) were self-referrals, this may signify that this sexual problem clinic has become more acceptable and awareness of its treatment aims has increased amongst our population. Surprising, this is in contrast to western countries like the United Kingdom where sexual dysfunction frequently presents in the gynaecology clinic as a secondary rather than as a main presenting problem.

There appears to be a lower proportion of female patients attending the sexual problem clinic (36.2%) compared with male patients (63.8%). In America in the

seventies, the proportion of female patients attending the sexual dysfunction clinic was 43.3%[12]. Our figures are closer to those reported in Russia in the eighties where the proportion was 39.4%[13]. Investigations in China however showed a remarkably low percentage of women attending their sexual dysfunction clinic; the proportion was 3.3% in Shanghai, 2.9% in Changsha, 6.9% in Beijing and 2.7% in Harbin[14]. In their study, the authors attributed the low proportion of clinic attendance of women to the sexual repression mentality brought about by the Cultural Revolution. In fact, this is exemplified also by our review, which showed the 28 "male" cases, and their subsequent diagnosis channeled to "female" cases. In 25 of these cases the husbands were the first to approach the clinic for help as the wife thought it may not be socially acceptable to do so. Considering this, the percentage of women (according to final diagnosis made) would actually rise to 43.4% in our study (p=0.1).

For a long time, Asian women were taught that the wife must obey her husband at all cost, as she is the property of her husband. Thus for many, sexual intercourse was for her only a duty as a wife, for fulfilling the need of reproduction. If a woman showed interest in sex, she would be accused of indecency and breaching her female role. Liu et al [15] in a sexuality survey showed that such beliefs are still prevalent in present day Chinese women. This could explain to a certain extent the discrepancy between the male and female proportion of patients seen in our Asian population compared to the western society. In our study population, Chinese women constituted almost 70%, although it was rare for an unmarried woman to seek help, whereas almost a quarter of the men was single.

Physical causes such as intact hymen, lower genital tract infection, congenital abnormalities and medical illness must always be excluded as possible sexual dysfunction. This may require the co-management of other medical and para medical disciplines to provide a holistic approach to these patients.

Vaginismus and vaginismus with non-consummation remains the commonest sexual dysfunction seen in our clinic. Vaginismus is defined as recurrent or persistent involuntary spasm of the musculature of the outer third of the vagina that interferes with coitus[16]. The involuntary spasm usually involves the perineal and levator-ani muscles, but in severe cases, adductus of the thigh, the rectus abdominis and gluteal muscles may be involved. Attempts at penetration can produce pain in the clenched muscle, thus aggravating the situation. Vaginismus may generalise to the point where any attempt at vaginal examination is impossible and the patient may take up the position of opisthotonos on the examination couch. Vaginismus leading to non-consummation of marriages is a commoner problem than generally believed. In one survey in 1962 of 700 consecutive cases of subfertility, 41 (6%) were due to non-consummation because of vaginismus 17. In our own cohort of sexual problem cases, the percentage is ever higher with 30 (27.8%) having vaginismus with non consummation and 21 (19.4%) having vaginismus.

Amongst the women who had vaginismus there were 11 Indians, 5 Malays and 35 Chinese (Table V). There is a disproportionately higher percentage of Indians (11 out of 13), compared to Chinese (35 out of 61). This is however statistically not significant ($p>0.05$) the clinical presentation of these patients was varied. Although help is sought specifically for non-consummation in some patients, the problem can be presented indirectly to the doctor. Sometimes, the diagnosis comes to light only when the women seek help for subfertility (2 patients) or when the husbands present with impotence. Couples may present, although married for several years but having never achieved penetration. In fact, there were two couples who were married for eight years before finally consulting their doctor for this problem.

The aim of therapy is to help the women regain voluntary control over her pelvic floor muscles. The treatment was a behavioral method aimed at teaching relaxation of the muscles of the pelvic floor together with a systemic desensitisation of the fear of vaginal penetration. All our patients were taught self-examination, which involves an educational vaginal examination where the basic female genital anatomy and the psychodynamics' of vagino-spasm are explained to the patient. Assurance is constantly given to the patient and the woman is taught to explore her own vagina. This is followed by Kegel's exercise[2]. In learning to do the exercises the woman develops cognitive awareness of the sensations of the lower vagina and recognition of the

contracted versus the relaxed muscles. Gradual appreciation of the different muscles groups and learning to control the tension amongst them will enable the women to overcome her problem.

Erectile failure and premature ejaculation constituted the majority of the male sexual dysfunction problems seen (113 patients or 80.1%). Erectile dysfunction or impotence is difficulty either obtaining a penile erection of sufficient rigidity to allow for vaginal penetration or maintaining the erection until ejaculation, assuming there is no ejaculatory disorder. While it is commonly believed that erectile dysfunction is mostly of psychogenic etiology, for many men over age 40, erection problems are caused by pathopsychologic changes. Significant factors are arteriosclerosis, diabetes mellitus, neurologic disorders and medical treatment e.g. pharmacological. In our study (54 out of 80) were more than 40 years old; this is almost 67.5%. Amongst the men who have premature ejaculation, 29 out of 33 (87.9%) are less than 40 years old. ($p<0.001$).

The treatment of erectile dysfunction depends in part to diagnosis. For erectile dysfunction secondary to a well defined organic pathology (eg. Uncontrolled diabetes mellitus or hyperprolactinaemia), the treatment includes pharmacological treatment to induce erections, drugs to treat the underlying condition, penile implants, or in selected cases penile surgery. In the patients where the psychological status is question, a referral to a relationship counsellor may prove to be rewarding.

Amongst the male patients there were six who also thought that the sexual dysfunction clinic as a venue to test for the quality of their semen. All of them were single male who were planning on getting married. Perhaps with better education, these patients could be advised on the proper channels to seek this treatment. Bancroft[10] has emphasised the value of having a coordinated range of services to meet the needs of couples with sexual problems, partly in order to offer appropriate range of helping skills and partly to allow for different patterns of presentation. More recently, Lewin[18] has suggested that sexual medicine be recognised as a new medical specialty and that the way forward is a closer academic and clinical integration between specialist working in gynaecology, urology, endocrinology and psychiatry. It is also the author's opinion that such a multi-disciplinary approach would be beneficial to the setting up of future sexual problem clinics in our country; this may be the most cost effective option in our quest to improve the sexual health of the nation.

Conclusion

Sexual dysfunction may adversely affect a person's self-esteem and his or her overall sense of well being. The obstetrician or gynaecologist can play an important role. The formation of a sexual dysfunction clinic in a women's hospital is perhaps the best form of logistic support to enable the practising gynaecologist to take a greater role in helping patients with sexual dysfunction.

Furthermore, having an understanding towards the prevalence of various types sexual dysfunction here, we would be able to coordinate the education of every clinician who is interested in sexual medicine, providing valuable practical experience and discussion in their training. It is also important for clinicians to realise the role that non medical personal like psychologists and medical social worker can play in addressing certain types of sexual dysfunction and timely referrals can minimise the patients anguish.

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