Descriptive Study of Some Egyptian Females Having Sexual Dysfunction and Attending Al-Azhar University Hospitals: Results of a Clinical Study with the Aid of Sexual Dysfunction Questionnaire

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For the majority of people, the most important relationship in their adult lives is sexual. Male sexual dysfunction, in the literature, had a greater interest than female sexual dysfunction. Hence, in Egypt, little is known about female sexual dysfunction either in the province of psychiatry or gynecology.

Our study aimed at illustrating the socio-demographic and clinical profile of some Egyptian female patients having sexual dysfunction and attending Al-Hussein and Bab Alshareia Hospitals. Complete gynecological examination and semi-structured psychiatric interview with the aid of sexual Dysfunction Questionnaire were completed for every patient. The sample consisted of 163 patients who were selected randomly, above 18 years of age, married and diagnosed as having sexual dysfunction.

The majority of them lied in the age group 20 and less than 30 years with a mean age of 27.5 years (+ 6.77). Most of the sample were working and educated. 57.7% of the sample had a duration of marriage of 7 years and more. 71.2% had children 59.5% of the sample gathered their information about sex and marital relations from their mothers. The minority of the sample (5.5%) had + ve family history of sexual dysfunction. Only 30.1% of the sample came complaining directly from manifestations of sexual dysfunction. The majority of the rest of the sample complained from pelvic heaviness (38.7%) and low back pain (28.8%). The most frequently found diagnoses were: Nonorganic dyspareunia (15.3%), nonorganic vaginismus (14.7%) and lack or loss of sexual desire (13.5%). The least frequent were: marked feeling of inadequacy of body and sex organs (1.8%), failure of genital response (2.5%) and excessive masturbation (3.1%).

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INTRODUCTION

For the majority of people, the most important relationship in their adult lives is sexual (Bancroft, 1988). Female sexual disorders have always been the province of psychiatry and gynecology, since the appearance of Kinsey's reports in the early 1950's who found that 10% of married women never experienced coital orgasm. (Malatesta & Adams, 1984).

Earlier research focused broadly on human sexuality. More recent workers have focused on sexual physiology and dysfunction. (Sadock., 1995). This later orientation is reflected obviously in re-

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cent psychiatric classificatory systems as I.C.D-10 (WHO; 1992 & 1993) and DSM-IV (American Psychiatric Association, 1994), that are correlated with the sexual physiological response cycle with its four phases: desire, arousal (excitement), orgasm and resolution. (Sadock, 1995).

The prevalence of sexual dysfunction in the community is difficult to assess. (Okasha, 1988), yet the available scientific data regarding their prevalence have been gleaned from clinic questionnaires and interviews from various patient groups arriving for treatment of one sort of disorder or another (Clayton et al, 1997).

Kaplan (1979) commented that "hypoactive sexual desire is probably the most prevalent of all the female sexual dysfunctions (Kaplan. 1979). Kilmann et al (1986) supported this point of view and found that amongst the attendants to sex-therapy clinics, desire discrepancies between partners were the most common problem and represented about 31% of the attendants (Kilmann et al, 1986). Kockott and Pfeiffer (1996) agreed with that inspirit of their working with a different sample of patients consisting of nonacute psychiatric patients who had hypoactive sexual desire disorder. While the underlying causes were multifactorial in most cases. (Kockott & Pfeiffer, 1996).

Frank and her colleagues (1976) reported that over 50% of women seeking marital therapy had sexual arousal deficiencies. Bancroft (1988) agreed and found in a German study after more than 2 decades of the previous study that 43% of the female sample reported some problems with sexual enjoyment and arousal, with further 9% expressing actual sexual aversion.

Levine and Yost (1976) found that among high school educated black women seen in a gynecological clinic, 5% had never been orgasmic with a partner, while 17% reported difficulty in reaching coital orgasm. Kolodney et al (1979) concluded that the category of inhibited female orgasm has a relatively lower incidence. Spector and Carey (1990), after 2 decades found similar result in their study and concluded that inhibited female orgasm mounts to 5-10%.

Data regarding the relative incidence and prevalence of vaginismus and dyspareunia show considerable variability. Cases of persistent dyspareunia were uncommon among Masters and Johnson's 510 couples (Masters & Johnson, 1970) who reported that transient dyspareunia is common among women. (Tollison & Adams, 1979). Clement and Pfafflin (1980) found that 20% of their female sample referred for sex therapy received a diagnosis of vaginismus . Kilmann et al (1986) reported that amongst the attendants to sex-therapy clinics 5% of the sample had vaginismus . However, Bahaman (1989) found that among the attendants to gynecological outpatient clinic, the most common female sexual dysfunction was dyspareunia (48%) while vaginismus represented only 6% of the sample.

In Egypt, no data are available about the relative incidence and prevalence of female sexual dysfunction. Although sexual dysfunction is an area of mutual interest for both psychiatry and andrology for males, psychiatry and gynecology for females, literature showed that researches in this area are scanty, yet, they focussed upon male sexual dysfunction especially impotence. (e.g. Demerdash et al 1978, El-Akabawi & Idarous, 1982).

The present study aimed at illustrating the socio-demographic and clinical profile of some Egyptian female patients having sexual dysfunction and attending

the gynecological out-patient clinic at Al-Azhar University Hospital (Al-Hussin and Babalshareia Hospitals) irrespective of having direct complaints of that dysfunction or not.

SUBJECTS AND METHODS

A sample of 163 female patients was selected randomly from the gynecological out patient clinics of Al-Azhar University Hospitals in Cairo, in the period from 15 March-14 August 1998. Inclusion criteria were:

. Diagnosis of sexual dysfunction.

. Age above 18 years.

. Married female.

A comprehensive history was taken from every patient. It included history of the present problem and search for manifestations of other gynecological (including endocrine disorders and drug treatment) or psychiatric disorders. Pelvic examination was done to exclude patients with organic causes. Semi-structured psychiatric interview was done to : 1) exclude other mental and behavioural disorder in ICD-10. 2) diagnose the occurrence of sexual dysfunction. 3) Apply the sexual dysfunction questionnaire to confirm the diagnosis.

The sexual dysfunction questionnaire was developed by the authors in Arabic language depending upon some questionnaires that were used in previous studies, e.g. Clayton et al. in (1997) and Corty et al. in (1998). The questionnaire consists of 2 parts: Part one: which is the identification data, part 2: the symptoms of sexual dysfunction. There are 16 sentences which reflect the symptoms that are correlated with the sexual physiological response cycle with its 4 phases: desire, arousal, orgasm and resolution. Each symptom is coded as absent or present. Pilot study was done prior to the present study to test the questionnaire and measure its validity and reliability. Validity was tested by the face validity technique through 5 referees from professors of psychiatry and psychology in Al-Azhar and Ain Shams Universities. Sentences that took approval from 4 out of the 5 referees are considered or modulated accordingly. Reliability was tested by test-retest technique after a period of 15 days with a sample of 30 patients from the gynecological out-patient clinics and it was 0.87.

RESULTS

The study was carried out on a sample of 163 married females. Their socio-demographic characteristics are presented in table (1). Their mean age was 27.5 $\pm$ 6.7 years. 53.4% of the sample were in the age group 20-less than 30 years. While, only 1.8% of the sample were above 40 years old. About 62.5% were career women or students, while housewives presented only in 37.4% of the sample. 59.5% of the sample were averagely or higher educated, whereas the illiterates were presented only in 33.1% of the sample. The mean duration of mariage of the sample was 5.2$\pm$ 3.77 years with the majority (57.7%) had a duration of 7 years and more. 71.2% of the sample had children. Maternal source of sex information represented the main source of information in the majority, i.e. 59.5% of the sample (Table 2). 94.5% of the sample denied the presence of a family history of sexual dysfunction (Table 3). Only 30.1% of the sample came to the clinic complaining directly of manifestations of sexual dysfunction (Table 4). Pelvic heaviness and low back pain represented the most

Table 1
Socio-demographic Characteristics of the Sample (No. = 163)

Data	No	%
Less than 20	19	11.7
20-less than 30	87	53.4
30-less than 40	54	33.1
40 and more	3	1.8
Arithemetic mean : 27.5 Standard deviation:±6.77		
Scientific careers	38	23.3
Clerk	31	19
Worker	15	9.2
Student	18	11
Housewife	61	37.4
High education	59	36.2
Prep & Secondary education	38	23.3
Read & Write	12	7.4
Illiterate	54	33.1
Less than 1 year	29	17.8
1-3	26	15.9
4-6	14	8.6
7 and more	94	57.7
Arithemetic mean : 5.2 Standard deviation : + 3.77		
No children	47	28.8
Having children	116	71.2

Table 2
Source of Sex Information

Data	No	%
Maternal source	97	59.5
Other sources	66	40.5
Total	163	100

Table 3
Family History of Sexual Dysfunction

Data	No	%
-ve family history	154	94.5
+ ve family history	9	5.5
Total	163	100

Table 4
Distribution of the Sample According to the Presence of a Direct Complaint from a Sexual Dysfunction

Data	No	%
Complaining directly	49	30.1
Complaining indirectly	114	69.9
Total	163	100

Table 5
Distribution of the Sample According to the Nature of the Complaint

Data	No	%
Pain during intercourse	25	15.3
Inaccessible intercourse	24	14.7
Pelvic heaviness	63	38.7
Low back pain	47	28.8
Vague sexual complaint	4	2.5
Total	163	100

Table 6
Distribution of the Sample According to the Clinical Types * of the Female Sexual Dysfunction

Data	No	%
Lack or loss of sexual desire	5	3.1
Sexual aversion	3	1.8
Lack of sexual enjoyment	9	5.5
Failure of genital response	2	1.2
Orgasmic dysfunction:		
General	14	8.6
- Situation (+ ve Orgasm with masturbation only)	6	3.7
Non organic vaginismus	19	11.7
Non organic dyspareunia	25	15.3
Excessive sexual drive	7	4.3
** Other sexual dysfunctions, not caused by organic disorder or disease:		
- Excessive masturbation	5	3.1
- Marked feeling of inadequacy of body and sex organs	3	1.8
More than one diagnosis	65	39.9

*Clinical types are sorted according to I.C.D.-10 classification of Mental and Behavioral Disorders Diagnostic criteria for research.
** Clinical types are quoted from DSM-III-R. by the American psychiatric Association as ICD-10 is deficient in these clinical types.

commonly presenting complaints, 38.7% and 28.8% respectively (Table 5). 39.3% of the sample had more than one diagnosis. Lack or loss of sexul desire presented in 3.1% of the sample, sexual aversion in 1.8% and lack of sexual enjoyment in 5.5%. Failure of genital response was present in 1.2%. Orgasmic dysfunction were present in 12.3% of the sample. Nonorganic vaginismus and nonorganic dyspareunia were present in 27% of the sample. Excessive sexual drive was present in 4.3%. Other sexual dysfunction quoted froms DSM-III-R were present, like: excessive masturbation, 3.1% and marked feeling of inadequacy of body sex organs in 1.8% of the sample (Table 6).

DISCUSSION

Sexual dysfunction, a term coined by Masters and Johnson (1970), are a group of behaviours whose response qualities (i.e., intensity, frequency, duration, latency and threshold) are considered deficient (Malatesta and Adams, 1984). Dysfunctional sexual behaviour is defined as failure to experience, or to engage effectively in one or more components of the stimulus-response hierarchy represented by the four phases of the sexual response cycle: desire, arousal, orgasm and resolution (Sadock, 1995).

Sexual dysfunction are so diagnosed only, when such disturbances are a major part of the clinical picture. They are not diagnosed if such dysfunction are symptomatic of other Axis I disorders. Moreover, if they are attributable entirely to organic factors, they are coded on Axis III (Sadock, 1995).

In recent years, there is increasing recognition of the significant incidence and importance of female sexual dysfunction and their distressing effects upon the female psychiatric status and relations with others (O'Donohue et al., 1997).

Sexual behaviour is diverse and determined by a complex interaction of factors. It is affected by one's relations with others, by life circumstances and by the culture in which one lives (Clayton et al., 1997). However, in Egypt, there are no previous studies in that field to clarify the sociodemographic and clinical profile of our patients as a necessary and inevitable step to effectively manage them. It seems that, there is a sizeable amount of anxiety about discussing sexual issues that might lead to an avoidance of the topic. So, the present study, can be seen according to the current socio-economic changes in our society-as a step in overcoming such crippling anxiety and a trial to draw a profile of our patients.

Career and educated women constituted the majority of the present study sample, which is contrary to their prevalence rates in the general population. This may reflect a sample bias, as the present sample comprised patients attending the outpatient clinic, i.e., represented patients that are aware of the presence of a problem and seeking medical help. As seeking help from medical profession does not depend only upon the actual morbidity, but depends to a large extent on the cultural background of the people and their attitudes (Owida and Abdel Kawy, 1992). Clerk (1986) reported that career and educated women were significantly more likely to present with sexual dysfunction and disorders than the illiterate unemployed women. He concluded that this may be due to psychological and interpersonal stressors characteristic of married couples when wives pursue careers (Clerk, 1986). Both explanations are plausible, until a community survey is done.

The majority of the patients were between 20-40 years old. This may reflect

that patients over 40 years rarely admit sexual complaints that may be a part of denial process as they may consider complaints from sexual matters as shamful. and/or reflecting acceptance of the partners to each other with time. However, denial as an explanation seems to be more probable as 94% of the sample has a duration of marriage for 7 years and more. By this percentage, results reflect chronic sexual problem and denoting previous avoidance behaviour to problems that might occur in the first few years of marriage with this duration of marriage. It is logical that 70% of the sample had children.

About 60% of the present sample reported that their mothers represented their main source of sex information. This is contrary to Loutfi et al. (1984) finding that women got their knowledge about sexual matters from sources outside the family (Loutfi et al., 1984). The present results denote that the family in our society is still the most important agent in the socialization process. On the contrary to that in western societies where peer groups are more important (Levin, 1992).

Our females seldomely complain of sexual dysfunction. This finding was reported also by Bachmann (1989). But, our figures of non-complainers are much higher. By this concept we can understand the result that about 95% mentioned that they have no family history of sexual dysfunction.

Pelvic heaviness and low back pain were the commonest expressive complaints to the underlying hidden sexual complaints. While in western studies about 50% was complaining of dysfunction in sexual arousal and enjoyment (Frank et al., 1976 and Bancroft, 1988).

39.9% of the sample had more than one diagnosis. The same finding was reported by Sadock (1995) in his review article about normal sexuality and sexual dysfunction.

Orgasmic dysfunction was found to be around 12%, this figure is approximately the same as in the study of Spector and Carey (1990).

Pfafflin (1980) in a sex-clinic found that 20% of the patients is complaining of vaginismus, it is 11.% in our study. The commonest clinical diagnosis in our study is non-organic dyspareunia 15.3% which is in agreement with the study of Bachmann (1989) which was done in a gynaecological clinic but he found a higher rate 43%.

Surprisingly, we found that the prevalence of excessive sexual drive and excessive masturbation were 4.3% and 3.1% respectively which need further investigations. Problems of sexual dysfunction are oftenly distressing to patients and their partners, hence the whole families, and have their bad effects upon one's relations with others at home or at work, i.e., they affect deeply and broadly the quality of patients' life and their well being. Thence, this area needs a lot of researches especially community-based researches.

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دراسة وصفية لبعض السيدات المصريات المصابات باضطرابات وظيفية جنسية والمترددات على مستشفيات جامعة الازهر: نتائج دراسة اكلينيكية وباستخدام استبيان الاضطرابات الجنسية الوظيفية

هدفت الدراسة الحالية لإستجلاء النسق الديموجرافى والإكلينيكى لبعض السيدات المصريات المصابات باضطرابات جنسية وظيفية ومترددات على مستشفى الحسين وباب الشعرية. وتم عمل فحص نسائى كامل، ومقابلة إكلينيكية نصف مقننة وتطبيق استبيان الاضطرابات الجنسية الوظيفية وذلك لكل مريضة. وتكونت عينة الدراسة من ١٦٣ سيدة تم اختيارهم عشوائياً من اللاتى بلغن ١٨ عاماً فأكثر ومتزوجات وتم تشخيصهم على انهن مصابات باضطرابات جنسية وظيفية.

وبلغ متوسط عمرهن ٢٧,٥ ± ٦,٨٨ عاماً. وكان معظمهن عاملات ومتعلمات ٥٧,٧٪ منهن مضى على زواجهن ٧ سنوات فأكثر ٧١,٢٤ ٪ منهن لديهن أطفال وكانت ٥,٥٪ فقط لديهن تاريخ عائلى لتلك الإضطرابات.

وقد أشتكت ٣٠,١٪ فقط من تلك الاضطرابات مباشرة بينما شكت الأخريات من ثقل بالحوض (٣٨,٧٪) وألم أسفل الظهر (٢٨٪) وكانت أكثر التشخصيات وروداً هى : الألم غير العضوى أثناء الجماع (١٥,٣٪). بينما كانت أقل التشخيصات وروداً هى : الإحساس الملحوظ بعدم الكفاءة للجسم وللأعضاء الجنسية (١,٨٪)، فشل الإستجابة الجنسية الحسية (٢,٥٪) والأستمناء الزائد (٣,١٪).