SOME ASPECTS OF SEXUAL KNOWLEDGE AND SEXUAL BEHAVIOUR OF LOCAL WOMEN. RESULTS OF A SURVEY — XII SEXUAL PROBLEMS AND CONCERNS

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SYNOPSIS

This article concludes this series and discusses the problems complained of by the 1012 women surveyed. 388 of 1012 (ie. 38.3 percent) of women encountered problems. The most common complaint was of dyspareunia (pain on intercourse) by 221 or 21.8 percent of the 1012 women.

122 (12.0 percent) women of whom 100 were married and 22 unmarried complained of lack of orgasm.

29 (2.8 percent) women complained that their husbands ejaculated too soon for their satisfaction.

Other problems encountered were of vaginismus, penile size or vaginal laxity, ejaculatory incompetence and erectile problems. Sexual disinterest though vocalised in the interview was not given as a complaint or problem by the women.

INTRODUCTION

Sexual problems of varying degrees are said to occur in fifty percent of married couples but the number of couples who do actually come forward for counselling and therapy are very few. Many are inhibited by their upbringing and the social climate from seeking aid for their problems and lead a day to day pragmatic existence as far as their sexual life goes.

A study of the problems or concerns which most couples have was undertaken. Since the overwhelming population studied were married, the problems encountered can be taken as a reflection of the problems faced by married couples.

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MATERIALS AND METHODS

1012 females who were patients of the Obstetrics and Gynaecology Unit of the Toa Payoh Hospital were interviewed with respect to the problems they encountered in their sexual activities.

RESULT

The ages of the sample varied from below 20 years of age to just over 40 years of age. All ethnic groups were represented. 89 percent were in the age of group of 20 to 34 years and 76 percent had over 10 years of education behind them.

89.5 percent (ie. 906 women) were married at the time of interview and so were indulging in regular sexual activities.

The duration of marriage of the married sample varied from below 1 year to over 10 years. 54 percent had been married for a duration of up to 4 years. ie they had opportunities for sexual experience for that same period — a period during which they were likely to have been very active sexually.

64.8 percent of the total sample had sexual encounters for a duration of up to 4 years.

Table 1 gives a breakdown of the problems or concerns which the women vocalised in response to the question of what sexual problem, difficulty or concern they had in their sexual relationships.

TABLE 1
SEXUAL PROBLEMS ENCOUNTERED BY 1012 WOMEN

Female Problems	No. of Women
Pain — Superficial or Deep	221 (21.8 percent)
No Climax — 100 married, 22 single	122 (12.0 percent)
Vaginismus	2
Big Penis One had multiple climax	2
Loose Vagina	2
Long Labia Majora Interferes	1
Husband wants sex too often (more than once/day and anal sex too)	1
Male Problems	**No. of Men**
Premature Ejaculation	29 (2.8 percent)
Unable to ejaculate or too long to ejaculate	5
Erectile Problems	1
Tired No sex drive	1
Paraphimosis	1
Total with complaints	= 388 women ie. 38.3 percent

Dyspareunia (pain on intercourse) was the biggest complaint and 221 or 21.8 percent of the 1012 women complained of this.

The main reason for this is because of the "Slam, Bang". "Thank You, Mam" sort of technique at sexual intercourse which was a regular feature and pattern for the majority.

122 (12.0 percent) for women constituting 100 married and 22 unmarried women complained of lack of orgasm.

29 (2.8 percent) of women complained that their husbands ejaculated too soon for their satisfaction.

The male problems were not verified by talking with the husbands but were problematic enough for the women to vocalise them. Most of these complaints (both male and female) had never been discussed with or mentioned to the husbands.

DISCUSSION

Largely, many problems in sexual matters are due to lack of communication and refusal to discuss likes and dislikes. Technique plays a secondary part in contributing to the problems.

I intend to discuss briefly most of the problems listed above but it would not be appropriate in this paper to discuss each specific problem in detail. I intend to write a separate series of articles discussing each of these problems and their management in detail in the near future.

388 or 38.3 percent of 1012 women had sexual problems or concerns.

Dyspareunia or pain an sexual intercourse was the main complaint in this series. 221 or 21.8 percent of the women complained of this. It is rather revealing that such a large number of women have pain on coitus. When one compares the frequency of this complaint as seen in clinic practice, this is a marked discrepancy. This means a very large number of women just tolerate and endure painful coitus as something they have to put up with. The overwhelming majority had never vocalised or complained about this painful problem to their mates.

Dyspareunia (1–3) can be disturbing to both partners and can be defined as recurrent or persistent genital pain in either partner associated with coitus. The discomfort can vary from momentary to intermittent twinges of pain, to intense discomfort which persists during coitus or can be just an intense ache. Any combination of this can occur before, during or after coitus. In due time anxiety replaces enjoyment and sexual pleasure for both partners is distracted or displaced by anxiety.

It should be remembered that males too can suffer from dyspareunia though commonly for most cases seen in practice the complainants are females.

Traditionally dyspareunia is considered as superficial or introital and deep or pain on pelvic thrusting.

Pain at the introitus is most often due to lack of lubrication. This results from insufficient arousal which in itself can be due to mental or physical fatigue, inadequate foreplay or ignorance about the anatomy and physiology of sexual activity. Compounded to these can be pregnancy fears. Other possible causes are a tight hymenal ring, hymenal strands, episiotomy scars, atrophic or organic vulvovaginitis.

Deep dyspareunia is often due to endometriosis, pelvic inflammatory disease, retroverted uterus, ovarian prolapse or premenstrual vascular congestion.

Iatrogenic causes can be physiological or psychological eg shortened vagina, scar at the vault, posthysterectomy.

Drugs and medication can lead to diminished desire and arousal responses eg antihypertensives, sedatives and hypnotics.

Post-coital pain can result in patients with a midline scar who have had a full orgastic response involving the abdominal muscles and scar.

Dyspareunia can lead to the development of other dysfunctions eg loss of desire, lack of lubrication,

inhibition of orgasm and avoidance of sexual activity. The causes then may become sexual issues, relationship issues or intrapsychic issues.

Orgastic Dysfunction (2–5)

This is the commonest complaint of western women as see from sex therapy clinic reports. However this was the second most common complaint of women in this series. 122 women (100 married and 22 single) or 12.0 percent of the 1012 women complained of not achieving climax or of not having climax to the frequency they expected.

Orgasm can be considered as the sole criterion for determining the degree of satisfaction which a female derives from coital activity. Many women get considerable satisfaction from arousal alone and even if they do not achieve orgasm, many females do find satisfaction in that their partners had enjoyed the contact and feel happy in that they had contributed to their mates' pleasure.

In most studies only about 30 percent of women orgasm regularly at coitus and about 10 percent of women are non-orgasmic by whatever means used. There is even controversy as to whether orgasm failure is a pathological condition or just a part of the spectrum of sexual responses of females.

Societies vary in their expectation of sexual responsivity of their females. It is a fact that women do reach orgasm with a greater consistency as they grow older. Till recent times sexual *gratification* for women was thought to be impossible nor desirable. However among educated local groups women do expect to achieve orgasm in sexual activity and their mates do want them too.

Orgasmic regularity is not necessary for experiencing satisfaction with sexual activity, but society expects orgasm from women and so many women are made to feel dissatisfied with their sex lives.

Orgasmic failure can result in irritability, emotional instability, restlessness, pelvic discomfort and loss of sleep. Women who are unhappy about their orgasmic frequency are more likely to seek treatment than are women who are not orgasmic but do not feel dissatisfied sexually.

Premature Ejaculation (2–4, 6, 7)

25 or 2.8 percent of 1012 women complained of this as a problem in their mates. They felt that this problem in their mates was distressing to their sexual satisfaction.

This condition is said to be the most common sexual dysfunction in the male and the cause is mainly pyschological. It is a problem with many men, especially the young who are just starting sexual activity. It also occurs in many men when they resume sexual activity after a period of abstinence.

Most of the men with this problem ejaculate just prior to or immediately upon penetration and intromission. Others are able to thrust a few times but ejaculate when they do not want to or expect to, ie. ejaculation is not under their control.

It is difficult to define premature ejaculation. Previously it was taken in terms of length of intravaginal containment prior to ejaculation or in terms of number of strokes the man was able to make prior to ejaculation.

Most recently it is defined in terms of female satisfaction or enjoyment, ie the problem exists if ejaculation occurs 50 percent of the time prior to the female orgasm. The main factor is inability to obtain control over the ejaculatory reflex once an intense level of sexual arousal has been attained. Once excited these men reach orgasm rapidly.

The condition, if persistent, can lead to sexual incompatability and interpersonal problems. The male can develop secondary erectile failure and. the female orgasmic dysfunction.

Vaginismus (4–6)

Two women had this problem. Vaginismus is an involuntary reflex due to imagined, anticipated or real attempts at intravaginal penetration. In this condition there is involuntary spasm of the muscles surrounding the introitus especially the sphincter vaginae, pubococcygeal muscles and outer third of the vagina.

Non-coital sexual activity is pleasurable and satisfactory and leads to orgasm. These women lubricate copiously, feel sexually aroused and are multiply orgasmic by non-coitus means.

Any pathology of the genitals or vaginal structures causing pain can lead to this condition. Psychological factors, pain at intercourse, sexual trauma, ignorance and fear of pain and injury by the phallus are among the causative factors.

The condition can persist for many years and lead to the condition of unconsummated marriages, apareunia for years or years of intraurethral coitus. In the milder forms of this condition, coitus is possible but is painful.

Penile and Vaginal Concerns (3, 5, 8)

Four cases occurred under this category.

Penises come in varying sizes, shapes, firmness and angulation. Most men consider their penis to be the wrong size or shape and every man thinks every other man has something bigger and better than him.

Most women think their vaginas are too small for the penis they have to accommodate though seldom does one hear of women complaining that their partner's penis is too small for their liking.

There is no size difference among erect penises and the stimulated vagina with accommodate and adapt itself to any size penis. Most women do not appear to have size preferences and even if they do, seldom do they vocalise about it.

At full erection the smaller organ doubles its length, whereas the longer flaccid organ elongates less. The smaller erect organ functions just as well as the longer penis.

The vagina is infinitely distensible and its effectiveness is influenced by anatomic and physiological factors such as vaginal angulation, sexual tension, increased transcervical expansion. There will definitely be difficulty in accommodating the erect penis, especially a large organ in a smaller sized vagina. Full accommodation is however often achieved in the first few thrusts of the penis regardless of the penile size.

Vaginal sizes do vary too. The large and obstetrically damaged vagina expends far beyond its physiological requirement. If there is associated copious lubrication, often there will be complaint that the penis feels "lost" in the vagina. There will be little direct stimulation at thrusting.

A proportion of women do have weak or atrophied pubococcygens muscles irrespective of age or parity. Multiparity per se does not cause over relaxation or lack of sexual sensations and responses. Episiotomy injury and inadequate repair of it appears to be a major contributory factor to unsatisfactory sexual function due to vaginal tone loss.

Disorders of Desire (2–4 5, 7)

Though only one woman complained that her mate

had no sexual desire due to feeling tired, many women had said the interview that their sexual satisfaction and ability to orgasm depended on their mood for sex.

Usually females can tolerate lack of full stimulation and still engage in coitus. However women are now, in this day and age, less willing to be passive participants.

In disorders of desire there is a partial or complete failure to obtain and or maintain the lubrication swelling response until completion of the sex act. In this condition the complainants derive little if any erotic pleasure from sexual stimulation. These individuals lack erotic feelings and do not lubricate and the vagina does not expand sufficiently to accommodate the erect penis. Many women with this complaint consider the sexual experience as an ordeal to be endured and try to avoid it.

Organic causes must be considered when there is a generalised loss of libido. Psychological, sociological, learning and conditioning, humoral, neuroendocrine and cognitive factors may be implicated. Persistent indifference to sexual activity can be life long or can follow a period of normal sexual desire. It can be situational as regards partner and environment or can be of a generalised nature.

There is no established norms of sexual activity or frequency for varying ages, social groups or relationship. Libido discrepancies can occur slowly or suddenly. Depression is the commonest cause. A dysfunctional partner can contribute as well. Other factors are loss of self esteem, anger/resentment toward the partner, divorce, separation or bereavement, religious or social taboos.

Relationship and communication failure or problems do play a major contributory role.

Lack of excitement in the female makes the male resentful as he feels his male prowess is inadequate.

Sexual Aversion (5, 7)

A few women did express aversion to some forms of sexual activity though they did respond to some forms of non-coital stimulation and coitus but were unable to tolerate touching or caressing of their genitalia or breasts or deep kissing. Some did express negative reaction to all aspects of sexual contact with another person and sometimes reacted with vomiting and nausea to having semen inseminated into their vaginas. Actually many women are victims of the myth that sex is man's responsibility for his enjoyment and that it is unfeminine to be sexually assertive.

Erectile Dysfunction (3, 4, 6, 7)

This can be transient, situational or of long standing duration and can be defined as inability to obtain and maintain an erection of sufficient firmness to permit coitus to be initiated or completed. One woman said her husband had this problem.

At one time it was widely thought that the cause was largely psychological but with more knowledge about sexual matters, current estimates are that about fifty percent of cases are due to organic causes.

It is true that transient failure in every male due to fatigue (mental or physical), anxiety, alcohol or other temporary circumstances does occur.

Among organic causes are diabetes mellitus, spinal injury, endocrine disorders, peyronie's disease, drugs, medication and alcohol abuse.

Among psychological reasons are guilt and conflict about sex, fear of injury (to self or partner), venereal disease and pregnancy fears, fear of interruption, disappointments, loss of self image and self esteem, fear of vagina dentata and an unduly assertive and demanding woman.

Resultant to the condition are frustration, humiliation, depression and marital discord.

Ejaculatory Incompetence (4, 6, 7)

This is an infrequent dysfunction. These men have no problem in attaining and maintaining an erection. In fact most of these men are able to sustain unusually long erections and can bring their partners to repeated orgasms but are unable to ejaculate intravaginally. For most with this problem, the condition is specific to coitus or a particular partner. Some are able to ejaculate by masturbation or oral stimulation, while there are others who are unable to ejaculate by whatever means used.

Five men fell into this category of ejaculatory incompetence. The cause is mainly psychological. All had had this problem from the on set of sexual activity. It is possible to develop the problem after an incident e.g. infidelity by wife. Some may be harbouring anger toward the wife or have pregnancy fears. Conditioning by masturbatory practices is a well known cause and one man did present this picture.

Among possible organic causes are diabetes mellitus, drugs and alcohol and neurological diseases.

CONCLUSION

This article concludes my study of local female sexual behaviour. Though the sample may be small and biased somewhat, I doubt whether any truly unbiased study can be done on this sort of subject. I can claim credit for having shown that where the approach by the professional is sincere and where a good rapport can be established, really frank answers to very intimate questions can be elicited. Further local women are not averse to discuss and vocalise their sexual lives, needs and wants and do have sexual problems too.

There is an urgent need for further studies and education and communication on sexual matters, both for the professional and the lay public. We doctors, as health care professionals, are well placed to fulfill and take the lead in this responsible role. We should take the initiative to open the discussion about sex and not wait for patients to bring up the subject of sex for discussion.

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