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Frequency of Sexual Dysfunction in a General Gynecological Clinic: An Epidemiological Approach

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Epidemiological data on female sexual functioning are presented. Fifty-nine 30- to 39-year-old Black women attending a gynecology clinic at University Hospitals of Cleveland for nonsexual complaints were interviewed to determine the frequency of sexual dysfunction. Seventeen percent had difficulty achieving orgasm in partner sexual behavior. Most of these women had a prior history of adequate sexual functioning; 5% had never been orgasmic. Ten of the 49 women who had no orgasmic difficulty were not satisfied with their sexual relationships. The relative risk of sexual dysfunction was 5 times greater in women who had undergone pelvic surgery.

KEY WORDS: sexual dysfunction; epidemiology; orgasm; gynecology.

INTRODUCTION

A careful estimate of prevalence is an important step in describing the types of female sexual problems, elucidating clues to their etiology, and planning for health services. However, prevalence studies have not been conducted, for various reasons. The sensitive, private, and subjective material requires special interviewing skills to elicit (GAP Report, 1973). Serious semantic and conceptual confusion about female sexual problems has existed (Kaplan, 1974). Results of traditional treatment methods have not been scrutinized (O'Connor and Stern, 1972). Considerable methodological difficulties are encountered in obtaining a random sample of the general population or a defined segment of the population (Kinsey *et al.*, 1953).

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Promising therapeutic approaches have recently emerged (Masters and Johnson, 1970). The confusing term "frigidity" has been replaced with more meaningful descriptions of actual problems; the need for clarifying data based on population studies rather than psychiatric patients has been reappreciated (Stoller *et al.*, 1973).

The basic question "How common are sexual problems?" cannot be answered through the clinical experience of sexual therapists because their referrals are highly selected from the White middle- and upper-income classes. This report cannot provide true prevalence data either as the sample used has not been firmly established as representative of lower socioeconomic class middle-aged Black women. Description of the frequency of various forms of sexual dysfunction in a group of patients not overtly seeking help for sexual problems, however, is a step toward defining prevalence.

METHODOLOGY

Every third woman aged 30-39 to enter the gynecology clinic of University Hospitals of Cleveland over a 7 week period received a letter inviting her to participate in a study of sexual functioning. When there was a refusal, the next appropriately aged woman was similarly invited. A maximum of three women were seen per day.

Sixteen women declined to participate. The 59 participants each received an additional explanation from the same gynecologist and signed a statement of informed consent. There were no dropouts in the course of the study. First, gynecological complaints were attended to by usual clinical methods and a treatment plan was explained to the patient. Then she was interviewed by the same examining gynecologist in another room for approximately 45 min. The semi-structured interview consisted of 114 questions covering demographic data, medical history, family attitudes about sex, masturbatory history, sexual preferences and behavior, and labeling of seven anatomical locations from a picture of the vulva (Smith *et al.*, 1972). After the interview, the gynecologist checked his recorded responses to each question and rated the patient's anxiety level.

Characteristics of the Sample

The sample was in many ways typical of the University Hospitals clinic population (Table I). The patients were Black inner-city residents, most of whom were born and raised in the South, had completed between 10 and 12 years of formal education, and were Protestant. Most came from families of four or more children. All but three were mothers; most were not currently married. Many were supported by public assistance programs. Most belonged to the lowest

Table I. Demographic Characteristics of 59 Black Women

Mean age	34 years
Religion	Baptist, 33; Protestant, 12; Catholic, 5; other, 9
Place of birth	South, 41; Cleveland, 18
Residence for most of life	South, 26; Cleveland, 30; other, 3
Both parents in home	Yes, 36; no, 23
Number of children in original family	Seven or more, 20; five or six, 8; four, 8; two or three, 19; one, 4
Educational attainment	9th or less, 1; 10th, 14; 11th, 18; 12th, 21; beyond, 5
Marital status	Married, 18; separated, 15; divorced, 18; single, 7; widowed, 1
Number of children	None, 3; one, 7; two or three, 27; four or five, 14; six or more, 8
Means of support	Employment, 17; public assistance, 33; husband or man, 9
Social class	VII, 38; VI, 5; V, 2; IV, 7; uncertain, 7

socioeconomic class (Hollingshead and Redlich, 1958). None of the sample came to the clinic with a specifically sexual complaint.

Data Organization

There have been two recent advances in the nosology of female sexual problems. Masters and Johnson (1970) introduced the term "orgasmic dysfunction" to describe women having difficulty achieving orgasm. They distinguished two types of orgasmic dysfunction: (1) primary – the lifelong failure to achieve orgasm by any means; (2) situational – when at least one orgasm had been achieved by some means. The situational orgasmic dysfunctions were subdivided into three forms of orgasmic inadequacy: coital, random, and masturbatory. The coital group, the most numerous, were orgasmic, but not with intercourse. The random group were only rarely orgasmic, by various means, and seemed to have little need for sexual expression. The few women classified as having masturbatory orgasmic inadequacy complained of an inability to achieve orgasm by self or partner manual genital stimulation but were coitally orgasmic.

Kaplan (1974) divided the dysfunctions on the basis of physiological response (Masters and Johnson, 1966). Women with various degrees of inhibition of the excitement or vasocongestive phase of arousal were labeled as having generalized sexual dysfunction. They were separated from women who could be excited but could not experience the orgasmic component of arousal. These latter women were described as having orgastic dysfunctions.

The study data are presented using a slight modification of Kaplan's classification system (Table II). The modification merely subdivides the excitement- and orgasmic-phase dysfunctions into primary and secondary forms. These dis-

Table II. Organization of Data

Dysfunctional

Excitement-phase dysfunctions

Primary: These women have a lifelong incapacity to become excited with partner sexual behavior. On rare occasions, a greater degree of arousal with a partner may be experienced.

Secondary: These women previously have been regularly and enjoyably sexually excited. In addition, they have frequently been regularly orgasmic.

Orgasmic-phase dysfunctions: These women regularly and enjoyably become aroused but are unable to achieve orgasm in partner sexual behavior.

Primary: These women have had a lifelong incapacity to obtain orgasmic release from sexual excitement. On rare occasions, they may have achieved orgasm with a partner.

Secondary: These women previously have been regularly orgasmic.

Vaginismus: The spastic involuntary contraction of the outer third of the vagina that makes penetration impossible or difficult and frequently painful. Vaginismus may or may not be associated with orgasmic difficulties.

No orgasmic difficulty: These women are regularly excited to orgasm with a partner.

a. Sexually satisfied: These women reported no other difficulty with their sexual lives.

b. Sexually not satisfied: These women reported a variety of problems.

tinctions separate women who have always or nearly always had the problem from those who developed it after a stable period of normal physiological functioning. The additional symptoms of dyspareunia or lack of feeling during intercourse are not considered as separate dysfunctions.

RESULTS

The Dysfunctional

Ten of the 59 women (17%) reported the inability to achieve orgasm with a partner by any means. Seven had excitement-phase dysfunctions; three had orgasmic-phase dysfunctions.

The excitement-phase dysfunctions were secondary in six of the seven women. Five of these women had previously experienced orgasm in at least 50% of sexual encounters. These same women now reported that for 5 months to 4 years they had never or rarely experienced any sexual excitement. A sixth woman, who had been regularly highly aroused and occasionally orgasmic, reported no arousal during the last 1½ years of sexual activity. These six women gave the

following reasons for their loss of arousal: gynecological surgery, two; partner change, two; gynecological surgery and partner change, one; unclear, one. One of the women with secondary excitement-phase dysfunction regularly masturbated to orgasm; two had not masturbated to orgasm for many years; three had never masturbated.

The seventh woman had a primary excitement-phase dysfunction. Her monthly intercourse was without excitement, lubrication, or sense of frustration. Intercourse was described as being unpleasant, often painful, and an experience to be "gotten over with." Prior to vaginal hysterectomy 2 years earlier, she had intercourse every 2 weeks and was very rarely orgasmic. She never masturbated.

Three women had orgasmic-phase dysfunctions. They reported great frustration because their high level of excitement never culminated in orgasm. This dysfunction was primary in two women, one of whom masturbated to orgasm regularly; the other never masturbated. The third woman developed this dysfunctional pattern following separation from her husband.

No vaginismus was revealed by history or pelvic examination.

The types of dysfunctions were not indicated in subjects' initial descriptions of their sexual problems. In fact, two of the ten dysfunctional women initially said they had no sexual problems. The dysfunctions among the three who said their problem was an inability to have an orgasm were secondary excitement phase, secondary orgasmic phase, and primary orgasmic phase. Among the three who reported "indifference" were two with secondary excitement-phase dysfunction and one with primary excitement-phase dysfunction. The two with "no feeling" had secondary excitement-phase dysfunctions.

No Orgasmic Difficulty

Eighty-three percent of the sample reported being regularly orgasmic with their partners. Thirty-five of the 49 women with no orgasmic difficulty reported rates of 67-100%; 14 reported rates between 33 and 50% (Table III). The frequency of intercourse ranged from more than daily to four times per year. The most common frequency was three times per week and the mean frequency was 2.8 times per week.

Thirty-nine of the orgasmic women denied having any sexual problems. Thus 66% of the sample were classified as being sexually satisfied.

Ten regularly orgasmic women said they had sexual problems and were classified as being sexually not satisfied. They gave the following explanations:

Table III. Estimated Rate of Orgasmic Attainment

%	100	80	75	67	50	33
n	27	1	1	6	7	7

indifference to sex, seven; painful intercourse, one; too infrequent intercourse, one; homosexuality, one. Of the seven "indifferent" women, four related their current low orgasmic rate of 33-50%, or reduced frequency of once every 2 weeks, to lack of foreplay. Two blamed pelvic events — i.e., an operation and a delivery. The one woman who "didn't want to be bothered" described a constant inner initial reluctance to engage in sex.

All the regularly orgasmic women, with the exception of the one exclusive homosexual, were capable of orgasm with intercourse. The extent to which they had accomplished orgasm by other means varied considerably (Table IV).

Table V summarizes the frequency findings.

Comparisons Between the Dysfunctional and No Orgasmic Difficulty Groups

There were no statistically significant differences (χ^2 with Yates' correction) between the two groups in demographic data, use of contraception, current pelvic pathology, chief complaint at the clinic visit, family attitudes about sex, adolescent or subsequent masturbation, mean frequency of intercourse, or discussion in the family of menstruation, origin of babies, and range of sexual behavior. The mean number of correct labels of female external anatomy was 3.8 in the dysfunctional group and 3.7 in the no orgasmic difficulty group.

There was no relationship between apparent anxiety during the interview and patient-defined sexual problems or orgasmic dysfunctions. Forty-five of the 59 women were quite calm during the interview.

There were statistically significant differences between the two groups in three areas. The dysfunctional group reported poor emotional health more frequently than the group without difficulty ($p < 0.02$). The criteria for poor emotional health were depression, schizophrenia, and alcoholism. Enjoyment of intercourse ($p < 0.001$) and the use of the side-to-side coital position ($p < 0.05$) were reported less frequently by the dysfunctional group (Table VI).

Almost half the sample, 29 women, had undergone gynecological surgery, including eight of the ten dysfunctional women. The relative risk of having a

Table IV. Mode of Orgasmic Attainment

Number	Intercourse	Oral stimulation	Manual stimulation
25	+	0	0
13	+	0	+
8	+	+	+
2	+	+	0
1	0	+	0
49	48	11	21

Table V. Summary of Findings: Total Sample = 59

		Number	Frequency
Sexual dysfunctions			
Excitement phase		7	
Primary with dyspareunia (1)			
Secondary (6)			
Orgasmic phase		3	
Primary (2)			
Secondary (1)			
Vaginismus		0	
	Total	10	17%
No orgasmic difficulty			
Sexually satisfied		39	
Sexually not satisfied		10	
Indifferent (7)			
Dyspareunia (1)			
Too infrequent (1)			
Homosexuality (1)			
	Total	49	83%

sexual dysfunction was 5 times greater in those who had undergone pelvic surgery.

DISCUSSION

The conclusions drawn from this study must be tempered by the knowledge that 16 women chose not to participate. The reasons for their refusals were not determined. Chart review revealed that these women did not differ statistically from the sample in percentage supported by public assistance, marital status, chief complaint, history of gynecological surgery, major medical illness, or gross mental abnormalities. They did, however, have a higher frequency of abnormal findings on pelvic examinations and more fibroids. Their gravidity and parity ratings were one unit lower than for the reported data sample. The mean-

Table VI. Comparisons Between No Orgasmic Difficulty and Dysfunctional Groups

	Emotional health		Current enjoyment of intercourse		Use of side-to-side coital position	
	Good	Poor	Yes	No	Yes	No
No orgasmic difficulty	42	7	48	1	26	23
Dysfunctional	6	4	6	4	2	8
p	< 0.02		< 0.001		< 0.05	

ing of these differences in terms of the sexual functioning of these 16 women is not clear. To the extent that the refusals might have been related tc sexual dysfunction, the frequencies reported in this study have been underestimated and may be regarded as minimum frequencies.

As far as could be determined, this study is the first to describe the frequency of sexual dysfunction in a sample of Northern, poor, urban Black women not presenting for sexual complaints. The relationship of these data to previous studies of female sexual problems among the lower classes is not clear. "Sexual dysfunction" is a relatively new term and no other prevalence data on any social class could be located. The data published by Kinsey *et al.* (1953) on female sexuality did not include any Black females. Their demonstration that both the frequency of orgasm with coitus and the absolute numbers of orgasmic women increased with increasing educational attainment has been the basis for many generalizations about sexual life among the lower economic classes. Rainwater's finding (1968) of fewer positive attitudes about sex and less enjoyment of sex in the lower classes seems consistent with the data of Kinsey *et al.* Rainwater's data included Black married couples. These, and a previous sociological study (Komarovsky, 1962), emphasize these class distinctions in spite of the fact that the majority of married lower-class women reported highly pleasurable sexual lives (Bell, 1974).

The majority of sexual problems encountered among the sample were secondary ones. Seven of the ten sexually not satisfied women who did not have orgasmic difficulty and seven of the ten women with sexual dysfunction reported a considerably better past sexual life. Most of these women recognized the causes of the decrements in sexual functioning. Surgery, partner substitution, and decreased foreplay were often blamed. Although the prevalence of some type of sexual problem is high (34%), the majority of these problems have not been lifelong.

The secondary nature of most sexual problems in this sample implies that help is more frequently necessary for changes in interpersonal relationships and in dealing with the effects of surgery than for the initial orgasms.

Only three women with primary dysfunctions were encountered: two of the orgasmic phase and one of the excitement phase. Thus, in this sample, there was a low frequency (5%) of lifelong inability to experience orgasm with a partner. The frequency of women who have never had an orgasm in Fisher's (1973) sample of 285 White (all but one), college-educated, paid volunteers in their 20s from a university community was the same — i.e., 5%. These figures from "nonpatients" contrast with those of Masters and Johnson (1970), who reported 56% of female complaints as a lifelong failure to achieve orgasm. Selection factors undoubtedly account for both this contrast and the similar experience of other sexual therapy clinics. Determination of true prevalence of the inability to experience orgasm awaits a more definitive study which will enable comparisons between socioeconomic groups.

Speculation concerning differences between the no-difficulty and the dysfunctional groups should be viewed carefully. Five significant findings out of 100 comparisons could be solely due to chance. There was an association in the sample between the patient's report of poor emotional health and sexual dysfunction. Systematic studies of this association have yielded inconsistent results (Fisher, 1973). However, such a relationship is consistent with the experience of some clinicians (Shainess, 1974).

The relationship between pelvic surgery and secondary sexual dysfunction is worthy of further study. It is possible that pelvic surgery is blamed for a sexual dysfunction which actually arose from another source. The frequency of occurrence in this sample, however, raises questions about the exact mechanisms underlying this previously recognized phenomenon (Singer, 1973).

Sexual responsiveness and sexual satisfaction involve more than orgasmic attainment. This study found that ten of 49 regularly orgasmic nondysfunctional women were not satisfied sexually. Although eight of ten dysfunctional women conveyed their dissatisfaction to the interviewer, the remaining two felt they had no sexual problems. It is also apparent from clinical experience that not all women who are unable to achieve orgasm are necessarily dissatisfied with their "dysfunction." This inconstant relationship between sexual physiological attainment and satisfaction is, in part, what complicates the epidemiological approach to sexual dysfunction.

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