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Sexual problems and their management: a survey of general practice in Northern Ireland

E C O'Gorman, L E Thompson

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SUMMARY

This survey suggests a similar prevalence of sexual problems in general practice in Northern Ireland compared with England and Wales. Of the respondents, 9.6% reported a much higher prevalence which may indicate a greater ability in detecting sexual problems and therefore implies that many cases are being missed. The majority of problems appear to be dealt with in general practice, although referral is often considered, with the Psychosexual Clinic being the preferred option. Difficulties encountered with referral are highlighted by the survey. It is suggested that provision of more information about the clinic, visits by therapists to practices and further training opportunities would help general practitioners in managing sexual problems.

INTRODUCTION

The rate of referral to the Psychosexual Clinic at the Belfast City Hospital is slightly lower than to similar clinics in England and Scotland.[1] Since two-thirds of the referrals to the Belfast clinic come from general practitioners, a questionnaire survey was undertaken to determine whether similar numbers of psychosexual problems are encountered in general practice in Northern Ireland compared with that estimated for Great Britain. This survey also estimated the proportion of psychosexual problems which general practitioners would refer to the clinic, found out the preferred management of these problems, and identified reasons that might hinder general practitioners from referring psychosexual problems.

METHOD

The questionnaire was designed and sent to one hundred general practitioners chosen at random from the list of general practitioners in Northern Ireland. The questions are listed in the results section.

RESULTS

Seventy-three general practitioners completed and returned the questionnaire; another two replied but felt unable to submit results, and twenty-five did not reply.

The Psychosexual Clinic, 68 Fitzwilliam Street (Belfast City Hospital) and the Department of Mental Health, The Queen's University of Belfast.

E C O'Gorman, MD, DPM, FRCPsych, Consultant Psychiatrist and Senior Lecturer in Mental Health, Inishowen, Crumlin, Co. Antrim.

L E Thompson, MB, BCh, DRCOG, MRCGP, General Practitioner.

Correspondence to: Dr E C O'Gorman, 68 Fitzwilliam Street, Belfast BT9 6AX.

Question 1: Approximately how many cases of sexual dysfunction (impotence, premature ejaculation, frigidity, vaginismus) or deviant sexuality (homosexuality or paedophilia) present to you in practice in a year? Only one doctor replied that he had no cases, and eight (11%) had over 10 cases per year.

TABLE I

Number of cases of sexual dysfunction or deviation presenting to each general practitioner per year

Number of cases	*Number of doctors*	*Percentage*
0	1	1%
1	12	16%
2—5	39	53%
6—10	13	18%
11—20	7	10%
More than 20	1	1%
TOTAL	73	100%

Question 2: What proportion of cases would you refer to the Psychosexual Clinic? Seven doctors (9.6%) would refer all cases, 13 (17.8%) more than half, 39 (53.4%) less than half, and 14 (19.2%) would refer none.

Question 3: Methods of management. Place in order preferred method of management: referral to a psychosexual clinic, to a medical or social agency (physician, endocrinologist, marriage guidance agency or the social services) or management within the practice. Forty-two doctors gave first preference to management within their practice, and 29 preferred referral to the Psychosexual Clinic.

TABLE II

Preferred methods of management

Methods of management	*Preference of management*		
	1st	*2nd*	*3rd*
Referral to Psychosexual Clinic	29	24	9
Referral to a medical or social agency	4	12	34
Management in practice	42	17	6

Three doctors marked two methods as first choice, 19 did not give a second choice, 23 did not give a third choice and one did not indicate any choices.

Question 4: Indicate up to three reasons which might prevent a general practitioner from referring a patient to a psychiatrist or psychosexual clinic if you feel they would strongly influence your decision not to refer. The most important reasons for non-referral were thought by this sample of doctors to be patient dislike of the psychiatric or psychosexual connotation, although distance and delay were also mentioned.

TABLE III

Reasons which might prevent a general practitioner from referring a patient with a psychosexual problem to a psychiatrist or psychosexual clinic (up to three reasons to be listed)

	Number of doctors	*Percentage*
1. Patient's dislike of referral to a psychiatrist	43	59%
2. Patient's embarrassment at attending a psychosexual clinic	36	49%
3. Disadvantages of the patient being labelled a 'psychiatric case'	32	44%
4. Distance to clinic	31	42%
5. Delay in obtaining an appointment	28	38%
6. No faith in psychiatry or psychosexual clinic	2	3%
7. Exacerbation of the problems by medical intervention	1	1%
8. The problem is felt to be incurable	0	0%

DISCUSSION

Nearly 90% of the general practitioners estimated that they saw between one and 10 cases of sexual dysfunction or deviant sexuality in a year, and about 50% thought that they saw between one and five. Using the 1971 National Morbidity Survey for general practice in England and Wales, Hodgkin[2] calculated a prevalence of 0.3 cases of male sexual dysfunction for 1,000 patients per year and 0.7 cases per 1,000 for female sexual dysfunction. In Northern Ireland the average practice list size at the time of the survey was 1,879, so that one or two cases per year would be expected on that basis. Although the survey can only provide an estimate of the prevalence of sexual problems presenting in general practice in the Province, it would appear that similar numbers of cases of sexual dysfunction present to general practitioners in Northern Ireland as do in England and Wales.

Sixteen per cent of the doctors saw only one case per year, while 9.6% saw between 10 and 20 cases. This might suggest a very large difference in the presentation of sexual problems in these two groups, but may in fact indicate that some general practitioners are more able to detect problems of this type than others. There is evidence to suggest that, while sexual problems are common, being present in 12% of attendants at a family planning clinic in Edinburgh,[3] they are often difficult to identify and only one in 10 patients will spontaneously present.[4] In addition to this evidence, Jachuck[5] found that, even when general practitioners asked their patients on anti-hypertensive therapy if they had sexual difficulties, the patients invariably said 'No', and it was only when the spouses were interviewed that substantial evidence of sexual difficulties was found.

About 10% of general practitioners said they would refer all cases; about 20% said they would refer none, while the largest group said they would refer less than 50%. These results, along with the preferences given for management options, indicate that family doctors in Northern Ireland usually deal with sexual problems

in their practices, but would often consider referral to the Psychosexual Clinic. Very few said they would refer to another type of specialist or agency. Additional comments indicated that two general practitioners did not know of the Clinic's existence. While these results would give support to the view that general practice is the most appropriate place for the management of the majority of sexual problems, it is clear that specialist help is often required. Although the survey did not uncover any large body of dissatisfaction with the type of service which the Psychosexual Clinic offers, a substantial number of doctors agreed that there were disadvantages involved with referring: these were psychiatric labelling and patient embarrassment, as well as travelling difficulties and appointment delays. It might be of help if more information were available about the specialist services that can be provided by the Clinic.

The problems associated with travelling distances to the Clinic would be alleviated by visits by therapists to practices and health centres. This could support the general practitioners who wish to treat such patients in the primary care setting. These measures would particularly help those doctors who see smaller numbers of sexual problems to acquire clinical competence in this area. More training opportunities for general practitioners in the management of sexual dysfunction could increase awareness of the extent of these problems and emphasise that patients may not need intensive treatment, but can obtain great relief from simply having the 'permission' to talk about their difficulties. They may also be helped by being given small amounts of information as suggested in the PLISSIT model of management.[6] This model is a description of different types of management ranging through P—Permission; LI—Limited information; SS—Specific suggestions; IT—Intensive treatment. The majority of sexual problems, it is suggested, can be treated without the need for specialist intensive treatment.

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