Sexological treatment in a public Danish somatic clinic

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Sexological treatment; Sexological therapy; Biopsychosocial; Medical evaluation of sexual dysfunction

Summary There are two public sexological clinics in Denmark. The aim of the paper is to describe treatment methods, medical evaluation performed according to diagnosis at referral and the distribution of sexual dysfunctions presented at the only public sexological clinic in Denmark placed in a somatic hospital. The uptake population is three million people. The clinic was founded in 2006 as a unit of a regional gynaecological obstetrical department. Only patients who are not in concomitant therapy and who are without abuse of alcohol or drugs and without major psychiatric illness or borderline disturbances are admitted. A review of the journals from 2006–2008 has showed the following distribution: the diagnoses among female patients were: hypoactive sexual desire 39.4%, vaginism 21.9%, dyspareunia 12.1%, anorgasmia 3.9%, partner-performance problems 18.8%, other problems 3.9%. The distributions of dysfunctions among male patients were: erectile dysfunction 16.8%, premature ejaculation 7.6%, anejaculation/delayed ejaculation 3.8%, hypoactive sexual disorder 8.8%, hypersexuality 0.8%, partner-performance problems 59.7%, and other problems 2.5%. Treatment is undertaken by a team of consultant gynecologists, nurses and a psychologist. A detailed description of our diagnostic and treatment setup is offered in this paper. The multidisciplinary approach makes a true biopsychosocial approach possible. Thus, hormone replacement therapy, Phosphodiesterase type 5 inhibitor (PDE-5) inhibitor treatment and use of antidepressants are combined with intensive therapy. Sensate focus training forms the sexological backbone of the therapy being used as sound in the patients’ sexual issues and problem solving abilities.

The clinic

There are two public sexological clinics in Denmark: the Sexological Clinic at the National hospital (Rigshospitalet) in Copenhagen, which is part of the psychiatric department and the Sexological Clinic in Jutland, which is part of the Gynaecological Obstetrical department in a somatic hospital. The latter clinic is described in this article.
Organisation

The Sexological Clinic in Jutland (SCJ) is a public clinic, formally attached to the Gynaecological Obstetrical department of the Regional Hospital in Randers. It is the only public clinic in a somatic hospital in Denmark. All treatments are reimbursed, thus the patients do not need to pay for consultations, but will have to pay for prescribed medicine. According to the Danish law, all patients treated in a public hospital must be referred by a doctor. Thus, all patients and their partners are referred by general practitioners, hospital doctors or specialists in urology, gynaecology, neurology, endocrinology, rheumatology or other specialities.

SCJ is situated in a 6-room house apart from the rest of the hospital and thus has its own waiting room, entrance and secretariat. All consultations are documented. The electronic files are only open to the secretary in order to obtain maximum discretion. If couples are treated, each person has his or her personal file.

In Denmark, patients in the health care system have detailed and comprehensive rights, thus all patients are entitled to have a copy of their file. Also, patients can complain to the national Board of Health if malpractice is suspected, this right protects patients treated by authorised medical staff and psychologists.

Therapists

There are five therapists; one clinical psychologist, two consultants who are specialists in gynaecology and obstetrics and two nurses, all of whom has a sexological training accredited by Nordic Association for Clinical Sexology (NACS). Furthermore, there is a psychology student, primarily handling preinterviews, and a full-time secretary. Of the five therapists at the clinic, the psychologist is the only one working full time at the clinic, with 20 sessions a week. The others are at the clinic 1-2 days a week, with four to 10 sessions a week. Group supervision is provided by two specialists in clinical sexology; one psychologist, one MD, with a 3-week interval.

Capacity

The clinic was founded in 2006. The number of visits has doubled every year since. In 2009, there were approximately 2500 visits. We expect a continued increase in patients in the coming years. The uptake area is all of Jutland and Funen representing an uptake population of approximately three million inhabitants. Some of the patients have to travel several hours to get to the clinic, which is situated more or less in the centre of Jutland.

Patient distribution

The sexual problems treated at the clinic, range from primarily medical problems to more psychological issues, such as dealing with the sexual problem as a couple.

We have recently collected data for the period January 13th, 2006-December 31, 2008, regarding distribution of sexual dysfunctions (Højgaard et al., 2010). A total of 256 female and 238 male patients completed treatment in this period (Table 1). The diagnoses among female patients were: hypoactive sexual desire 39.4%, vaginism 21.9%, dyspareunia 12.1%, anorgasmia 3.9%, partner-performance problems 18.8%, and other problems such as secondary sexual dysfunction due to neurological damage to the genitals, pain at orgasm and transsexuality 3.9%. The distributions of dysfunctions among male patients were: erectile dysfunction 16.8%, premature ejaculation 7.6%, anejaculation/delayed ejaculation 3.8%, hypoactive sexual disorder 8.8%, hypersexuality 0.8%, partner-performance problems 59.7%, and transvestism/transsexuality 2.5%.

Since 2008, approximately 150 men and 150 women are treated yearly. Approximately 80% of all patients are in a stable relationship, 20% are singles. A large majority is heterosexual, but homosexual and bisexual patients are also treated for sexual dysfunctions.

We aim to treat sexual dysfunctions and thus we neither treat paraphilias, nor transgender issues or sex offenders all of whom are treated at the other clinic in Denmark (The National Hospital in Copenhagen). Exclusion criteria for treating patients are drug—or alcohol abuse, and major psychiatric illness or disorders. We recommend that patients are not involved in other forms of psychotherapeutic treatment simultaneously. If they are, we advise them to either terminate the other therapy, or postpone the sexological treatment.

Formal procedures

All patients are referred by medical doctors who are asked to forward a detailed description of the patient’s medical history, including medicine anamnesis. Also, patients must be assessed by the referring doctor for depression and somatic disturbances known to be of importance for the sexual function (Tables 2 and 3). All referrals are thus assessed for whether they provide sufficient information and if not, we ask for additional information (i.e. medical history, blood tests, physical examination, screening for depression, etc). If patients are in a relationship, we recommend that the partner is informed on the necessity of his or her participation as well.

We then decide if the patient should come to a pre-interview, which nearly all patients do, within 4 weeks. At this interview the final diagnosis is made, based on anamnesis and ICD10 criteria. Infertility patients and patients with serious somatic illnesses such as cancer, are seen as soon as possible (within weeks) without a previous pre-interview. The reason to prioritize these two groups is our belief that an early intervention after the diagnosis of a serious illness will give these patients hope; furthermore, sexual issues are often not discussed with the patients and their partners in other contexts than ours. The reason to prioritize infertility patients is that these patients often can avoid further infertility treatment if their sexual dysfunction is treated. As the success of fertility treatment deteriorates with the age of the female patient, we find it unethical to put these patients on a waiting list. All other patients are put on a waiting list after a pre-interview.

We aim at reducing our present waiting period of approximately 6 to 8 months by performing pre-interviews. The
Table 1  Distribution of patients in SCJ 1/1 2006—31/12 2008.

<table>
<thead>
<tr>
<th></th>
<th>Female patients</th>
<th>Male patients</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>n = 256 (%)</td>
<td>n = 238 (%)</td>
</tr>
<tr>
<td>Vaginism</td>
<td>56 (21.9)</td>
<td>40 (16.8)</td>
</tr>
<tr>
<td>Dyspareunia</td>
<td>31 (12.1)</td>
<td>18 (7.6)</td>
</tr>
<tr>
<td>Anorgasmia</td>
<td>10 (3.9)</td>
<td>9 (3.8)</td>
</tr>
<tr>
<td>Hypoactive sexual desire</td>
<td>101 (39.4)</td>
<td>21 (8.8)</td>
</tr>
<tr>
<td>Hyposexuality</td>
<td>0</td>
<td>2 (0.8)</td>
</tr>
<tr>
<td>Partner-performance problems</td>
<td>48 (18.8)</td>
<td>142 (59.7)</td>
</tr>
<tr>
<td>Other diagnosis (transsexuality, etc.)</td>
<td>10 (3.9)</td>
<td>6 (2.5)</td>
</tr>
<tr>
<td>Total</td>
<td>256 (100)</td>
<td>238 (100)</td>
</tr>
</tbody>
</table>

Table 2  Diagnostic set up for male patient.

<table>
<thead>
<tr>
<th>Male patients diagnosis at referral</th>
<th>Physical examination</th>
<th>Laboratory tests</th>
<th>Psychiatric assessment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Erectile dysfunction</td>
<td>Body weight and height, BMI, BP, pulse, penis and scrotal palpation, rectal examination of prostate gland</td>
<td>PSA, androgen hormone profile, FSH, LH, prolactin, HgA1c, cholesterol Triglycerides, LDL, HDL, Hgb</td>
<td>Depression score</td>
</tr>
<tr>
<td>Premature ejaculation</td>
<td>Penis and scrotal palpation, rectal examination of prostate gland</td>
<td>Thyroid hormones</td>
<td></td>
</tr>
<tr>
<td>Retarded ejaculation</td>
<td>Body weight, height, BMI, Penis and scrotal palpation, rectal examination of prostate gland</td>
<td>Thyroid hormones, HGA1c</td>
<td>Depression score</td>
</tr>
<tr>
<td>Lack of libido</td>
<td>Penis and scrotal palpation</td>
<td>Thyroid hormones, prolactin, androgen hormone profile, FSH, LH, Hgb, HGA1c</td>
<td>Depression score</td>
</tr>
<tr>
<td>Hypersexuality</td>
<td>Androgen hormone profile</td>
<td>Androgen hormone profile</td>
<td></td>
</tr>
</tbody>
</table>

Theoretical background

Biopsychosocial

Our theoretical background is biopsychosocial. We put great emphasis on the holistic perspective, seeing the person both as a ’’body’’, as an individual, and as part of an inter-

Table 3  Diagnostic set up for female patients.

<table>
<thead>
<tr>
<th>Female patients diagnosis at referral</th>
<th>Physical examination</th>
<th>Laboratory tests</th>
<th>Psychiatric assessment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anorgasmia</td>
<td>Gynaecological examination</td>
<td>Estradiol, FSH, LH</td>
<td>Depression score</td>
</tr>
<tr>
<td>Vaginism</td>
<td>Gynaecological examination</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dyspareunia</td>
<td>Gynaecological examination</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lubrication problems</td>
<td>Vaginal ultrasound Gynaecological examination</td>
<td>Estradiol, FSH, LH</td>
<td></td>
</tr>
<tr>
<td>Lack of libido</td>
<td>Gynaecological examination</td>
<td>Thyroid hormones, androgen hormone profile, prolactin, HgA1c, estradiol, FSH, LH</td>
<td>Depression score</td>
</tr>
</tbody>
</table>
active context with others. When patients are referred, we assess the dysfunction according to the biopsychosocial perspective before deciding on an approach. Often, we work multidisciplinary as co-therapists in order to be able to combine different approaches. We think ourselves very fortunate to have such a great variety of medical and psychological backgrounds within the staff.

**PLISSIT**

Sexologically, we rely on the PLISSIT-model (Annon, 1976) as we find it to be a helpful model when conducting sexological treatment, ensuring "permission" as a basis for all treatment (Fig. 1).

An example of "Limited information" is psychoeducation, which is an important aspect of our work. We thus give information on subjects ranging from contraceptives and lubricants, information about side effects of medication taken by the patient, to biological functions, psychological reactions, and the models concerning lust from both Basson (2000) and Masters and Johnson (1966).

"Specific suggestions" include descriptions of specific positions to enhance erection, or to minimize pain. Other examples are recommendation of lifestyle changes such as reduction of alcohol or tobacco intake, weight loss or physical training. We lend teaching material i.e. DVDs concerning erotic massage, orgasm and arousal.

At this level, we also use the "Triangle of well-being" (Fig. 2). Each side of the triangle represents a part of the couples/individuals life; society, family, and partner. We ask the patients to describe their current situation and to reflect on whether there is a reasonable balance among the three sides or not. If not, we negotiate specific changes that could be made, in order to increase balance in the patients’ life, and perhaps make more room for intimacy.

On the "Intensive therapy" level, we work rather eclectically. Our approach depends very much on the situation and the patient(s), and includes psychodynamic, cognitive, cognitive behavioural and systemic interventions. Usually, it is the psychologist who intervenes at this level. Patients are allocated according to areas of expertise, so that a patient can do gynaecological training with a doctor (i.e. vaginism), and also work with the psychologist on the emotional/relational ramifications of the dysfunction.

**Medical evaluation**

All patients are screened for depression using the Hamilton Rating Scale for Depression (Ham-D scale) in Danish before treatment. The test is mandatory before referral and is thus performed by the patient’s GP.

All patients are controlled for common co-morbidities. At the pre-interview, a detailed medical history is recorded including use of medicine, tobacco, drugs and alcohol. The following is a presentation of the medical evaluations regarding each dysfunction.

**Erectile dysfunction**

The following data on patients with erectile dysfunction are collected to elucidate co-morbidities: physical examination of penis and scrotum, body weight and height, BMI and blood pressure. Blood tests are performed to rule out presence of hyperlipoproteinemia, diabetes, hyperprolactinemia, hypogonadism and prostate cancer. The erectile function is evaluated by using the Erectile Hardness Score (EHS) in Danish as we regard this as a simple tool that quantifies the severity of the problem and is related to successful intercourse (Goldstein et al., 2008). In case of diabetes, the patient is referred to an endocrinologist. Hypogonadotrophy, hypogonadism and hyperprolactinemia is further evaluated by MR scan of the pituitary gland.

**Premature ejaculation**

Thyroid hormones are measured in all men complaining of ejaculatory dysfunctions to rule out hyperthyroidism. The patient’s level of stress and anxiety is evaluated in the pre-interview.
Retarded ejaculation

These patients undergo: physical examination of penis and scrotum including sensitivity tests, body weight and height, BMI and blood pressure. Blood tests are performed to rule out the presence of diabetes or hypothyroidism. If findings are abnormal, the patient is referred to an endocrinologist and if a neurological problem is suspected, the patient is referred to a neurologist.

Hypersexuality

At the pre-interview, these patients (who are mainly men) are evaluated for personality disorders that might be a contraindication for sexological treatment. Also, patients are interviewed about abuse of alcohol or drugs or other addictive behaviour. Androgen hormone profile is checked in male patients.

Hypoactive sexual desire

Referred patients are tested for hypogonadism, hypothyroidism, diabetes and hyperprolactinemia.

Anorgasmia

Hormonal parameters to rule out diabetes and hypogonadism are checked in female patients with anorgasmia, these patients also have a genital exam in which sensitivity in the genital area is tested as well as presence of urinary continence to rule out neurological problems.

Dyspareunia, vaginism

All patients with dyspareunia and vaginism have a genital exam and a vaginal ultrasound preferably performed by one of the two gynecologists at our clinic.

Treatment strategies

All treatment is contract-based, which means that there is always a goal clearly defined and agreed upon by the patient(s). Most patients are assigned homework to be done alone or with the partner. Stress and anxiety caused by the situation is alleviated by the prescription of sensate focus training which forms the sexological backbone of the therapy. It is used as a probe into the patients’ sexual issues and problem solving abilities. Focus is always on the interrelational problems caused by the dysfunction.

Erectile dysfunction

If relevant, the patient is recommended to lose weight, reduce alcohol and tobacco consumption and to exercise. First choice of treatment of erectile dysfunction (ED) is a Phosphodiesterase type 5 inhibitor (PDE-5) inhibitor; sildenafil, tadalafil or vardenafil on-demand commencing at a maximum dose. When coital frequency is expected to be higher than twice weekly, or spontaneity is demanded by the couple, 5 mg tadalafil on a daily base is the choice of treatment. If PDE-5 inhibitor treatment is unsuccessful, the next step is alprostadil intracavernous injections or more rarely referral to a university hospital urology department that can perform penis prosthetic surgery.

Not uncommonly, the partner also reports a sexual dysfunction which needs to be treated.

Premature ejaculation

Treatment is mainly psychoeducative aiming at reducing anxiety and stress. The patient is introduced to the stop-start and/or pause-squeeze technique and is instructed by the therapist to practice this on his own. When he is able to control ejaculation, the partner is instructed to masturbate him in the same way. Nongenital stimulation is part of the therapy. Rarely other treatment is offered such as imipramin 20 mg 2—4 hours before expected coitus.

Delayed ejaculation

Therapeutic strategies involve information, permission to explore sexuality including fantasies and masturbation as some of these patients have a religious upbringing with many taboos. The therapy aims at facilitating the ability to ejaculate in the presence of the partner by gradually decreasing the distance between him and his partner when masturbating. Reciprocal masturbation is an important step towards penetration without ejaculation and finally intravaginal intercourse with ejaculation. Patients who never have experienced an ejaculation when awake usually borrow a medical vibrator (FERTI CARE® personal) to achieve knowledge about sensitive areas of the penis and to recognize pre-ejaculatory sensations.

Hypersexuality

These patients are taught methods to postpone and later to control fulfilment of needs. All these patients are seen by the psychologist. The treatment-approach is basically the same that is used in treating substance-abuse (i.e. alcohol and drugs). Partly helping the patient manage his or her impulses, and also helping them find out what is the cause of this particular pattern, enabling them to cope in other ways. In these cases, it is extremely important that the partner also participates, but often the partner is unwilling to do so, or the patient does not want them to, because the partner only knows the tip of the iceberg, so to speak, regarding the behaviour of the patient (i.e. visiting prostitutes).

Hypoactive sexual desire

Sensate focus training and aversion therapy are often powerful tools in these cases combined with intensive therapy due to the emotional stirring that these exercises may, but do not always provoke. The patients are presented with simplified models concerning lust from both Basson (2000) and Masters and Johnson (1966). The Triangle of well-being is another tool that is beneficial. The three models evoke discussions that help pointing out work areas for the therapy.
This dysfunction often causes a high degree of conflict and distance between couples, doubts and fear of infidelity, so counselling is very important.

**Anorgasmia and lubrication problems**

Menopausal women are prescribed hormonal replacement therapy (HRT). Vaginally-administered estrogen is preferred when dyspareunia, lubrication problems and/or anorgasmia is the main problem in menopausal women. In younger women, the focus is first to exclude physical reasons, which are rare. These women are more accurately pre-orgastic, rather than anorgastic. Treatment in this case contains counselling on masturbation techniques and introduction to vibrators, etc. For lubrication, we recommend silicon-based lubricants or almond oil.

**Vaginism/Dyspareunia**

Some patients referred from a fertility clinic need to be comfortable with vaginal ultrasound and procedures like transvaginal oocyte pickup or intrauterine insemination. These procedures are trained by performing repetitive mock procedures by one of the two gynecologists in the clinic. Every procedure is thoroughly described to the patient before each consultation in order to reach a level of stress that can be accepted by the patient.

Other patients focus on the sexual implications of the diagnosis. Young patients (18–30 years) are offered group therapy. The uptake is continuous, attempting to have a group of eight members. The group thus contains old and new members which gives new members hope and older members the satisfaction of realizing their own advances. The group therapy is highly structured with four 2-hour sessions of physiotherapy in which the participants are taught pelvic anatomy and how to relax pelvic floor muscles. Two group therapists (nurse and doctor) are responsible for the weekly sessions, which are supplemented by couples or individual therapy. The patients are also instructed in use of dilatators. The involvement of the partner is facilitated by his participating in the dilatators training and by doing separate focus training.

**Sexual health and treatment goals**

We put great emphasis on the individual person/couple, in helping them determine what is "right" and "normal" for them.

At the beginning of treatment, patients psyche express a desire to achieve "normality", in the sense that they will be able to have intercourse, maintain an erection, have vaginal orgasms, become aroused with certain intervals, etc. The initial treatment is aimed at establishing a common understanding (or rather discarding) of "normality", and explaining basic sexual functions, in order to be able to reach a common treatment goal.

A very common example, are women who believe themselves to be anorgastic, because they can "only" have clitoral orgasms, and not vaginal orgasms. It is important to note, that all patients are referred by a doctor, so interestingly many doctors must also regard this as inability to achieve orgasm.

This is a very obvious relic from Freud, who claimed that clitoral orgasm was a sign of an immature sexuality, and that only women with the ability of having vaginal orgasms were regarded as mature sexual individuals (Freud, 1905). It is puzzling how such an ancient and erroneous belief can have survived to such a great extent, but none the less, it is an assumption that we very often encounter in the clinic.

For these women, and their spouses, the initial treatment goal for the woman is to be able to have vaginal orgasms, or perhaps determine whether there is something wrong with her, physically, which makes it impossible for her to have vaginal orgasms. When we explain to them, that actually only one quarter to one third of women (Hite (1976), Lloyd (2005)) tend to have vaginal orgasms, and that it is perfectly fine to "only" have clitoral orgasms, they usually react with surprise, disbelief, and finally relief. Many men seem to have the impression, that most of the women they have known have had vaginal orgasms, which is quite interesting of course. Most couples are delighted to find, that there is nothing "wrong" with them, and often further "treatment" is unnecessary. Some couples need specific suggestions as to how they can best include clitoral stimulation in their sexual experience, so the new treatment goal becomes expanding the common sexual repertoire so to speak, or communicating to the partner what they need to enhance the sexual experience.

Another example, are women with vaginism. Often, the initial treatment goal for these couples is to be able to have intercourse, without pain. Most patients achieve the ability to have intercourse. For others, it may become possible, but not without pain, and for a third group, penetration never really becomes an option. Thus, some of these patients gradually have to revise their treatment goal. For a majority of our patients, sex is synonymous with intercourse. They find it very hard, initially, to imagine that they will be able to have a rewarding, satisfactory sex life, without being able to have intercourse. With these patients, we work on the understanding and broadening of sex as a concept. What are the basic needs they wish to fulfill through intercourse, and could these be fulfilled by other sexual activities? Often, we find that the couple eventually revises their treatment goal from "interruption", to "a satisfying sex life". We then help them determine what that is, to them.

In our experience, most patients are highly motivated to talk about their sexuality with us, but that does not necessarily mean that they have ever really talked about it with others, sometimes not even their partner. In some cases, the therapist functions almost as a catalyst; the mere presence of the therapist is often synonymous with a permission to talk about sexuality. In this regard, it is of course a huge advantage that treatment takes place in a public clinic, specifically designed to handle sexual dysfunction. The sign on the door in some respects works as an open invitation. At times, it would seem, the couple speaks to each other through the therapist, not in a negative way, but as if the therapist is a medium through whom the couple can direct their thoughts and questions, and thereby also convey them to their partner, without having to tell their partner directly, initially anyway. In time, couples usually start talking directly to each other, and often express great relief in
having found a common ‘language’ to talk about sexuality. Sometimes, we find that patients simply do not have the vocabulary to talk about sex, and part of the treatment is also finding words that the individual feels comfortable with. We try to be good role models with the vocabulary that we use; direct but never vulgar; no slang, no childish words, no euphemisms, that is what we feel most comfortable with, but we encourage couples to find their own words.

Conclusion and perspectives

In conclusion, treatment goals can be defined very broadly; the overall treatment goal can be said to be for patients to have, what they define, as a satisfying sex life, with themselves and/or others.

But in the process of obtaining that goal, we often have to work through many other layers, such as lack of vocabulary, feelings of shame, guilt, redefinition of ‘normal’, and a limited sense of what sexuality is, other than intercourse. This requires a good therapeutic alliance, a certain amount of psychoeducation, and not least, a good sense of humour! The amount of referrals has proven a large need of having at least two public sexological clinics in Denmark.

The concept of multidisciplinary approach has proven its value in our clinic enabling us to treat a wide spectre of sexual dysfunctions from a true biopsychosocial perspective with the somatic and the psychological aspects working together, and not separated from each other.

Even though, sexology to a large extent has had to reinvent itself, we are pleased to see that it is a rapidly expanding field that is important in its own right, and not just as a part of other areas of expertise. We are thus able to be a professional counterweight to the more unsubstantiated, but very visible figures in the media, since the Health Authorities in Denmark do not authorize sexologists—‘sexologist’ is thus unfortunately not a protected title in Denmark.

The presence of our public sexological clinic facilitates creating a forum in which professionals, primarily GPs and psychologists who deal with problems related to sexuality in their work can be counselled. The clinic is active in providing information to the public about sexuality and sexual dysfunction, for instance through articles in newspapers, journals, appearances on radio, TV, etc., and also through teaching (students as well as professionals).

As sexological treatment in Denmark is centralised, it will be possible to conduct and participate in research in the sexological field.

Conflict of interests statement

None.

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