Sex therapy and counselling

The likelihood that a person will approach a health professional with a sexual problem has increased over the last few years, due to the greater level of openness in society with regard to sexual issues.

However, many patients still find difficulty with discussing sexual problems. If the patient senses any discomfort on the part of the healthcare professional they may not be able to discuss such a sensitive issue.

Healthcare professionals may also be reluctant to pursue sexual issues because they are uncomfortable with the topic, or because they do not feel sufficiently knowledgeable or skilled to address issues that may be raised by the patient.

Effective help therefore depends on providing a comfortable, open and confident environment for the patient to discuss their difficulties and the most appropriate course of management.

How common is sexual dysfunction? (Epidemiology)

- About 40-45% of adult women and 20-30% of adult men have at least one manifest sexual dysfunction.[1]
- A Bandolier study showed lifetime prevalence of sexual problems of 68% for women and 54% for men.[2]
- The prevalence of sexual dysfunction increases with age.
- Erectile dysfunction in men is the sexual dysfunction most studied and is thought to be very common worldwide. One study reported a prevalence as high as 52% in men aged 40-70.[3]
- Increasing physical activity lowers the incidence of erectile dysfunction.[4]

Factors that may be related to sexual dysfunction

- Psychological problems - eg, depression, anxiety, substance abuse.
- Physical ill health in either partner.
- Job or financial stress.
- Relationship or family problems.
- Sexual stress and anxiety.
- Common physical causes of sexual desire issues include:
    - Endocrine - eg:
        - Hypo-oestrogenism.
        - Hypoandrogenism.[5]
        - Hyperprolactinaemia.
        - Hypothyroidism.
    - Medication - eg, antidepressants, anti-androgens.
- Common psychosocial issues include:
    - Religious and family messages.
    - Unwanted sexual experiences.
    - Prior dysfunctional relationships.
    - Current relationship issues - eg, fear of commitment or separation, career, having children, role equity, drifting apart, adaptation to life events, affairs.

Sexual dysfunctions[6]

The International Classification of Diseases 11th edition (ICD-11) defines sexual dysfunctions as syndromes that comprise the various ways in which adult people may have difficulty experiencing personally satisfying, non-coercive sexual activities. Sexual response is a complex interaction of psychological, interpersonal, social, cultural and physiological processes and one or more of these factors may affect any stage of the sexual response. In order to be considered a sexual dysfunction, the dysfunction must:

- Occur frequently, although it may be absent on some occasions.
- Have been present for at least several months.
- Be associated with clinically significant distress.

Assessment of sexual dysfunction

- Define the problem - nature, recent or long-standing, how it relates to the individual and the couple in terms of cause and effect.
- Assess sexual drives of both partners.
- Relationship of couple and social relationships in general.
- Sexual development, including traumatic experiences.
- Psychiatric and medical history, including pregnancies, childbirth, abortions, drugs and alcohol.
- Assess mental state, especially depression.
- Assess the trigger for attendance to seek help and the motivation for treatment.
- Relevant physical examination and investigations, depending on context and likely cause(s) of problem.

Values and attitudes

- Try to develop an honest self-awareness of your own areas of comfort and discomfort with sexual issues.

- It is easy to avoid asking important questions in an area in which we may be uncomfortable. Make a point of addressing such issues in a way that is comfortable for both you and the patient and effective in securing the necessary information.
- Try to refrain from projecting your own values and attitudes on to those of the patient, either verbally or non-verbally. Doing so may reduce the patient's comfort and feeling of acceptance, or introduce inappropriate assumptions into the history.

Talking with patients about sexual issues

- Whenever possible, involve both partners in evaluation and treatment.
- All people may have sexual interests or concerns, including the elderly, the disabled and those with chronic illness.
- Patients may reflect a wide diversity of experiences, values and preferences. Be sensitive to gender and cultural differences but do not assume that any one patient necessarily fits a gender or cultural stereotype.
- It takes courage to disclose a sexual dysfunction or a sexual trauma. Such disclosures must be taken seriously and addressed in a sensitive manner.
- Ensure an environment of confidence and trust. An empathetic approach will convey an attitude of availability and acceptance.
- Ensure clarification that will result in sufficiently specific information and avoid confusion and misunderstanding.
- Be sensitive to the optimal time to ask the most emotionally charged questions.
- Look for and respond to non-verbal cues that may signal discomfort or concern.
- Be sensitive to the impact of emotionally charged words - eg, rape, abortion.
- If you are not sure of the patient's sexual orientation, use gender-neutral language in referring to his or her partner.

- Explain and justify questions and procedures.
- Explain and reassure as you examine.
- Intervene to a level at which you are qualified and feel comfortable.
- Refer to qualified medical or mental health specialists as necessary.

Referral resources

- **Sex therapist** - psychosexual problems, relationship and other psychological issues.
- **Couple therapist** - when relationship issues are a primary contributor to a sexual dysfunction. Relate is the UK's largest provider of relationship support for individuals and couples.[7]
- **Individual psychotherapist** - when depression, generalised anxiety or substance use are major issues affecting the patient.
- **Physiotherapist** - when comorbidity related to pelvic floor tone is diagnosed.
- **Gynaecologist** - if female sexual dysfunction requires specialised evaluation or treatment.
- **Urologist** - if erectile dysfunction requires specialised evaluation and treatment.

Further reading

- Cacchioni T, Wolkowitz C; Treating women's sexual difficulties: the body work of sexual therapy. Sociol Health Illn. 2011 Feb;33(2):266-79. doi: 10.1111/j.1467-9566.2010.01288.x.
- Female Sexual Health Consensus Clinical Guidelines; Journal of Obstetricians and Gynaecologists Canada, December 2017
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4. Lamina S, Agbanusi E, Nwacha RC; Effects of aerobic exercise in the management of erectile dysfunction: a meta analysis study on randomized controlled trials. Ethiop J Health Sci. 2011 Nov;21(3):195-201.
5. Guidelines on the management of sexual problems in men: the role of androgens; British Society for Sexual Medicine (December 2010)
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