

Let's talk about sex



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Background

As sexual wellbeing is an important aspect of good general health, and sexual difficulties are a concern for 20–40% of the adult population, general practitioners (GPs) have a key role to play in initiating discussions about sex and sexual difficulties with their patients.

Objective

This article encourages GPs to take the lead in initiating a conversation about sex and sexual difficulties with their patients by taking a brief sexual history as a routine part of a medical history. If any sexual concerns are identified, a longer appointment can be arranged for a detailed history and examination, and to discuss treatment options, including referral.

Discussion

Sexual difficulties are common and can affect a patient's quality of life. There is a high risk of sexual difficulties arising from illness, medication, and personal and relationship difficulties. Erectile dysfunction is particularly important to identify as it is a predictor of cardiovascular and other microvascular disease.

Sexual difficulties (Box 1), while common, often go untreated. Surveys indicate that doctors and patients are reluctant to talk about sexuality and sexual concerns^{1–4} (Box 2); however, these ought to be assessed, as would any other health issue. People with disabilities or in same-sex relationships may be even more reluctant to talk about these problems, especially if they sense doctor discomfort. The importance of assessing and treating sexual problems associated with chronic disease is now considered to be an important part of holistic care.⁵

A brief sexual history (Box 3), taken as part of a medical history with new patients, during preventive health checks or as part of a review of chronic illnesses lets patients know that their doctor is willing and able to talk to them about sex and offer treatment for sexual difficulties or referral if needed. The doctor's awareness of the many factors that can affect a healthy sex life helps frame this discussion (Box 4).

Patients often believe there must be a medical cause if they have sexual problems. They feel as if they want to have sex but cannot, causing frustration for them or their partner. They may, therefore, request medication or other treatment to 'fix it'. However, because sexual symptoms can be the bodily expression of many sorts of distress, biological, psychological, sociocultural and relationship factors need to be considered.^{6,7}

Box 1. Sexual difficulties

Female sexual difficulties

- Painful intercourse – Deep dyspareunia/vaginismus: one in 10 women
- Lack of libido (DSM-5: FSAD): four in 10 women
- Anorgasmia: one in three women

Male sexual difficulties

- Erectile difficulties: one in five men
- Premature/delayed ejaculation: one in four men
- Lack of libido (DSM-5: MHSDD): one in four men
- Anorgasmia
- Concerns about penis

DSM-5, Diagnostic and Statistical Manual of Mental Disorders, fifth edition; FSAD, female sexual interest/arousal disorder; MHSDD, male hypoactive sexual desire disorder

The psychosexual consultation

The patient's psychosexual history (Box 5) helps us understand the meaning of the presenting symptom, with the symptom investigated in the context of the patient's life. Medical issues are addressed, and an examination offered. Other questions relate to the patient or couple, not just what isn't working; when there are problems, patients are often preoccupied with what isn't happening, and intimacy is lost. Advantages and disadvantages of behavioural and medical treatment (symptomatic treatment) are discussed. The treatment offered should go beyond the

Box 2. Reasons for reluctance to discuss sexual difficulties

Why patients don't tell their doctors about sexual difficulties

- Shame, embarrassment
- Believe the problem is part of age/illness/medication
- Feel distressed by/disgusted with their body (eg following prostatectomy, mastectomy, colostomy)
- Unaware that treatment is possible
- Sensitive to doctor's reluctance to talk to them about sexual difficulties

Why doctors don't ask patients about sexual difficulties

- Sexual history was not included in a traditional medical history
- Knowledge: Little teaching about sexuality and sexual difficulties in medical school
- Knowledge: About certain sexual issues and treatment possibilities beyond medication
- Lack of time: Investigating a sexual problem takes time
- Worry about offending the patient
- Stereotyping: Doctor thinks patient is too old, sick, or disabled for sex
- Doctor with untreated sexual difficulties may find it harder to talk about sexual difficulties with patients

Box 3. Brief sexual history as routine part of medical history: Sample questions

1. 'How are things going sexually? Any worries with your relationship or sex life?'
2. 'Have you had any difficulties with erections or anything else to do with sex?'
3. 'It's not uncommon for men of your age/with your condition (eg diabetes/high blood pressure/depression/cancer/chronic disease) to have problems with erections. It's also common when men are feeling stressed. If you have any problems, it's important you tell me. Treatment can improve your health and quality of life.'
4. 'It's not uncommon in a new relationship/with a new baby/after a difficult childbirth/around menopause/as you get older to experience sexual difficulties. Pain can be a problem, or changes in your level of interest in sex. If you have any concerns, it's important that you tell me because sexual difficulties can put stress on your relationship and affect your quality of life, and there are treatments available.'

If there are problems, make a longer appointment to allow time for a full psychosexual history and examination, to order relevant tests and discuss treatment options.

symptomatic to address the causes of the difficulty. This avoids the problem of one sexual symptom leading to another if medication or behavioural methods alone are used to eliminate symptoms. While medication can improve a symptom regardless of cause, drugs do little to boost self-confidence or improve relationships. Furthermore, drugs are not always effective. If the patient is part of a couple, both partners should be invited to discuss treatment options because both are affected.

Part 1: Factors affecting sexuality

Sexuality is a fundamental aspect of every human being. Although some think that people who are older, sick or disabled are – or should be – asexual, with no sexual feelings, desire or need for sexual expression, these people are no different in their desire for intimate physical connection. This is also true for people who have had surgery that affects sexual function, such as radical prostatectomies, and those who have had spinal cord injuries that affect sexual function.⁸

A recognition of the erotic potential of the whole body was articulated by a young man many years after a spinal cord injury in which he lost sensation and movement from the waist down, including the ability to have an erection. He said:⁸

I felt asexual for a long time because a man's sex was supposed to be in his penis, and I couldn't feel my penis. It didn't occur to me that it felt good to have my arms stroked ... I learnt ... I don't have to do anything with my genitals to have sex.

This does not, however, deny the unique connection that penetrative sex can offer.⁹

Sexual pleasure

Sexual enjoyment for partners in long-term relationships requires more than the functioning body parts needed for casual sex, with its emphasis on performance. Enjoying life together and dealing with differences and conflict create the context for a lively relationship and enjoyable sex over time.¹⁰ While behavioural and medical models have penetrative sex as the main goal,¹¹ their phallogocentric definition of 'normality' excludes the sexuality of female same-sex relationships and the majority of heterosexual women who have a broader definition of intimacy and sexual connection than penetrative sex. Mutual affection and the physicality of sex are both important.

Of interest is that older people in new relationships often have active sex lives, just as do younger people in new relationships, suggesting that interest, not age, is the more important factor with 'libido'.

Psychosomatic disorders

Psychosexual difficulties belong to a group of conditions known as psychosomatic (mind–body) disorders. When patients feel so distressed that they cannot think (psyche) or talk about their feelings, their body (soma) expresses feelings of pain, fear, inadequacy or resentment via a symptom. Colloquially, the body

'does the talking' when the person cannot. This is similar to the communication of pre-verbal infants, who, unable to speak, cry out to let us know something is wrong, but their cry needs to be understood for the correct remedy to be offered.¹²

Sexual symptoms can be confusing. The symptom is located in one person's body (the patient's), and can be a result of medication or disease, but is often due to 'dys-ease' caused by painful feelings about sex or reflecting difficulties between partners. Even when the symptom is a result of disease, patients and their partners may need help dealing with what the sexual symptom means for each of them and what they want to do about it. Treatment consists of learning to talk about uncomfortable feelings. The conscious recognition (mind/psyche) of painful feelings frees the body (soma) from the need to show distress via symptoms¹³ and makes it possible to deal with underlying problems.

Medication

Sexual difficulties can result from medication, including antihypertensives, antidepressants and antipsychotics. Cigarettes, alcohol, methadone and non-prescription drugs (eg antihistamines, topical vaginal medications) can also cause sexual difficulties. If symptoms start around the same time as the commencement of a new medication, the medication

Box 4. Factors affecting sexuality

1. Background: Culture, religion, family attitudes to sex
2. Response to menarche, menstruation, pregnancy, menopause, ability to use tampons, or response to wet dreams
3. Sexual beliefs (eg is it permissible for female to initiate or say no to sex?)
4. Previous history of trauma, especially sexual or physical abuse, traumatic vaginal examinations
5. Painful birth, episiotomy, infertility and its treatment, termination, miscarriage, stillbirth
6. Ability to accept idea of pleasurable response to self-stimulation
7. Surgery that may affect body image: Mastectomy, hysterectomy, radical prostatectomy, ileostomy/colostomy. Effect on self or partner
8. Severe illness: Diabetes, hypertension, cancer, arthritis, any chronic illness
9. Life stage (eg anxiety at the start of a relationship [typical symptoms are premature ejaculation and vaginismus], exhaustion with young children ['lack of libido'], menopause and midlife, older age). These are ordinary life stages but are profoundly important psychologically
10. Suitable contraception
11. Physical setup – Is there privacy?
12. Emotional relationship with partner – Respect for partner and self
13. Medication – Prescribed or recreational
14. Are intercourse or sexual relations not desired, physically painful or problematic for either partner?

Considering these factors helps us begin to understand what life and family circumstances may have contributed to the individual's/couple's presentation.

should be suspected of causing the sexual symptom until proven otherwise.¹

Sexual abuse and sexuality

Patients with a history of sexual abuse, especially those who have not had therapy to deal with the abuse, may present with sexual difficulties. They may experience intense pain, guilt, fear or disgust with sex. Some have difficulties becoming aroused or enjoying touch, even when they are in a good relationship with their partners. Some feel emotionally distant during sex, or have disturbing and intrusive thoughts and fantasies.¹ Others, who have dissociated from their bodies, may have multiple partners if they (unconsciously) let their body be used as it was in the past.

Box 5. Psychosexual history, examination and tests

Aim: To understand the symptom in the context of the patient's life

Patient describes the problem and their understanding of it

Symptom: Sudden/gradual onset; every time/specific situations/specific partner

Previous treatment and outcomes

General history

- Brief outline of life history, including family life, school, friendships, work
- Medical history, in particular diabetes, alcohol abuse, high blood pressure, smoking, chronic diseases
- Surgical history, in particular pelvic surgery, mastectomy
- Prescribed and recreational drugs (eg antidepressants, antipsychotics, marijuana)

Sexual and relationship history

- How did the patient find out about sex?
- Parents' attitudes to sex (cultural, religious, family attitudes). Were their parents affectionate to each other?
- Sexual history: any recurrent difficulties, context in which they occurred, if there have been situations that have been symptom-free
- History of physical abuse, childhood sexual abuse, adult sexual trauma, including painful vaginal examinations
- Current situation: what's life like now (home life, relationship, work, any problems they perceive)
- Why has the patient come now? They may have had the symptom for years
- Partner involvement and cooperation

Specific questions for same-sex couples²³

- The coming-out history, including any negative messages
- Medical concerns, including human immunodeficiency virus (HIV) status
- Family and community support

Examination

Female: general medical/gynaecological check-up/vaginal examination if relevant

Male: blood pressure, heart rate, waist circumference, pulses, urogenital, focused neurological

Tests

Fasting glucose, cholesterol/lipid profile, full blood evaluation

If indicated: liver function test, testosterone, prolactin, luteinising hormone, thyroid-stimulating hormone, urinalysis

In order to develop enjoyable adult sexual relationships, survivors need to be able to differentiate between what is happening now by choice and what was happening then by coercion. They need to learn to feel good about their bodies and sexual feelings in spite of the abuse. They need to avoid sexual behaviours that undermine the healing process, especially obligatory sex, which by definition mimics abuse dynamics. It is also helpful to identify triggers.¹

Life changes

Sexual difficulties are more likely to occur at times of major life changes, such as at the start of sexual experience with a new partner, after marriage or the birth of a child, or around menopause. Sexual difficulties are also more common when there are illnesses or other stresses, because sexuality is affected by the way people feel in the rest of their lives.¹⁰

Part 2: Sexual difficulties

Erectile difficulties

One in five men over the age of 40 years has erectile dysfunction,^{14,15} and one in 10 are completely unable to have erections. Because erectile dysfunction is a predictor of cardiovascular and other microvascular diseases, including diabetes and kidney disease, depression and alcoholism, it is important to ask about erectile difficulties. When there is a medical cause, the onset is usually gradual and early morning erections may be lost.

Diagnosing erectile dysfunction provides an important opportunity to screen for risk factors (eg smoking, obesity, hyperlipidaemia, hypertension). Routine tests include glucose, cholesterol and testosterone levels. Other tests are only done when there are specific indications.¹⁴

Stress-related erectile dysfunction usually starts around the time of the stressor. With erections inextricably linked to feelings of masculinity, potency and self-worth, erectile dysfunction is associated with feelings of shame, inadequacy and loss. Even when erectile dysfunction is a result of medical issues or medication, the associated feelings need to be addressed.

Phosphodiesterase type 5 (PDE5) inhibitors such as sildenafil, are often prescribed as first-line treatment. Medication can be useful for occasional difficulties or for men having casual sex when performance is their main concern. However, only 50% fill a second script and only about 30% still use them after 6–12 months.¹⁶

Premature ejaculation

Premature ejaculation affects 20–40% of men.¹⁷ There are no medical causes, though some speculate that lifelong rapid ejaculation may have a genetic component. The physiological problem is a lack of ejaculatory control,¹⁸ causing distress for one or both partners, and these men feel inadequate. While dapoxetine is commonly prescribed because it increases intravaginal ejaculatory latency time (IELT) when compared with

placebo,¹⁷ it may not delay it enough, especially when IELT is less than one minute. Some authorities still suggest reducing penile sensation using local anaesthetic gel or double condoms,¹⁴ or PDE5 inhibitors to allow erections to continue after the man has ejaculated, but these methods are counterproductive because they reduce sexual pleasure.

Treatment options include psychosexual therapy alone, or in combination with behavioural therapy ('stop–start' techniques) or dapoxetine.

Lack of libido

The Diagnostic and Statistical Manual of Mental Disorders, fifth edition (DSM-5) defines lack of libido in women as sexual interest/arousal disorder (FSAD), and in men as male hypoactive sexual desire disorder (MSHDD). Sexual interest can be affected by illness, medication, hormonal change and fatigue. More commonly, it is affected by relationship issues. When patients say that everything is 'fine' with a partner who has brought them for treatment, there may be unconscious anger or resentment. This is especially so when their partner wants sex, but is not interested in non-sexual intimacy. The relational aspect of this medicalised diagnosis is borne out when a patient is not interested in sex with their 'appropriate' partner, but is sexually interested in someone else.

If sexual difficulties such as premature ejaculation, erectile dysfunction or vaginismus are only treated symptomatically with medication or behavioural techniques, patients may later present with a lack of libido, indicating that underlying personal or relationship issues have not been resolved.

Pain with sex

Women who experience deep pain with intercourse need a gynaecological referral to assess pelvic pathology. Women with vaginismus experience pain with penetration or are unable to tolerate penetration. On examination, they have vaginal spasm. Most enjoy intimacy and may orgasm.

Penetration may be consciously desired but experienced unconsciously as forced entry. The tightening of vaginal muscles is a self-protective mechanism as these women are (unconsciously) afraid of being hurt.

The physical pain and tightening reflect painful feelings that need to be addressed (eg from childhood sexual abuse, previous painful vaginal examinations, local pelvic pathology). Doctors often refer women with vaginismus to specially trained physiotherapists to teach them about their anatomy and physiology. Using vaginal trainers to help them tolerate insertion of increasingly sized dilators is currently the most widely used treatment.¹⁹ This is a form of behaviour therapy (systematic desensitisation). While this may be enough in simpler cases, it does not address the fear of penile penetration,²⁰ and what that means to the woman, or any relationship difficulties that may need to be addressed.

A biopsychosexual approach uses the physical ('What does it feel like?') to explore the subjective experience ('What is it like for you?'). In sessions, the patient learns to talk about painful physical sensations and painful emotional experience – what hurts in her body and her life.

Anorgasmia

Anorgasmia is often associated with a difficulty in relaxing or 'letting go', sexually and more generally. While up to a third of women never experience orgasm, many enjoy their sexual relationship despite this. Others become orgasmic in their 30s or 40s as they become more confident in themselves and their sexuality.

Conclusion

The psychosexual framework considers the symptom in the context of the patient's life. It helps patients understand the meaning of the symptom, and acknowledge and deal with the challenges in their lives. The use of medication as first-line treatment has often been based on unrealistic and inaccurate patient and clinician expectations of its benefits.^{21,22} While medical and behavioural treatments sometimes alleviate symptoms, and can be useful in simpler situations, treatment aims are sexual pleasure as well as the ability to function sexually.

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