Sexual dysfunctions and sex therapy

The role of a general practitioner

CPD

Vijayasarathi Ramanathan,
Margaret Redelman

Background
Medical management is undeniably an important therapeutic intervention for selected sexual dysfunctions, but it does not serve as a stand-alone approach to treat many common sexual dysfunctions such as lack of interest in sex, sexual performance anxiety, inability to reach orgasm or too quick an orgasm.

Objective
The aim of this article is to highlight the role of general practitioners (GPs) in recognising sexual problems, encourage initiation of conversation about sexual dysfunction with patients and raise awareness of sex therapy and presentations that may benefit from referral to sex therapists.

Discussion
GPs in Australia have a significant role in addressing sexual health concerns despite practice-related and doctor–patient-related barriers, thereby promoting the healthy sexuality of Australians. Sex therapy is a specialty comprised of various medical, cognitive, emotional and behavioural interventions. Sex therapists, who are healthcare professionals with tertiary training in human sexuality, can share care with GPs to help individuals and/or couples understand, improve and resolve their sexual dysfunctions.

HEALTHY SEXUAL FUNCTION within one's expected norm and desire for sexual activity is an important aspect of sexual health.[1] According to the American Sexual Health Association, sexual function is the ability to experience sexual pleasure and satisfaction when desired. It is an important component of quality of life (QoL) as it is associated with physical and mental wellbeing and relationship satisfaction (if applicable).[2] Sexual function is influenced by a person's biology (physical and physiological), psychology (feelings and thoughts) and society (interpersonal, cultural, literacy and contextual factors).[3] The importance of sexuality varies between people and fluctuates in individuals' lives. It is important to understand the patient's needs and not impose a burden of expectation that the patient does not want. However, as sexuality is often viewed as intercourse, there is room to introduce patients to a broader sexuality involving outercourse, masturbation/self-pleasure and sensual touch. This fits well with ageing, chronic or disabling diseases and disabilities.

Nomenclature is not standardised well in the field of sexuality. 'Sexual problem' is an umbrella term to refer to sexual concerns, sexual difficulties, sexual dysfunctions and sexual disorders. A useful distinction between the two most commonly used terms is a time factor, with a sexual difficulty lasting <6 months and a sexual dysfunction lasting >6 months. In Australia, there are research data on sexual difficulties, but not on sexual dysfunctions, collected from a large national representative sample of approximately 20,000 adult men and women. According to the 2013 Australian Study on Health and Relationships, lack of interest in sex was the single most common sexual difficulty for both men and women.[4]

Sexual dysfunctions have many mediating factors including psychological and sociocultural factors, lifestyle factors and health (especially obesity, sleep disorders, anxiety, depression, chronic disease and side effects of medications).[5] Erectile dysfunction can precede cardiovascular symptoms by 2–3 years and cardiovascular events by 3– 5 years.[6,7] Therefore, paying attention to sexual function is relevant to broader health outcomes and an opportunity for aggressive intervention. For optimal management of sexual dysfunctions, biomedical management options are an important therapeutic intervention but cannot serve as a 'stand-alone' intervention.[8]

In Australia, general practitioners (GPs) play a key part in initiating discussions about sex and sexual difficulties with their patients; however, there are barriers between patients and GPs that make it difficult for both to commence the discussion.[9] This article's intention is three-fold: 1) to highlight the vital role of a GP in recognising sexual problem(s) in their patients; 2) to provide some practical guidance on how to initiate a conversation about sexual dysfunctions with their patients and 3) to raise awareness about 'sex therapists' and the significance of sex therapy in the optimal management of

common sexual dysfunctions. Sex therapy techniques and strategies for specific sexual dysfunction are beyond the scope of this article.

The role of a general practitioner in recognising sexual problems

Sexual dysfunction is considered a medium priority by GPs,[1] and sexual dysfunctions are not a common problem managed by Australian GPs.[10] Yet, continuity of care in a good and trusting relationship places the GP in an ideal position to initiate a discussion about sexual problems, when relevant, but also to assess and plan the interventions and follow-up needed to ensure that sexual problems are addressed, ameliorated as possible and potentially resolved. GPs can find addressing sexuality issues difficult for many reasons categorised as doctor barriers (lack of knowledge/training), patient barriers (sense of embarrassment), doctor–patient interaction issues (different genders, cultures, ages) and contextual concerns (lack of time).[11–13] All the above mean that sexual communication between individuals, and individuals and GPs does not consistently address patients' sexual concerns. This can significantly affect the QoL of patients with flow on effects to relationships, family life and productivity in society. Another aspect of this field is helping patients navigate sexuality in difficult circumstances. One example of this is when a partner dies and the surviving partner seeks new relationships in a changed environment, especially regarding sexually transmissible infections. Alternatively, a partner may have moved into a facility that has strict rules for enabling/permitting sexuality.

Sexual dysfunctions: General practitioners and the PLISSIT model

GPs who are not trained in sexual medicine/sex therapy but would like to address sexual (dys)function issues with their patients can use different stages of the Annon's PLISSIT model (Permission, Limited Information, Specific Suggestions and Intense Therapy; Box 1).[14] Each level requires greater knowledge, confidence and counselling skills. The first two stages (Permission and Limited Information) are highly applicable in the general practice setting for the management of sexual dysfunction.

Permission

GPs can raise the topic of sexual concerns directly or indirectly. Ways in which practices can make it easier for patients to raise the issue of sexual function include having sexuality-positive posters in the waiting room and/or a notice on the GP's desk indicating that they are happy to discuss sexual concerns. Humour may also assist with lowering sexual anxiety; however, it must be appropriate to the doctor–patient relationship and context. It is also important to include questions related to sexual function in routine history-taking for other medical conditions, especially cardiac function, diabetes and depression. In this way, the message is clearly given that the GP considers sexual function important and relevant. Consequently, when the patient has a sexual concern, they are likely to be more comfortable raising it. In the direct approach, the GP introduces questions about the patient's sexuality as part of routine history-taking. They may ask, 'Have you noticed any changes with your sexual function?' or state, 'We know that sexual problems are sometimes experienced by patients/with these sort of conditions/taking these medicines' etc. By doing so, it establishes that it is appropriate to discuss sexual matters in that consultation and, more importantly, expresses the GP's willingness to clarify any doubts, answer questions and/or initiate treatment. A 2017 article authored by Goodwach provides a good framework and a list of questions to initiate discussion about sexual difficulties as part of routine medical history.[9] While elements of sexuality (and sexual difficulty) differ from that of a general history, the practice of history-taking is one of the core strengths of a GP.[11] The initial embarrassment/discomfort of doing something new quickly becomes confidence and habit when the patient's appreciation of the doctor raising an important issue is shown and positive benefits follow.

Limited Information

It is not uncommon for patients to be influenced by misinformation about sexual functioning and misled by claims about 'normalcy' and 'quick fixes' that in turn could precipitate or perpetuate sexual problems. This second step involves providing factual and sometimes statistical information about healthy sexual function or dysfunction in a customised way using a 'question and answer' style, bearing in mind the patient's health literacy level. For example, a male patient whose intravaginal ejaculatory latency time (IELT) is approximately seven minutes could be distressed by the fact that he has no control over his ejaculation and wonder whether it could be due to some underlying medical problem on the basis of his limited sexual knowledge obtained from pornography. A GP could address this patient by reassuring him that the normal range of IELT in men is between two and six minutes, and that his ejaculatory experience (subjective premature ejaculation) is not related to a medical condition.[15] Many sexual problems are not caused by specific sexual dysfunction in a patient but are due to interpartner misconceptions, assumptions and outcomes. This conversational and collaborative approach with the patient can be therapeutic in its own way as it can generalise/normalise some of the concerns that the patient has, which may be all that is required. There can be a gradation of involvement in addressing the sexual dysfunction, but the most important step is raising the issue with the patient and thereby signalling that it is a valid, legitimate area of medical concern that can

Box 1. The PLISSIT model to help the physician conceptualise their approach[14]

1. Permission: take a pro-sexual stance and encourage sexual questions and concerns
2. Limited Information: give scientifically validated information in the framework of a biopsychosocial approach to sexual problems
3. Specific Suggestions: provide basic information about addressing the most common sexual problems
4. Intense (sex) Therapy: refer to a qualified sex therapist and, in most cases, reinforce the couple approach (where applicable)

be addressed with a GP. Then – depending on personal inclination, time, experience and education – the matter can be dealt with by the GP and/or referred for sex therapy.

What is sex therapy? Who are sex therapists?

Psychosexual therapy, commonly referred as sex therapy, is a specialty comprised of cognitive-behavioural interventions, mindfulness techniques, systems/couple interventions and psychotherapy. The aim of sex therapy is to help individuals and couples understand, improve and resolve their sexual difficulties. These difficulties can involve performance anxieties, arousal and orgasmic difficulties, sexual pain, fear or aversion to sexual behaviour or relationship issues; these can be influenced by family of origin and past and present sexual experiences.

Sex therapy is not a panacea solution for achieving idealised sexual performance. Rather, it aims to restore as much functional capacity as possible, using multifaceted strategies to facilitate satisfying long-term sexuality. Patients are given education, strategies and exercises to do at home. Some of the common issues treated with sex therapy include lack of interest in sex, desire discrepancy between two individuals and the fallout from this difference, erectile dysfunction, painful penetration, vaginismus, past sexual abuse, concerns relating to gender identity and sexual orientation, orgasm difficulties, fear and anxiety about sexual performance and concerns about penis size or specific sexual behaviour. Patients may have preconceived incorrect ideas about sex therapy, such as believing that sex therapy involves some form of physical/sexual contact with the therapist during the session, which in turn may stop patients from accessing sex therapy. A GP can clarify such misconceptions, explain that sex therapists are professionals who deal with human sexuality and its problems, and/or refer patients to appropriate websites that contain detailed information about the profession and sex therapists' code of practice. Fee structure, concession for Health Care Card holders and access to bulk billing or private health insurance varies among sex therapists depending on their primary profession.

Ideally, sex therapists should be healthcare professionals with some training in human biology, physiology, psychology and individual and couple counselling; psychotherapy skills; and a specific tertiary qualification/training in human sexuality. In addition, sex therapists should have undergone values and attitudes reassessment training to provide inclusive care. Gender, age, cultural background and sexuality of a sex therapist are not relevant in terms of provision of professional care, although the specific preference of the patient should be taken into account.

In Australia, sex therapy is not a recognised professional category with standardised professional accreditation and registration to protect patients. This means that anyone can call themselves a sex therapist/sexologist. The primary/referring health professional needs to take on the responsibility of ensuring that the referral is to an appropriate, professionally competent sex therapist. The Society of Australian Sexologists (SAS) is the professional body representing sexologists across Australia. ASSERT NSW is a similar organisation in NSW.

In Australia, Sydney University and Curtin University in Perth provide postgraduate programs in sexology and sexual health. Both universities work collaboratively with the national professional body (SAS) to establish and evolve professional standards of sexologists in Australia. Self-education through reading, attending relevant workshops, talks and conferences, and membership of SAS or ASSERT NSW provide a segue into this field. A list of useful professional and patient resources is provided at the end of this article.

Conclusion

Sexual functioning is a multifaceted process that requires coordinated functioning of many body systems and an adequately healthy state of mind and emotions.[16] Effective, holistic medical care includes addressing sexual health concerns. This has a major role in the QoL of patients and their intimate partners. However, when a sexual problem is addressed in a suboptimal or rushed manner (whether it be during a medical intervention or sex therapy), the impact can be detrimental to the individual/couple. It can result in a relapse of the sexual problem[17] and/or trigger new sexual/non-sexual problems.

It is important to emphasise that no one needs to be an expert in sexual medicine to provide meaningful care. Most patients simply need a health practitioner who is aware of the sexual aspects of lifestyle factors and medical conditions, as well as sexual side effects of medications; inquires about sexual changes and problems; provides proper information and explanations to reduce anxiety; and prescribes an appropriate medication and/or makes an appropriate referral to a sex therapist. Patients need recognition of their basic right to remain a sexual being despite disease, disability or ageing, and GPs have a significant role in this area of medicine/health. In fact, one of the most important aspects that the GP can provide is acknowledgement that a sexual dysfunction is a valid area of concern and that help is available.

Key points

- GPs play a significant part in recognising the need and appropriate timing to address sexual problems and initiate sex-related discussions with their patients.
- Considering partners, when applicable, in the management of sexual dysfunctions is of great clinical relevance and importance because when one partner has a problem, then two individuals have a problem.
- GPs can choose the extent of their clinical involvement (bearing in mind the PLISSIT model) to correspond with their capabilities and time constraints.
- Sex therapy aims to restore as much functional capacity as possible.
- Sex therapists are healthcare professionals who manage various sexual problems, and the website of professional bodies hosts a list of certified sex therapists in addition to their qualifications/credentials.

Resources

- Textbooks
  - Wylie K, editor. ABC of sexual health. 3rd edn. Chichester, WS: John Wiley & Sons, 2015.
  - Howard JR. Helping people with sexual problems. Hawthorn East, Vic: IP Communications, 2010.
- Referral information
  - The Society of Australian Sexologists, www.societyaustraliansexologists.org.au
  - ASSERT NSW, www.assertnsw.org.au
- Websites
  - Professional updates: European Society for Sexual Medicine, www.essm.org
  - Patient resources: International Society for Sexual Medicine, www.issm.info

Authors

Vijayasarathi Ramanathan MMed, GDipSexHlth, PhD, FECSM, Lecturer in Sexual Health, Faculty of Medicine & Health, University of Sydney, NSW; President, Society of Australian Sexologists, NSW.
vijay.ramanathan@sydney.edu.au

Margaret Redelman OAM, MBBS, MPsychotherapy, Medical Sex Therapist, The Male Clinic, NSW

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References

1. Humphery S, Nazareth I. GPs' views on their management of sexual dysfunction. Fam Pract 2001;18(5):516–18. doi: 10.1093/fampra/18.5.516.
2. Mitchell KR, Mercer CH, Ploubidis GB, et al. Sexual function in Britain: Findings from the third National Survey of Sexual Attitudes and Lifestyles (Natsal-3). Lancet 2013;382(9907):1817–29. doi: 10.1016/S0140-6736(13)62366-1.
3. Brotto L, Atallah S, Johnson-Agbakwu C, et al. Psychological and interpersonal dimensions of sexual function and dysfunction. J Sex Med 2016;13(4):538–71. doi: 10.1016/j.jsxm.2016.01.019.
4. Richters J, Visser RO, Rissel CE, Simpson J, Grulich AE, Smith AMA. Sex in Australia: Sexual difficulties in a representative sample of adults. Proceedings of the 42nd annual meeting of International Academy of Sex Research, 29 June 2016; Malmo, Sweden.
5. Schlichthorst M, Sanci LA, Hocking JS. Health and lifestyle factors associated with sexual difficulties in men – Results from a study of Australian men aged 18 to 55 years. BMC Public Health 2016;16(Suppl 3):71–80. doi: 10.1186/s12889-016-3705-6.
6. Jackson G, Boon N, Eardley I, et al. Erectile dysfunction and coronary artery disease prediction: Evidence–based guidance and consensus. Int J Clin Pract 2010;64(7):848–57. doi: 10.1111/j.1742-1241.2010.02410.x.
7. Billups KL. Erectile dysfunction as an early sign of cardiovascular disease. Int J Impot Res 2005;17 (Suppl 1):S19–S24. doi: 10.1038/sj.ijir.3901425.
8. McCarthy B. Sex made simple: Clinical strategies for sexual issues in therapy. Eau Claire, WI: PESI Publishing & Media, 2015; p. 1–11.
9. Goodwach R. Let's talk about sex. Aust Fam Physician 2017;46(1):14–18.
10. Cooke G, Valenti L, Glasziou P, Britt H. Common general practice presentations and publication frequency. Aust Fam Physician 2013;42(1–2):65–68.
11. Ross MW, Channon-Little DL, Rosser BRS, editors. Sexual health concerns: Interviewing and history taking for health practitioners. 2nd edn. Sydney: MacLennan & Petty, 2000.
12. Dyer K, das Nair R. Why don't healthcare professionals talk about sex? A systematic review of recent qualitative studies conducted in the United Kingdom. J Sex Med 2013;10(11):2658–70. doi: 10.1111/j.1743-6109.2012.02856.x.
13. Nusbaum MRH, Gamble GR, Pathman DE. Seeking medical help for sexual concerns: Frequency, barriers, and missed opportunities. J Fam Practice 2002;51(8):706.
14. Annon JS. Behavioral treatment of sexual problems: Brief therapy. Hagerstown, MD: Harper & Row Medical Department, 1976.
15. Waldinger DM. Problems of ejaculation and orgasm in the male. In: Wylie K, editor. ABC of sexual health. 3rd edn. Chichester, WS: John Wiley & Sons, 2015; p. 73–76.
16. Bronner G, Korczyn AD. The role of sex therapy in the management of patients with Parkinson's Disease. Mov Disord Clin Pract 2017;5(1):6–13. doi: 10.1002/mdc3.12561.
17. McCarthy B, McDonald D. Sex therapy failures: A crucial, yet ignored, issue. J Sex Marital Ther 2009;35(4):320–29. doi: 10.1080/00926230902851330.