

SEXUALITY AND PRIMARY HEALTHCARE: HOW CAN WE TALK ABOUT SEX?

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No approach in medical care deserves the term holistic as long as sexuality has not been addressed.

-Woet Gianotten, Nice - 2017



AGENDA

- Why humans have sex?
- The importance of sex
- Sexual Health
- Sexual Dysfunction and mortality
- Consultation setting
- Tools
- Take-home messages
- Bibliography

WHY HUMANS HAVE SEX?

Arch Sex Behav (2007) 36:477–507

DOI 10.1007/s10508-007-9175-2

ORIGINAL PAPER

Why Humans Have Sex

Cindy M. Meston · David M. Buss

237 reasons!

4 main factors

13 sub-factors

Physical:

- Stress reduction
- Pleasure
- Physical desire
- Experience seeking

Goal Attaining:

- Resources
- Social Status
- Revenge
- Utilitarianism

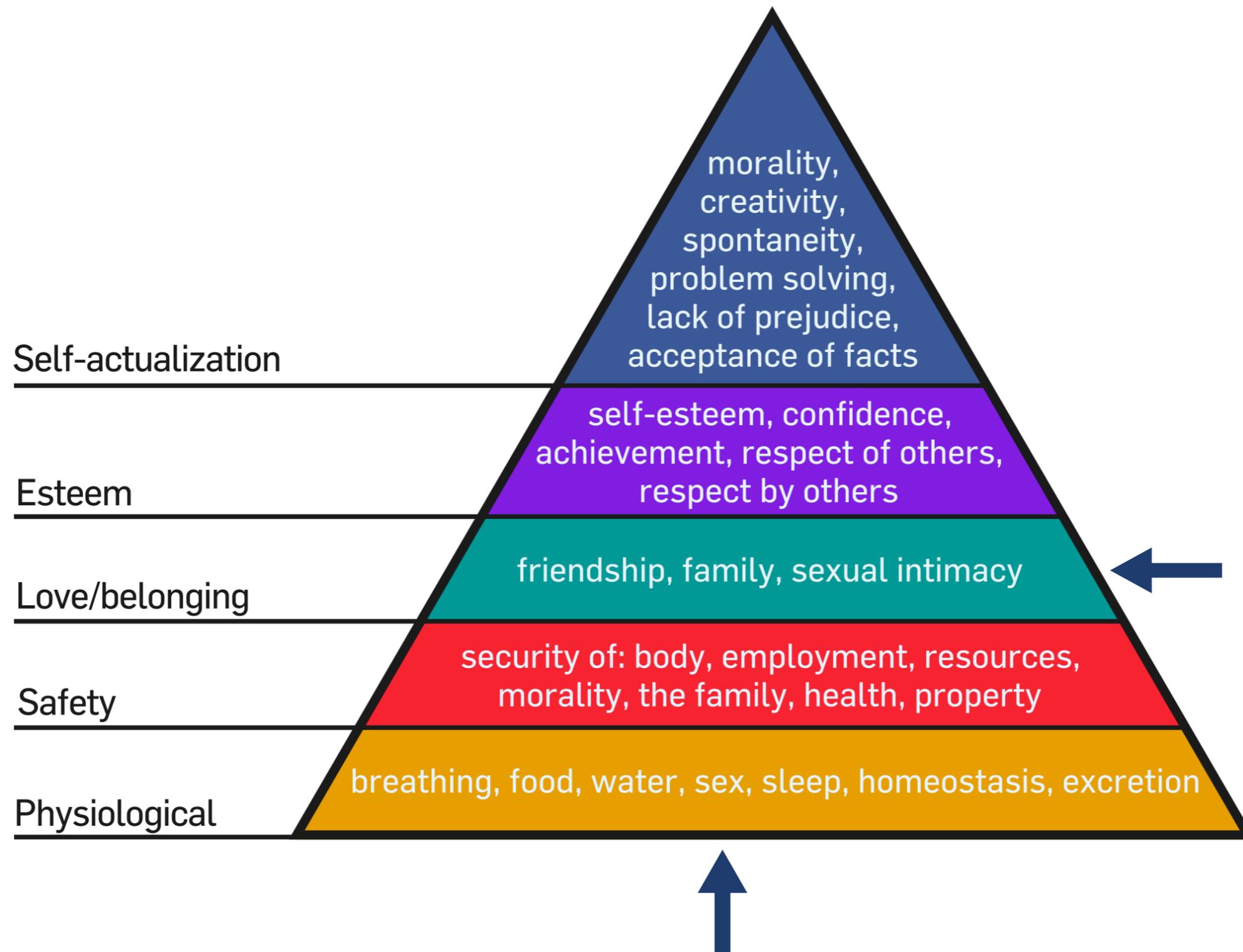
Emotional:

- Love/ commitment
- Way of expression

Insecurity:

- Self-esteem boost
- Pressure/ Duty
- 'Keeping' the partner

THE IMPORTANCE OF SEX



THE IMPORTANCE OF SEX

Sexuality is a key aspect of the human being and it encompasses sex, gender identity, sexual orientation, eroticism, intimacy and reproduction. (WHO, 2012)

It is experienced and expressed in thoughts, fantasies, desires, beliefs, attitudes, values, behaviors, practices, roles and relationships.



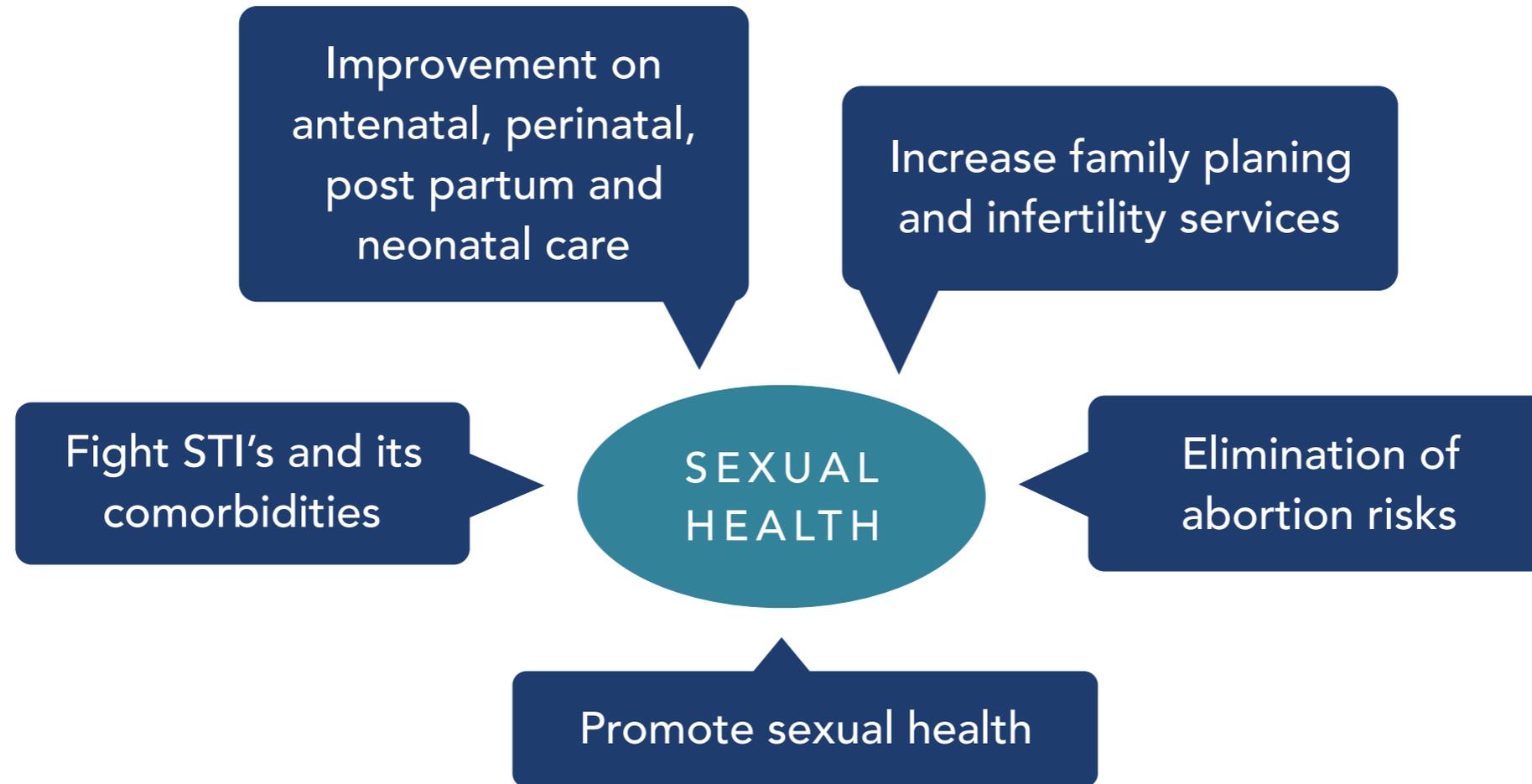
SEXUAL HEALTH

Sexual health is a state of physical, emotional, mental and social well-being concerning sexuality.

It requires a positive and respectful approach of sexuality, allowing for autonomous and satisfactory sexual experiences, free from coercion, discrimination or violence.

The elevated prevalence of disease related to risky sexual practices unveils the need for prioritizing prevention and promotion of sexual health, instead of merely treating the resultant disease, on what concerns public health.

SEXUAL HEALTH



IMPORTANT ROLE FOR THE FAMILY PRACTITIONER

SEXUAL HEALTH

Sexual problems can have a multidisciplinary etiology: emotional, relational, organic or iatrogenic.

- Promote patient's ability to develop satisfactory sexual relationships
- Allow for the sharing of fears and concerns regarding sexual orientation or gender identity
- Understand the close relationship between mental and sexual health

Sexual problems can also help to diagnose chronic illness.

SEXUAL DYSFUNCTION AND MORTALITY

J Sex Med. 2015 Nov;12(11):2130-3. doi: 10.1111/jsm.13032. Epub 2015 Nov 12.

Erectile Dysfunction and Mortality in a National Prospective Cohort Study.

Loprinzi PD¹, Nooe A².

CONCLUSIONS: ED is associated with increased premature mortality risk. The present findings have major public health and clinical implications in that ED is a strong indicator of premature mortality. Therefore, patients with ED should be screened and possibly treated for complications that may increase the risk of premature death.

J Sex Med. 2009 Sep;8(9):2445-54. doi: 10.1111/j.1743-6109.2009.01354.x. Epub 2009 Jun 15.

Erectile dysfunction and mortality.

Araujo AB¹, Travison TG, Ganz P, Chiu GR, Kupelian V, Rosen RC, Hall SA, McKinlay JB.

CONCLUSIONS: These findings demonstrate that ED is significantly associated with increased all-cause mortality, primarily through its association with CVD mortality.

Medscape Medical News

Erectile Dysfunction a Red Flag for Mortality, Cardiovascular Events

Norra MacReady

March 19, 2010

Medscape
Medical News 

SEXUAL DYSFUNCTION AND MORTALITY

J Sex Med. 2014 Jun;11(6):1519-26. doi: 10.1111/jsm.12460. Epub 2014 Mar 3.

Weaker masturbatory erection may be a sign of early cardiovascular risk associated with erectile dysfunction in young men without sexual intercourse.

Huang YP¹, Chen B, Yao FJ, Chen SF, Ouyang B, Deng CH, Huang YR.

Curr Opin Urol. 2016 Mar;26(2):140-5. doi: 10.1097/MOU.0000000000000257.

Erectile dysfunction in young patients is a proxy of overall men's health status.

Capogrosso P¹, Montorsi F, Salonia A.

SUMMARY: Erectile dysfunction does not represent an uncommon condition among young men. Considering the amount of data demonstrating a strong correlation between several life-risky comorbidities and erectile dysfunction, a careful and comprehensive general health assessment of patients complaining of erectile dysfunction should be carried out, regardless of patient's age. The identification of erectile dysfunction as an early sign of a major comorbidity would allow the implementation of therapeutic measures aimed at improving the overall health status and life expectancy across the entire aging process.



Sexual dysfunction is an **early sign** of important comorbidity, allowing us to improve **preventive care**

CONSULTATION SETTING



PATIENT'S EXPECTATIONS

- Perception of sexuality as important;
- Reluctant to initiate the subject out of shame;
- Fear the doctor will not pay attention to it;
- Lack of time during consultation.

Only 14% of women spontaneously initiate the subject. (Kingsberg S, 2004. Ramalheira L, 2011)

In reality, it may never be brought up if the responsibility of initiating it is left to the patient. (Harsh V, 2008)

CONSULTATION SETTING

Even though patients expect the doctors to address their sexual problems, these, very often, do not possess the necessary training/skills/knowledge to comfortably discuss the subject.

There is a lack of clarity concerning the role of the **Family Practitioner** on Sexuality-related communication on the **Primary Healthcare setting**.

Frequently family practitioners **delegate** this subject to other colleagues, assumed as more knowledgeable on the subject, like Gynecologists and Urologists.

CONSULTATION SETTING – GYNECOLOGISTS

Sexual problems are perceived as important on consultation.
Short sexuality courses are optional;
Routine screening of sexual problems is low (7,9%);
Psychosocial transitions or stress are considered not important.

(Kotmel A, 2014)

Sexual satisfaction is mostly not addressed.
Sexual orientation, sexual identity or pleasure are rarely evaluated;
1/4 of the gynecologists as expressed disapproval for the patient's
sexual practices;

(Sobecki JN, 2012)

CONSULTATION SETTING – UROLOGISTS

Urologists question sexual function more often than FP.
Same groups are deliberately not screened (immigrants);
Sexuality screening is focused on erectile dysfunction;

(Platano J, 2014)



CONSULTATION SETTING

Typical Avoidance Strategies

Becoming medical and technical

Female patient: "I don't have an orgasm"

Doctor: "So we should carry out a vaginal examination" or
"Okay we should investigate your hormone levels"

Trivialising

Female patient: "Having intercourse with my partner feels painful"

Doctor: "Well, relax or have a glass of champagne in advance" or
"Just wait for the right man" or
"Lets talk first about more important things"

Misplaced emphasis

Female patient, 62 years old, suffered from breast cancer 2 years ago:

"I feel a lack of desire. I'm completely desperate. It has become a real problem in my marriage"

Doctor: "Well, at your age... and let us be happy that you overcame the cancer"

Premature solutions

Female patient: "I have a lack of desire"

Doctor: "Let me make an appointment with an expert" or
"I will write you a prescription"

CONSULTATION SETTING – TABUS

PATIENT'S PERSPECTIVE

- Emotional factors (anxiety, shame, guilt)
- Age (life span)
- Perception of the sexual function as unimportant
- Unawareness of therapeutic options
- Physical limitations
- Lack of privacy
- Lack of trust
- Low response rate from the doctor

CONSULTATION SETTING

DOCTORS' PERSPECTIVE

- Personal discomfort with the subject
- Subject perceived as inappropriate
- Uncomfortable with sexual language
- Lack of information regarding therapeutic options
- Fear of offending the patient
- Problems in their own sexuality
- Lack of time in consultation
- Anticipation of difficulties on those perceived as different from self (different sexual orientation, ethnic background, cognitive deficit).

CONSULTATION SETTING

DOCTORS' PERSPECTIVE

Religion, politics and beliefs regarding morality **structure and performance** of the doctors' practice. Negative attitudes more frequent on topics like abortion, maternal health and HIV.

This discomfort **is not transversal** to the discussion of topics related to organic pathology related to sexuality.

Gender stereotypes or personal experiences may **alter** our way of addressing the topic, interfering with our **ability to overcome** our own beliefs to meet the patients' needs.

Personal perceptions become our **biggest communication obstacle.**

IMPORTANT TOPICS

- Respect by the patient
- Do not jump into conclusions
- Ask for permission
- Clarify confidentiality
- Inquire about patient's doubts/concerns - active listening
- Ask the patient to explain by their own words
- Avoid prejudice or being judgemental ('You should...')
- Use broad terms 'someone special'/'someone important'
- Use open questions
- Avoid labels or gender stereotypes
- Avoid professional voyeurism
- Acknowledge our own limitations

“There is no such thing as a “norm” in sex;
Norm is a guy who lives in Brooklyn.”

Dr Alex Comfort (1920 – 2000)
Physician, anarchist, pacifist, conscientious objector and
prolific writer, probably best known as author of *The Joy of
Sex* (1972)

SEXUALITY RELATED COMMUNICATION

Brief Sexuality-Related Communication (BSC): should be used opportunistically during consultation in order to promote counseling, approaching sexuality and personal psychological issues related to sexual well-being. (WHO, 2015)

BSC constitutes a great tool for opportunistic screening, different from the taking of a sexual history.

The benefits of this tool surpass the inconvenients, even though more studies are needed.

SEXUALITY RELATED COMMUNICATION

4 elements:

A

- Attending: initiate the subject

‘Do you have any questions related to sexual issues?’

R

- Responding: introduce the conversation

‘Are you pleased with your current sexual life?’

‘Does your sexual life happen as you wish?’

‘How do you feel about your sexual life?’

P

- Personalizing: identify concerns, difficulties or dysfunctions related to sex

‘Some people with your condition (hypertension, cancer...) tell me they

struggle a bit with sexuality. How does this happen for you?’

I

- Initiating counseling: provide the required information and identify steps that can be taken.

SEXUAL HISTORY

Search for the 6 P's:

- Problems
- Partners
- Practices
- Pregnancy prevention (selected contraceptive method)
- Past (past history of STI's)
- Proteção

Adapted from: CDC: a guide to taking a sexual history (www.cdc.gov/STD/treatment/SexualHistory.pdf)

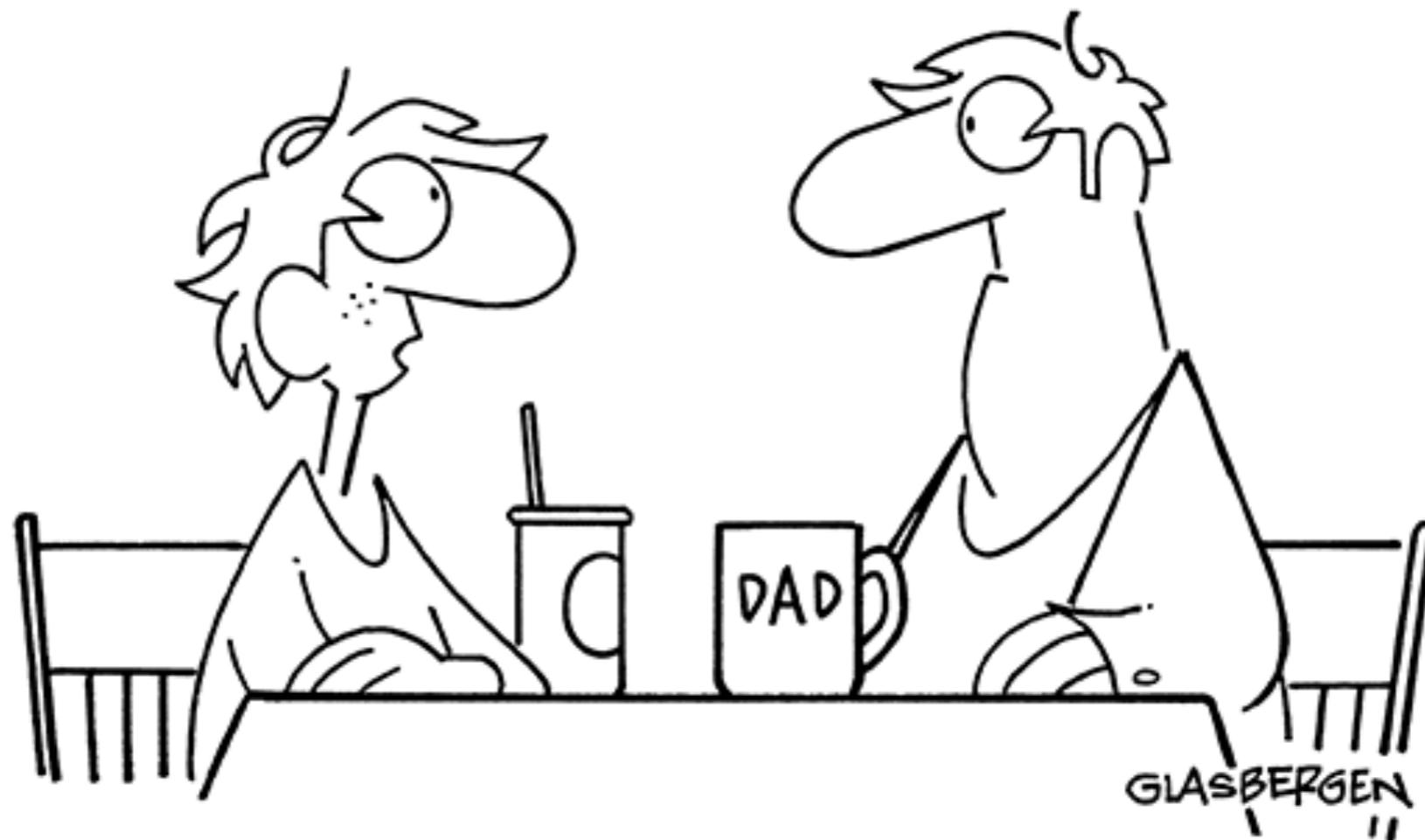
Act according to the 5 A's:

- Assess knowledge/ behavior
- Advise and inform
- Agree on goals and methods
- Assist in overcoming obstacles
- Arrange for follow-up

(WHO 2014)

ADOLESCENTS

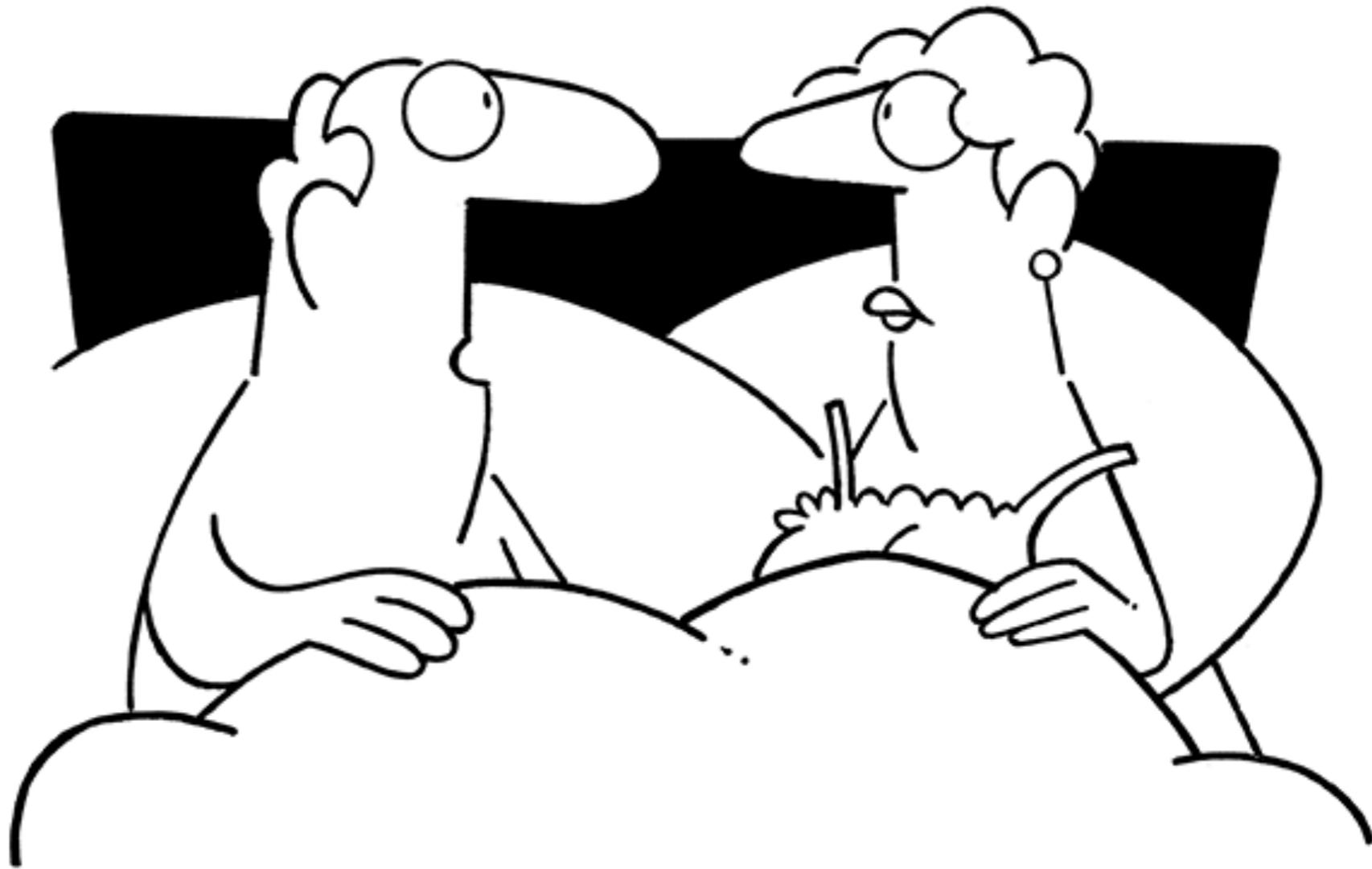
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**“I already know a lot about sex, mostly from television.
Are funny insults the most common form of foreplay?”**

ELDERS

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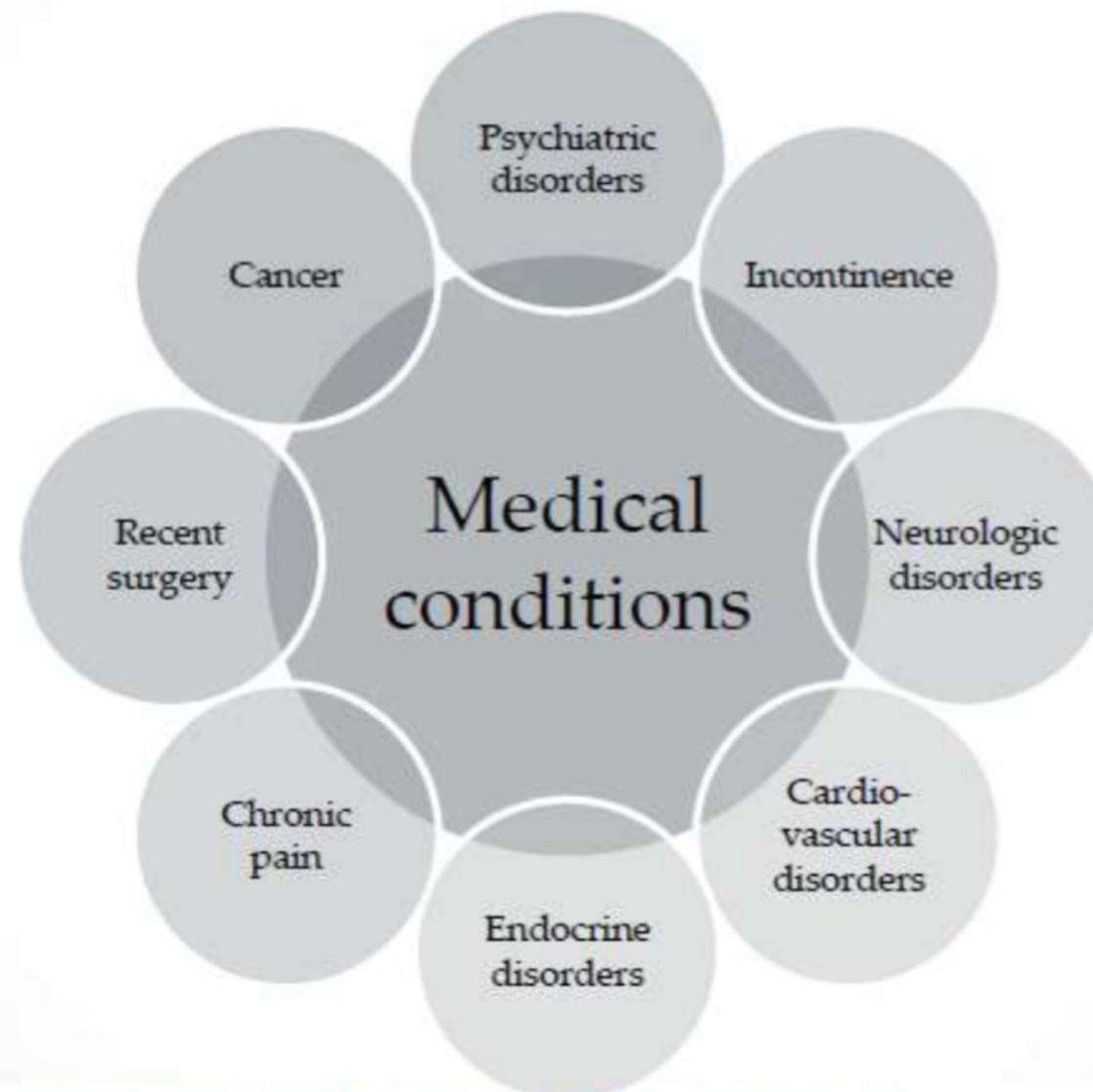
“Ours is an eternal love. It takes you an eternity to get started and it takes me an eternity to finish.”

THE FORGOTTEN GROUPS

Psychiatric patients	2.4%
Autism spectrum disorder group	0.3%
Mentally retarded	0.8%
Chronic diseases	14.4%
Cancer patients / survivors	4.4%
Dementia / cognitive impairment	1,1%
Physically handicapped	2,9%
Sensory handicapped (blind / deaf)	0,5%

THE FORGOTTEN GROUPS

Medical conditions that may affect sexual function

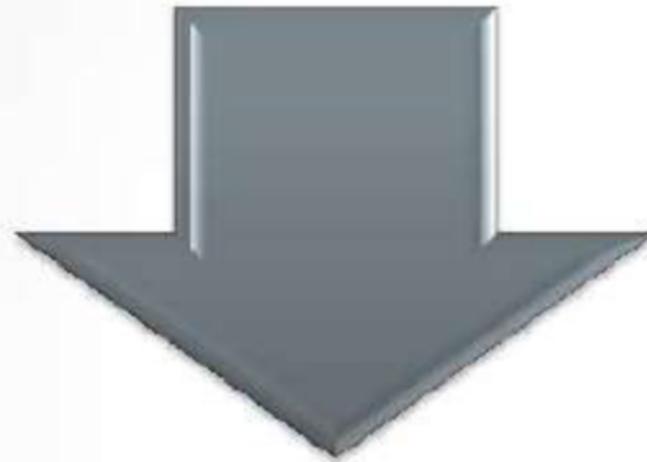


<http://www.arhp.org/publications-and-resources/clinical-proceedings/nyn>

Basson R and Schultz WW. *Lancet* 2007;369:409–424; Rees PM et al. *Lancet* 2007;369:512–525

THE PHYSIOLOGY OF SEX

Sexual desire is mediated by a balance between inhibitory and excitatory factors



Excitatory factors:

- Testosterone
- Estrogen
- Progesterone
- Melanocortin
- Dopamine
- Opioids

Inhibitory factors:

- Serotonin
- Prolactin



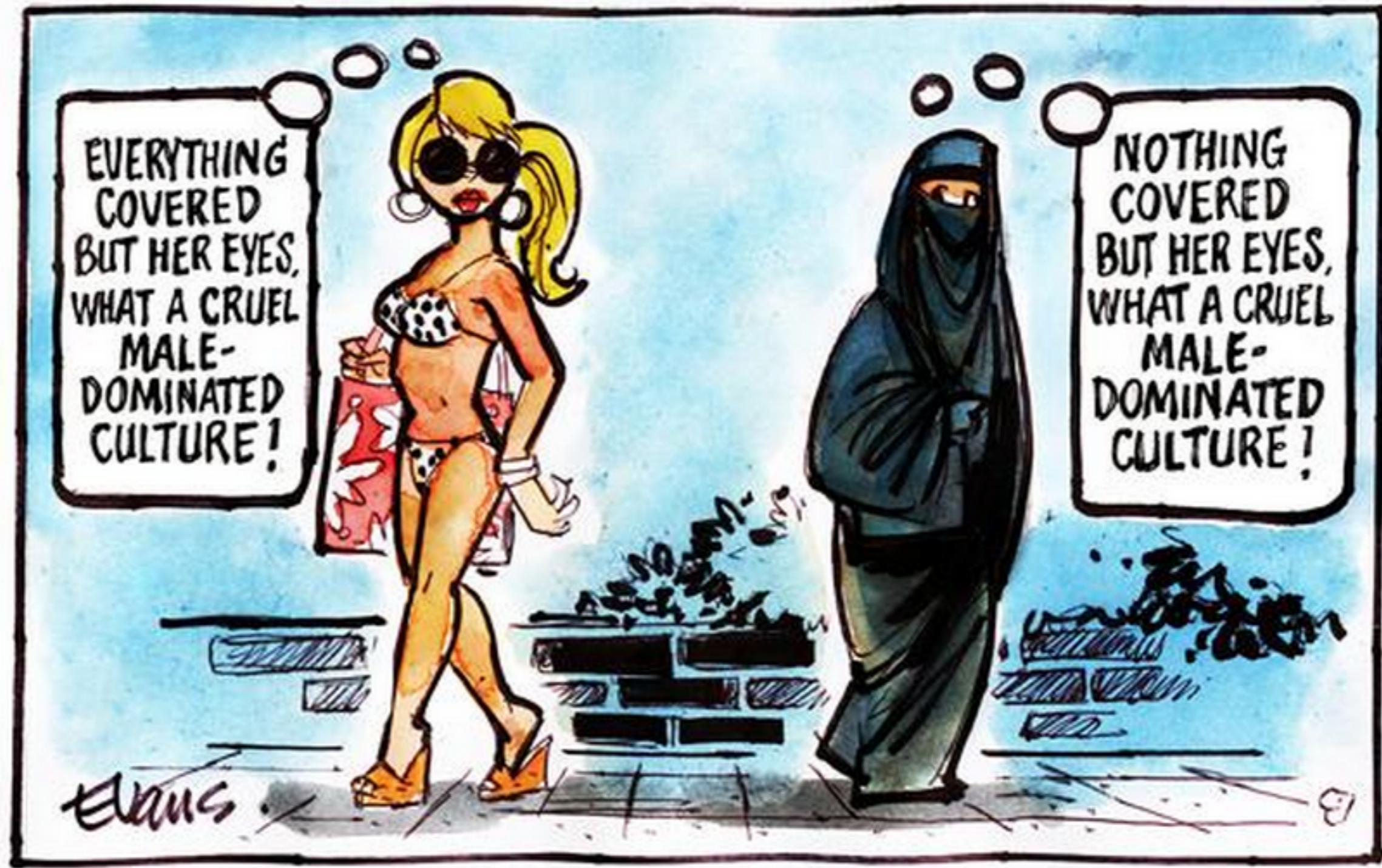
THE PSYCHOLOGY OF SEX

Psychologic factors that may affect sexual function



TAKE HOME MESSAGES

- Keep a professional attitude, free from prejudice
- Comfort/ Tranquilize/ Facilitate
- Be empathetic
- Do not banalize the topic
- Do not use slang or insults
- Open-ended questions
- Include the subject along the consultation naturally
- Do not be scared of sexual language
- Provide information and clarify the available therapeutical options
(Stevenson R, 1983)



EVERYTHING
COVERED
BUT HER EYES,
WHAT A CRUEL
MALE-
DOMINATED
CULTURE!

NOTHING
COVERED
BUT HER EYES,
WHAT A CRUEL
MALE-
DOMINATED
CULTURE!

ELANS

67

MOST OF ALL

- Do not make assumptions or jump into conclusions based on external looks or prejudice;
- Do not allow stereotypes to take place in your office, decreasing your ability to be empathetic;
- We do not need to agree with our patient's life choices to support them or inform them wisely;



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“I’m going to a lawyer today to have myself legally declared young and sexy.”

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THANK
YOU!

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