Sexual Dysfunction: The Psychological Burden

Kirstie Turner
Editorial Administrator

ESHRE's platform 'Focus for Reproduction' published an article before the congress, on 7th May 2019: 'Discussion, counselling and psychological support all necessary for treating sexual dysfunction in fertility care'. The key topics, which outline the links between sexual dysfunction and psychological health, are summarised in this congress feature.

INTRODUCTION

In an age when we are working towards having an open conversation around mental health, patients undergoing treatment for infertility caused by sexual dysfunction should not be exempt. ESHRE's platform 'Focus for Reproduction' delves into the issue in their precongress article calling for better psychological support for patients undergoing treatment in a fertility care setting.[1] We are only seeing the start of a much-needed focus on mental health, but this needs to go much further; psychological interventions could even be pivotal in treating sexual dysfunction that is hindering fertility. While research into this topic remains inconclusive, there is a suggestion that sexual dysfunction can be treated with discussion therapy or cognitive behavioural therapy as opposed to the use of medication.[1] It is time to address the burden of psychological issues and the impact these can have on couples trying to conceive. Infertility causes and intervention were, unsurprisingly, hot topics at EHSRE 2019, and along with their platform covering the issue, there was a session dedicated to 'Fertility Outcomes and the Male'.[2]

PSYCHOLOGICAL ROLE

As discussed by ESHRE's 'Focus for Reproduction' platform, Nobre's research[3] outlined the importance of cognitive factors, which can be significant predictors of sexual desire, and lack thereof resulting in sexual dysfunction in some cases. Negative connotations surrounding sexual activity were found to be influential on sexual desire; for males, the pressure of sexual performance was a psychological burden, and females displayed reservations surrounding sexual intercourse due to the perceived need to be conservative.

Nobre found discrepancies in sexual arousal indicators for females; subjective indicators, such as physical arousal, were not always concurrent with psychological feelings. This suggests that physical and mental aspects of sexual desire are different, and it is important to address both. If sexual dysfunction is being caused by a cognitive factor, such as the aforementioned concerns regarding sexual performance or conservativity, the treatment choice should reflect this. A lack of interest or desire for sexual activity could be a barrier to conceiving and confronting these issues could lead to a healthier mindset surrounding sex, resulting in an increase in sexual intercourse, raising the chances of pregnancy.

If the case of sexual dysfunction is caused by psychological issues, it makes sense for the first treatment port of call to be psychological therapy. Each individual's psychological wellbeing differs, and therefore any interventions should be handled on a case-by-case basis, taking these cognitive sex differences into consideration. Addressing concerns regarding sexual performance may be highly beneficial to a male patient but may not be to a female patient.

TREATMENT OPTIONS FOR SEXUAL DYSFUNCTION

Psychological Interventions

Premature ejaculation is considered to be the most common cause of sexual dysfunction, with a prevalence of >30% worldwide.[4] Psychosexual counselling can be an effective treatment option as many cases are psychogenic, caused by performance anxiety, low self-esteem, avoidance of sexual intercourse, partner hostility, and decreased quality of relationship.[5] Psychosexual counselling can have a range of means to diminish the problem, resulting in improve ability to reproduce: techniques to control ejaculation, increase sexual confidence, decrease performance anxiety, adapt to sexual repertories, overcome intimacy barriers, address interpersonal issues, face their feelings surrounding sexual dysfunction, and improve communication within the relationship.[5]

While psychological interventions within sexual dysfunctions have been studied, it is in limiting numbers. Brigitte Leeners, University of Zurich, Zurich, Switzerland, outlined the limitations of using small samples of patients. This renders conclusions insignificant. Cultural differences are also a challenge for comparing data from different countries, hindering the opportunity to compare and contrast the available data. Leeners outlines the therapy options surrounding low sexual desire, vaginismus, and fear of sexual intercourse.[6]

Pharmaceutical and Medical Interventions

Medical interventions for male patients experiencing sexual dysfunction include shockwave treatment, penile implant surgery, and oral inhibitors to treat erectile dysfunction: a

condition that affects 11–69% of men experiencing infertility.[1] Phosphodiesterase type 5 inhibitors can be used to alter semen parameters: motility and morphology see small increases. However, the heightened nitric oxide levels released during sexual stimulation can impact negatively upon this. Paolo Capogrosso, San Raffaele Scientific Institute, Milan, Italy, said these inhibitors are safe for use but cannot be recommended.

Clomiphene and anastrozole can be successful treatment options for normalising testosterone levels: an important factor considering there is a 45–69% prevalence of hypoactive sexual desire in infertile men. Flibanserin is U.S. Food and Drug Administration (FDA)-approved for treatment of hypoactive sexual disorder, but this pharmaceutical intervention has a limited effect.

EDUCATION SURROUNDING SEXUAL DYSFUNCTION

There is a call for better education of sexuality to help reduce infertility problems. Paul Ezlin, Leuven University Hospital, Leuven, Belgium, has recommended that clinicians work towards an open discussion on sexuality with couples. Barriers to opening this discussion include time constraints and a lack of sexuality education for doctors. Ezlin suggests using the permission, limited information, specific suggestions, and intensive therapy (PLISSIT) model for identification of issues, rather than waiting for problems to develop.

A significant step in recognising the psychological role in sexual dysfunction is improving communication with patients. Eline Dancet created 'Pleasure and Pregnancy' with colleagues, a 6-month programme designed to educate patients on a range of topics including psychosexual education, communication exercises, and mindfulness. The creation of this online tool came after research came to light that suggested that couples had an unmet desire for advice.

CONCLUSION

While opening a discussion surrounding sexual dysfunction is of key importance, it is vital to consider patient preferences. Ana Gomes, University of Porto, Porto, Portugal, expressed caution regarding over-diagnosis of sexual dysfunction. Some couples find therapy beneficial when they are experiencing sexual dysfunction implemented by pressure for 'sex on the clock'. On the other hand, some couples find a softer approach more appropriate, with a 'door open approach' to discussing dysfunction, and it is important to identify the correct approach on a personalised basis.

While pharmaceutical interventions offer some viable possibilities, there is a real chance of solving infertility caused by dysfunction through psychological therapies. Problems can be prevented from the very beginning if the right questions are asked during medical assessments, outlining the importance of the role of the physician. Mental health is not something we can ignore in infertility and it is time for cognitive treatments to be more widely considered, along with offering better psychological support for couples undergoing fertility treatment.

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