Psychosexual Services

- Definitions

Psychosexual therapy or counselling is mainly talking therapy for patients (individually or in couples) with sexual difficulties.

Sexual Medicine is the provision of medical assessment and treatment to patients with mainly physical factors associated to their sexual presentation.

Bio-psychosocial model is a way of assessing the overall needs of a patients and proving care and treatment accordingly.

- Background to psychosexual services

In the NHS, psychosexual clinics have been provided within sexual health and HIV clinics. Overall, part of the successful referral pathway is the open access to sexual health clinics. At the point of assessment the patient has the opportunity to express any concerns regarding their sexual functioning and then be referred appropriately to a specialist physician or a psychosexual therapist depending on their presentation. General practitioners (GPs) have been able to refer patients to specialist psychosexual services regardless of their postcode. Psychosexual services have been operating from within sexual health clinics as they have always been an integrated part of the directorate. A study by Shepherd et al (2010) concluded that the majority of the patients within their sample with a sexual problem indicated a preference for their treatment to be provided in sexual health.
Recent trends.

The number of patients referred for psychosexual therapy at a Central London Hospital has been increasing. There has been a significant increase in the recent years of patients seeking psychosexual therapy for Sober Sex. Men having sex with men (MSM) who have been in the Chemsex scene have been attending drug support clinics for their drug use and from there on they need to address their sex lives. According to Stuart (2018) Chemsex is the link of three specific drugs, crystal methamphetamine, mephedrone and GHB/GBL – used in sexual contexts, specifically by gay men.

Although, not yet reported or studied, psychosexual services are providing the tools to high risk MSM patients for healthier sex lives.

“The process at the beginning I doubted but through homework and self-study I reached through barriers I hadn’t known were there. I am now in recovery and through the tools of meditation, routine overall mindfulness of well-being I am becoming the man of my age with responsible outlook and a happy life, relationship and future. I am so very grateful. Thank you” Patient feedback, July 2016

Prevalence

A large National Survey of Sexual Attitudes and Lifestyle (Natsal-3) in 2013 showed that of 15,000 men and women (between the ages of 16 and 74), 42% of men and 51% of women have complaints of sexual problems. This study further showed that the following specific sexual dysfunctions were reported in both women and men-decreased interest in sex, lack of sexual enjoyment, pain at sex, no excitement at sex, difficulty orgasming, orgasming more rapidly than wanted to, as well as erectile dysfunction in men and dryness at sex in women.

A recent study conducted by Malik et al (2018) assessed the psychosexual needs of patients in five London sexual health clinics. 31% of the patients who filled the questionnaires (934 patients) reported a sexual problem. Associated distress was reported by 79.5% of the patients. According to their findings, the
patients were interested in a range of interventions and 67.8% expressed preference to be supported in a sexual health clinic.

Another study by Shepherd et al (2010) compared the sexual problems and their prevalence amongst two inner city London sexual health centres. Questionnaires were completed by 868 patients. The results showed that more women (43%) than men (32%) presented with sexual problems. The sexual problems reported varied from reduced interest in sex, to arousal and ejaculation difficulties. What is significant about this study is that only a minority of patients with sexual problems were receiving help despite almost half of the patients wanting it. The paper recommended that increased identification and treatment of sexual problems is essential in sexual health clinics.

- Prevention

Although harder to prove, psychosexual therapy can provide longer term and lasting effects in harm minimisation especially with high risk group of patients.

“I like the way the therapy is integrated into this sexual health service...I feel strongly that this is something that should be available on the NHS. It is not only effective, but also cost effective, since it pre-empts or arrests problems that will be more costly and time consuming for the NHS further down the track if not addressed therapeutically” Patient feedback, July 2016

- Demand

There is a high demand for psychosexual services in sexual health clinics. At Sexual Health directorate of a Central London Hospital the current waiting time is between five and six months.

- Access

A Central London Sexual Health clinic currently receives over 500 psychosexual therapy new referrals a year. The referrals have been forwarded from the GPs
and sexual health services as well as other agencies from inside and outside the local area. Our most recent contract has limited access to local residents with commissioners making it clear that funding for psychosexual intervention is not within the public health remit. A member survey (2017) was conducted by BASHH (not published) which incorporated 202 responses. When asked specifically about “change in variety of sexual health services provided in local area compared to equivalent period last year”, 40% (81) of respondents said there had been a decrease in psychosexual health services in the past 12 months.

- Funding

Psychosexual funding has been provided by local authorities until recently. The budget for psychosexual therapy was integrated with the Genitourinary Medicine (GU) and was seen as an integral part of a patient’s sexual well-being. According to the Commissioning Sexual Health Services and Interventions document by the Department of Health (2013)(1), the sexual health aspects of psychosexual counselling were going to be funded by Local Authorities and the non-sexual health elements by Clinical Commissioning. Currently the local authorities and commissionaires do not claim responsibility towards the funding of psychosexual services within sexual health clinics. A report (White, 2017) on the state of sexual health clinic closures published in the British Medical Journal raises concerns about the vulnerable budgets such as the psychosexual counselling.
• Standards

The European Federation of Sexology (EFS) and the European Society of Sexual Medicine (ESSM) in their syllabus of Clinical Sexology advocate a biopsychosocial model when it comes to the best treatment of sexual difficulties(2).

The World Health Organisation (WHO) states that sexual health is a state of physical, mental and social well-being in relation to sexuality; it is not merely the absence of disease, dysfunction or infirmity. Sexual Health requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free coercion, discrimination and violence. For sexual health to be attained and maintained, the sexual rights of all persons must be protected and fulfilled (3).

According to the British HIV Association (BHIVA), British Association for Sexual Health and HIV (BASHH) and Faculty of Sexual and Reproductive Healthcare (FSRH) guidelines (2017) the recommendations are:

- We recommend that annual enquiry about sexual function, and broader sexual wellbeing, should be standard of care for all patients living with HIV
- Access to sexual dysfunction services should be available, and pathways in place for referral from HIV services to services skilled in treating sexual problems.
- We recommend that all men with sexual problems have a full sexual history and a focused physical examination, including evaluation of cardiovascular risk.
- We recommend investigation of male sexual problems should include evaluation of bioavailable fasted morning testosterone level, prolactin and thyroid function as a minimum, along with fasting lipids and screening for diabetes if not recently tested.
- All women presenting with sexual pain should be offered a physical examination by a clinician with expertise in sexual problems or sexual health
- It is good practice to offer examination to all women where physical factors associated with their sexual problem cannot otherwise be excluded
We recommend services record data collected during annual reviews to develop an evidence-base regarding sexual function in transgender people living with HIV.

This response could not find any evidence that this guideline is followed by Sexual Health and HIV clinics. So if we are not asking the above questions because of the closures and lack of funding to psychosexual services, how can we really serve the patients holistically? The therapeutic model is brief and effective. Patients have reported positively on their evaluation of the service.

“Changed my life only for the better. I was sexually acting out and caught many STDs apart from HIV. I feel like I am a changed man”, Patient feedback, May 2016

“I am very grateful for the therapist’s work and I hope she can continue helping other people for the many years to come” Patient feedback, June 2016

“Make services more easily available. I was waiting years (literally) and made to jump through hoops” Patient Feedback, April 2018

“I am extremely grateful for the clinic and the therapist for the help. I have been to therapy before but this was the first time I went this deep and got to the point where I can elaborate a plan of action towards happiness” Patient Feedback, June 2018

“Please keep doing the great work” Patient Feedback, April 2016

“We would definitely recommend the therapist and the clinic and are extremely thankful...” Patient Feedback, March 2016

If we are no longer going to be funded to provide a holistic care to the sexual health needs of a patient, then how are we to serve by the definition of sexual health according to WHO? How are we serving our patients according to the biopsychosocial model advocated by the EFS and ESSM?
Collaborations

A psychosexual clinic in central London has been collaborating with a Church for the well-being of gay and Christian men, who struggle with the conflict between the two identities. An NHS ethically approved study is currently on-going which hopefully will show that collaborations such as this might offer the model of working with harder to reach communities. If the study reaches a successful completion, it would offer an alternative, outreach intervention directly to the hard to reach community (Men having Sex with Men and Christian). If the psychosexual services are funded within the NHS, they can prove cost effective and have a lasting, holistic impact to sexual minorities. Further collaborations between sexual health clinics and religious establishments could be initiated around the country based on this model.

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References

need for psychosexual services. Journal of Sexual and Relationship Therapy. 24: 249-260