DOI: 10.1111/bdi.13227

COMMENTARY

BIPOLAR DISORDERS WILEY

Questions in Psychiatry (QuiP): Sexual behaviours and practices

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Funding information
The author(s) received no financial support for the research, authorship and/or publication of this article.

This brief article is the second in our series on sexual well-being[1] that aims to provide a basic understanding of this vital aspect of most people's lives. This perspective is often not considered when assessing and managing patients with serious mental illnesses such as depression and bipolar disorder.

This QuiP focuses on sexual *practices* and/or *behaviours* (SPBs), and we have assumed that readers are familiar with terms such as gender and sex (see previous QuiP for clarification[1]). Sexual practices and behaviours play a significant role in the overall well-being of all individuals—including those living with mental illness.

In order to formulate appropriate questions and be able to consider responses in context, it is necessary to have sufficient background knowledge. For example, awareness of how common various sexual behaviours are in the general population, and how these vary according to age and gender helps appreciate whether an individual's experience falls within expected practices.

From a clinician's perspective, there are two questions that warrant consideration:

1. When managing psychiatric disorders, is information concerning sexual practices and behaviours relevant and how important is it to functional outcomes?
2. Does assessing and asking questions about sexual practices and behaviours adversely impact the professional relationship of clinicians with their patients?

We will attend to these matters in detail in subsequent QuiPs. But suffice to say, this knowledge is pivotal to gaining a comprehensive understanding of a person's experience of a mental illness. Therefore, it is of paramount importance to give consideration to this aspect of a person's life and ask the relevant questions as part of a clinical psychiatric assessment. Indeed, delving into these matters is arguably a core function of psychiatrists and psychologists, and for most patients, it is an opportunity that they often anticipate and appreciate.

Therefore, in this QuiP, we briefly define the terms used to describe sexual behaviours and practices and provide a framework for assessing these.

1 | DEFINITIONS AND TERMS

When asking about SPBs, it is critical to use clear, precise language to minimise confusion (see Table 1). This is important, because patients often use colloquial terms to refer to sexual anatomy, for example genitalia, and their SPBs. Problems are more likely if less formal terms are used as these often have a variety of meanings that are usually contingent on vernacular, and this complicates an already potentially confusing topic. Furthermore, by adopting formal language, clinicians can ensure that patients address any questions put to them with greater precision. Discussing matters in a clinical context rather than an informal one is also important because it helps maintain a professional and objective stance.

TABLE 1 Terms and definitions commonly used to describe sexual behaviours and practices

Libido	A person's sexual desire or drive for sexual activities
Masturbation	Erotic stimulation of one's sexual organs. Can be conducted via manual stimulation (i.e. the hands), via sex toys (i.e. vibrators or dildos) or by other bodily contact not including sexual intercourse
Mutual masturbation	When two (or more) individuals stimulate each other's sexual organs at the same time. Can be conducted via the same means as 'masturbation' above
Intercourse	Physical sexual contact involving the genitals of at least one person
Sexual intercourse	Sexual contact between individuals entailing penetration. In most instances, sexual intercourse refers to vaginal intercourse.
Oral sex (or oral intercourse)	Sexual activity involving oral stimulation of the genitals. Can entail giving or receiving (to or by a partner respectively). Referred to as *cunnilingus* when performed on a woman or *fellatio* when performed on a man
Anal sex (or anal intercourse)	Sexual activity involving anal penetration. Typically, insertion of the penis, finger(s) or other objects (e.g. sex toys)
Orgasm	The climax and/or culmination of sexual arousal, characterised by feelings of intense pleasure and usually involves the ejaculation of semen in males and vaginal contractions in females

2 | SEXUAL BEHAVIOUR

When assessing SPBs, it is useful to structure one's enquiry and make use of a schema. Sexual practices and behaviours should be explored systematically, beginning with fundamental components such as sexual desire (libido). This is because ultimately, sexual desire drives sexual thoughts, feelings and behaviours, and it is essential for both solo and partnered sexual practices.

The term *libido* refers to an individual's sexual desire or interest in having sex. It is best thought of as *the internal drive an individual possesses to engage in any kind of sexual activity*. A persons' interest in sex serves as an important foundation for appraising sexual well-being and it is usually a useful indicator of sexual functioning alongside SPBs.[2] For example, sexual fantasies can be positive influences as they allow individuals to express and explore their sexual desires freely and uninhibited.[3] Furthermore, although the 'goal' of sexual desire is not always sexual activity, sexual drive can serve as a useful proxy for overall well-being and functioning. This is particularly the case in mood disorders where alongside other symptoms, diminished libido is often a good indicator of depression or anxiety and may reflect a general reduction in motivation and energy. Conversely, an increase in libido may signal a manic syndrome.

2.1 | Masturbation

Sexual desire is a fundamental drive that is essential for actively engaging in all sexual behaviours, including solo sexual activities such as masturbation. Therefore, this is an important behaviour for clinical enquiry, and it is helpful to bear in mind that masturbation is common and practiced by both sexes from an early age. Indeed, it serves as a useful, safe and accessible means for individuals to gain sexual satisfaction and explore their sexual preferences. And this is how it is best considered.

In terms of defining masturbation, it usually involves touching or rubbing one's sexual organs to gain sexual pleasure. And although it is most often practised alone, it is also sometimes practised in the company of a sexual partner and may involve the use of sex toys such as vibrators or dildos.

2.2 | Partnered sexual practices

By definition, partnered sexual practices involve another individual and these include a variety of sexual activities such as sexual intercourse, oral sex, mutual masturbation and anal sex (see Table 1). Again, sexual desire is central to engagement in partnered sexual practices, although it is worthwhile noting that some individuals may report engaging in these practices in the absence of strong sexual desire—for example, to benefit their partner. This underscores the importance of assessing *all* of these components together because assessing individual sexual behaviours separately is likely to provide an incomplete picture of overall sexual well-being. Therefore, a comprehensive and integrated picture of a person's sexual practices and behaviours is needed to gain a proper understanding of a person's fulfilment in this domain (See Figure 1).

2.2.1 | Sexual desire

Libido is the core driver of sexual behaviours and practices. It should be assessed both cross-sectionally and over time and the overall degree of interest in sex should be gauged with respect to exploratory behaviours, and the frequency and satisfaction of sexual practices. When assessing sexual interest, it is also important to specifically ask about sexual fantasies and the use of pornography.[1]

2.2.2 | Solo practices

Sexual desire directly influences engagement in solo practices such as masturbation. Masturbation should be assessed in terms of whether past personal history (e.g. early experiences) and cultural and religious factors impact this practice. In addition, the frequency with which the person is engaging in masturbation, how satisfied an individual feels in this regard and whether an individual is comfortably exploring sexual behaviours that interest them including for example the use of sex toys are all considerations that are worthwhile exploring.

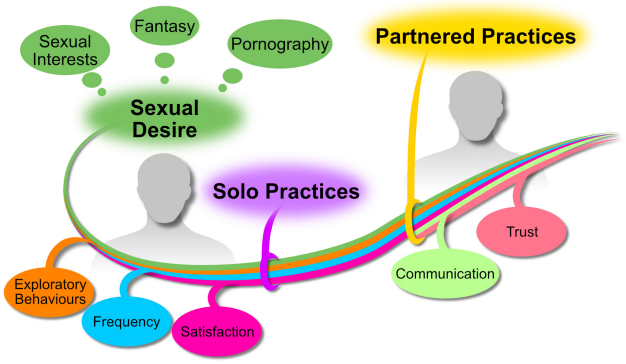

FIGURE 1 Assessing sexual practices and behaviours. This schematic illustrates the various components of sexual practices and behaviours. These can be assessed beginning with individual sexual desire and its various facets such as interests and fantasies, and then considering sexual practices; solo then partnered. It is important to note that these factors are all interrelated and have an iterative relationship. They are shown here to highlight how one can explore these components systematically when assessing sexual well-being in a clinical setting.

2.2.3 | Partnered practices

As with masturbation, many of the same considerations need to be considered when asking about partnered sexual practices. Past experiences are particularly important as they may impact functioning, and again it is necessary to enquire about the frequency of various partnered sexual practices and how satisfied the individual feels in this regard. Additional important considerations in the context of a relationship are trust and communication. When engaging in partnered sexual behaviour, good communication and trust are critical. Again, the frequency of engaging in sexual practices and the satisfaction that an individual has about their sexual relationship with their partner should be assessed if deemed relevant.

3 | SEXUAL DEVELOPMENT

Like other components of a patient's general well-being, it is also worth exploring sexual behaviours and practices viewed through a developmental lens. Therefore, after asking about current SPBs as

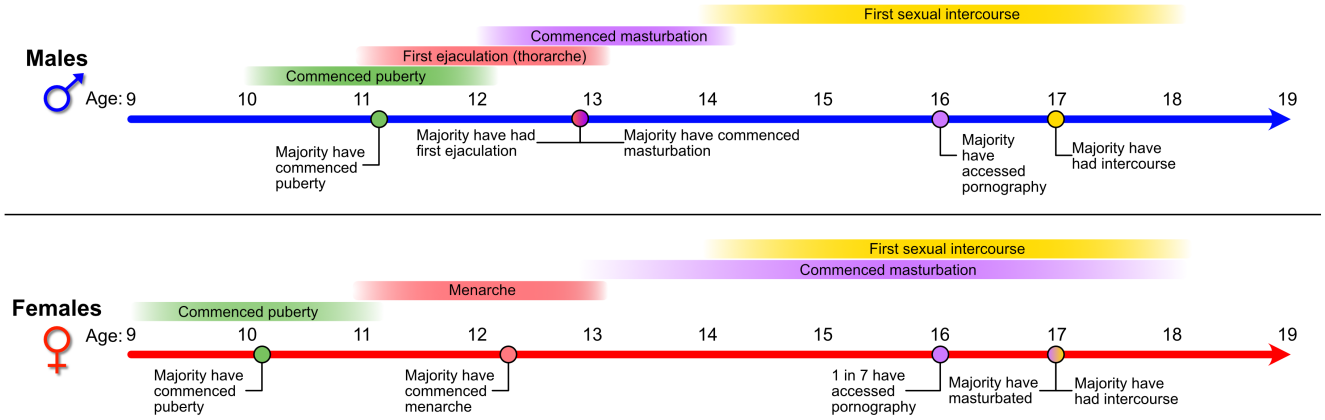

FIGURE 2 Sexual developmental milestones in males and females. This schematic illustrates the average age of key milestones that occur during sexual development in adolescence. The ages of these milestones are derived from averages across datasets from North America, Europe, Australia and the United Kingdom. The horizontal bars indicate the window within which particular milestones occur. The circles along the time axis indicate the age at which the *majority* of adolescents have passed each particular milestone. This inevitably varies from one individual to the next but the schematic provides a useful guide for reference to typical milestones. Overall, it is notable that females begin puberty at an earlier age to males; however, sexual practices such as masturbation commence later and are less common in females when compared to males of the same age group. This is reflected in other behaviours, for example by age 13, the majority of males experience their first ejaculation (through masturbation or though nocturnal emissions)[4] and have engaged in masturbation (typically twice weekly). In contrast, it is more typical for adolescent females to report masturbating a few times per year.[5] Males and females also differ in their use of pornography, in that most males have accessed pornography by age 16, whereas only approximately one in seven females will have accessed pornography by this time. These differences in patterns of masturbation and pornography use are maintained to some extent into adulthood. But despite these differences, the majority of both males and females have engaged in sexual intercourse by age 17.

an adult, it is useful to understand the developmental context of these behaviours commencing in adolescence (see Figure 2). This is because atypical sexual development, either due to biological reasons or because of external impacts such as trauma, may have a longstanding impact on SPBs as an adult. Furthermore, as many psychiatric disorders such as depression and anxiety can also first emerge during this time, there are potential bidirectional effects between sexual development and the onset of a mental illness that should be explored. Figure 2 illustrates a timeline of typical sexual developmental milestones, both biological (e.g. menarche) and behavioural (e.g. sexual intercourse and masturbation). The schematic is by no means exhaustive, but it provides a general framework for an individual's sexual development through adolescence into adulthood.

In this QuiP, we have focused specifically on sexual well-being in adulthood. However sexual development and its impact on sexual well-being commences in adolescence, and it may be helpful to assess these aspects[1]—noting that there are additional complexities that need to be taken into consideration (see Figure 2). For more detailed and specific information regarding sexual well-being in adolescents, see footnote*.[2]

4 | CONCLUSION

Sexual practices and behaviours form a key component of sexual well-being and in turn are important for an individual's overall functioning and sense of self. It is therefore critical that the fundamental components of sexual behaviours are assessed routinely, especially in those with mental illness, for whom there may be a greater likelihood of impairment in this regard. When assessing these components, it is critical that clear, precise language is used and that a developmental perspective is also considered to build a comprehensive understanding of the individual's current sexual well-being. This QuiP has provided a brief overview of the components that make up sexual practices and behaviours as well as a broad schema for how to work through each of these systematically.

ACKNOWLEDGEMENTS

Open access publishing facilitated by The University of Sydney, as part of the Wiley - The University of Sydney agreement via the Council of Australian University Librarians.

CONFLICT OF INTEREST

G.S.M. has received grant or research support from National Health and Medical Research Council, Australian Rotary Health, NSW Health, American Foundation for Suicide Prevention, Ramsay Research and Teaching Fund, Elsevier, AstraZeneca, Janssen-Cilag, Lundbeck, Otsuka and Servier; and has been a consultant for AstraZeneca, Janssen-Cilag, Lundbeck, Otsuka and Servier. The author E.B. declared no potential conflict of interests with respect to the research, authorship and/or publication of this article.

DATA AVAILABILITY STATEMENT

Data sharing is not applicable to this article as no new data were created or analyzed in this study.

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ENDNOTE

* https://www.adolescenthealth.org/Resources/Clinical-Care-Resources/Sexual-Reproductive-Health/Sexual-Reproductive-Health-Resources-For-Adolesc.aspx

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