DOI: 10.1111/bdi.13259

COMMENTARY

BIPOLAR DISORDERS WILEY

Questions in psychiatry (QuiP): Assessing sexual well-being

Gin S. Malhi[1,2,3] | Erica Bell[1,2]

[1]Academic Department of Psychiatry, Kolling Institute, Northern Clinical School, Faculty of Medicine and Health, The University of Sydney, Sydney, New South Wales, Australia

[2]CADE Clinic, Royal North Shore Hospital, Northern Sydney Local Health District, St Leonards, New South Wales, Australia

[3]Department of Psychiatry, University of Oxford, Oxford, UK

Correspondence
Gin S. Malhi, CADE Clinic, Department of Psychiatry, Royal North Shore Hospital, Level 3, Main Hospital Building, St Leonards, NSW 2065, Australia.
Email: gin.malhi@sydney.edu.au

This article is the fourth in our series on sexual wellbeing and its core components, which together serve as foundational knowledge upon which one can then assess sexual functioning. The *assessment* of sexual functioning is the focus of the present article, which outlines how and when this should be assessed.

1 | SEXUAL FUNCTIONING

A recurrent theme over this series of QuiPs has been that aspects of sexual well-being go beyond simply those that are physical, and encompass subjective and cultural attitudes, beliefs, and values. Likewise, this article utilises a broad definition of sexual functioning that encompasses sexual desire, subjective arousal, orgasm, satisfaction and pain.[1] Many of these and various *sexual behaviours* have been addressed in more depth in previous QuiPs in which we have also provided basic definitions. Therefore, knowledge of these terms and related issues is assumed for the purposes of this article.

Furthermore, it is important to note that in this article we do not consider issues pertaining to fertility. Anxieties and concerns surrounding fertility often contribute to difficulties in sexual functioning and may in some cases be related to psychiatric diagnoses or the treatment of mental illnesses. But concerns regarding fertility and conception should generally be referred to an appropriate specialist, and psychiatrists and psychologists should focus on those concerns directly related to mental illness and its treatments.

2 | FACTORS TO CONSIDER

The box below lists factors for consideration. For each factor that is potentially contributing to sexual dysfunction, it is important to note whether it occurred in the past or present and is ongoing.

Factors to consider when assessing sexual functioning

Psychological factors

- Mental illness (e.g. anhedonia, reduced libido)
- Subsyndromal symptoms (e.g. anxiety)
- Trauma (e.g. emotional, physical, sexual abuse)

Physical health

- Chronic medical conditions (e.g. cardiovascular disease, diabetes)
- Gynaecological and reproductive history (e.g. endometriosis, polycystic ovarian syndrome, use of hormonal contraception)

Treatments

- Psychotropics (e.g. antidepressants, antipsychotics)
- Medications (e.g. diuretics, antihypertensives)
- Complementary therapies (e.g. St John's Wort)

3 | ASSESSING SEXUAL FUNCTIONING

Raising the topic of 'sex', especially in the context of mental health problems requires sensitivity and good clinical judgement. For some patients, it may not be a priority and may even seem irrelevant. Further, it can be a difficult topic to broach when taking a psychiatric history and assessing a mental state. But clinicians routinely examine equally sensitive issues. For example, when taking a psychiatric history asking about suicidal thinking is now routine, and in general practice (primary care) it is now commonplace to ask patients about domestic violence or abuse involving a partner or a parent. And although there are clear differences between sexual functioning, suicide and domestic violence, by examining the way in which we approach the latter topics we may be able to borrow some useful insights as to how sexual functioning can be assessed in the context of a mental illness.

First, it is important to note that just as we often feel the need to enquire about suicidal thoughts and behaviours in every patient, it may not always be appropriate to do so, in every consult. At the same time, the decision to enquire about sexual functioning should *not* be influenced by factors such as age or relationship status. However, it is important to bear in mind that a patient with a history of sexual trauma, or someone who has already discussed several sensitive topics within the assessment may not be receptive to enquiries about sexual functioning at this time. This then requires clinical judgement.

Another aspect that the topic of sexual functioning shares with suicide, is that when this topic is first broached with a patient, they may be dismissive or state that there are no concerns. However in the future, once the patient is more comfortable, and you have established sufficient rapport and trust, they may share their difficulties and signal that the topic is open for discussion. At the same time, it is important to note that shame and guilt are common feelings associated

FIGURE 1 Schematic representation of sexual functioning assessment during anamnesis. The various components that clinicians assess when taking a history and conducting a mental state examination are shown based broadly on the Maudsley approach. Arranged as if around a clock face, the clinical and developmental history precedes further in-depth explanations of the person's current circumstances before finally recapitulating and formulating a diagnosis and management plan. Factors that may impact sexual functioning are shown within the 'clock face'. These can be assessed if the opportunity arises. Initially, when assessing the presenting complaint, and its immediate history the patient may spontaneously volunteer any sexual difficulties they have been experiencing. However, if this does not occur it may be possible to explore this by assessing whether *past or current diagnoses*, *symptoms or treatments* have impacted sexual functioning. When taking a developmental and family history, it may be possible to explore the impact of *trauma, and/or the patient's sexual development*[a] and *sexual identity*[b] on current sexual functioning. When returning to current circumstances and functioning, it may be possible to enquire about current *relationships and sexual practices*[a]. Finally, when concluding an assessment, it is often useful to ask open-ended questions to ensure that nothing of importance has been overlooked and that all the relevant and necessary information has been gathered. It is important to note that (for a variety of reasons) it may not be appropriate to assess sexual functioning on every occasion and that if this area is not fully examined in one assessment it can be addressed at a later time.

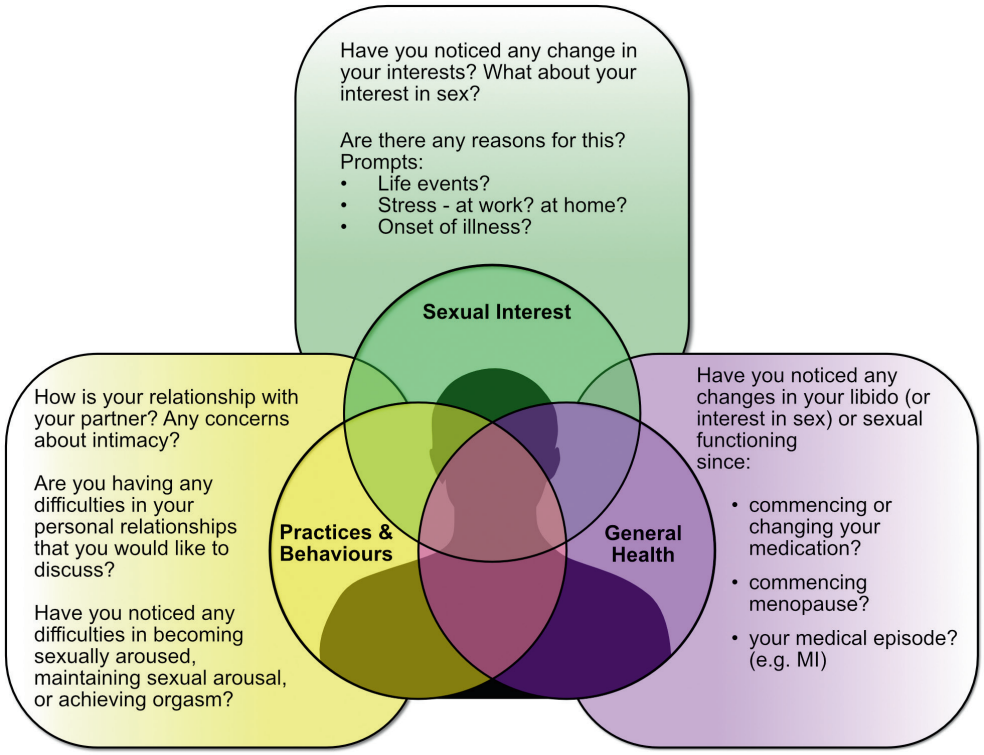

FIGURE 2 Key domains that should be addressed when assessing sexual functioning. This schematic shows the three key domains that should be addressed when assessing sexual functioning. Sexual interest includes sexual desire (libido), and changes in this domain can signify psychiatric disorders such as depression. The domain of general health includes physiological factors that can impact sexual functioning such as medications (e.g. antidepressants, diuretics, hormonal contraceptives), medical conditions (e.g. chronic diseases such as heart disease or diabetes), or other factors such as menopause. Finally, practices and behaviours should also be assessed, and these can be solo practices such as masturbation, or practices with a partner, such as intercourse. Within each domain, exemplar questions or statements have been included that can be used to tactfully approach each domain in an assessment, which can commence with any of the three domains depending on each patient and the circumstances of their consultation.

with suicide, domestic violence and problems concerning sexual functioning, and therefore assuring patients that these topics can be safely explored in the context of a clinical environment is critical.

With increasing awareness and knowledge, it is now accepted that both domestic violence and suicide can and where indicated should be inquired about tactfully. For example, appropriate questions to broach these topics sensitively include, '*Does your partner treat you with respect?*' and '*Do you sometimes feel that you would rather not be here?*' Similarly, sexual functioning can be raised at an appropriate juncture and should be given some context by explaining the reasoning behind why you are asking such questions. For example, '*How is your relationship with your partner?*', '*Are you having any intimacy difficulties?*' or '*Have you noticed any change in your libido?*'

4 | IMPACT OF ILLNESS ON SEX

Sexual dysfunction is common in individuals diagnosed with depression. Most commonly this entails decreased libido, but depression can also result in difficulties with arousal (erectile dysfunction and vaginal dryness) and orgasm (absent or delayed).[2] This is to be expected, as depression impacts and indeed comprises changes in mood, energy and interest and in particular the capacity to experience pleasure, and, therefore, it is no surprise that depression lowers sexual interest, engagement in sexual activities and the ability to gain satisfaction. As a consequence, this impacts the depressed individual's confidence and self-esteem. Depression also usually cooccurs with other conditions such as anxiety, and medical health problems such as cardiovascular disease, many of which can directly impact sexual function.

Importantly, the link between sexual dysfunction and depression appears to be both strong and bidirectional, meaning those with sexual dysfunction should be screened for depression and vice versa.[3] Overall, those with depression have been shown to have a 50%–70% increased risk of developing sexual dysfunction, and those with sexual dysfunction have a 130%–210% increased risk of developing depression.

In addition, sexual dysfunction is also a frequently reported side-effect of many treatments used to manage depression, often leading to poor treatment adherence or withdrawal and cessation.

5 | FORMAL ASSESSMENT OF SEXUAL FUNCTIONING

Several scales are available for assessing various aspects of sexual functioning, and these may be of use when conducting a more thorough examination. However, unfortunately, normative values for scores on

these scales are not available as yet. When assessing sexual dysfunction it is important to use neutral and inclusive terms such as 'partner', and to frame questions using non-judgemental language. It is also important to avoid using colloquial language as far as possible. This helps maintain a professional relationship and ensures greater specificity.

Second, it is important to avoid making assumptions based on a person's age, appearance, marital status or any other extraneous factors. Note, unless the relevant questions are asked, it is not possible to know a person's sexual orientation, behaviours or gender. Finally, if a person is transgender they may have a preference for certain pronouns and, therefore, this should be ascertained.[4] The figure provides examples of questions that can be utilised to explore the various domains of sexual functioning (Figures 1 and 2).

6 | CONCLUSION

In sum, when assessing sexual functioning, psychiatrists should do so with the knowledge that they are not expected to address any or all aspects of sexual functioning, with each patient at each assessment. Furthermore, if sexual dysfunction is identified, it is the role of the psychiatrist to determine what proportion of this dysfunction is due to an underlying psychiatric illness, or due to treatments for a psychiatric illness (e.g. antidepressants). If sexual dysfunction is not primarily due to either of the above contributing factors, then the psychiatrist should refer the patient either back to the general practitioner or to a specialist in the relevant field who can provide targeted care (e.g. an endocrinologist).

FUNDING INFORMATION

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. [Correction added on 30 November 2022, after first online publication: funding statement has been added.]

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 conflicts of interest 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.

ORCID

Gin S. Malhi https://orcid.org/0000-0002-4524-9091
Erica Bell https://orcid.org/0000-0002-8483-8497

ENDNOTES

[a] See QuiP: Sexual behaviours and practices, *Bipolar Disorders* 24(3).

[b] See QuiP: Sexual well-being and mental illness, *Bipolar Disorders* 24(1).

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