The effects of sexual therapy interventions for sexual problems

This is an excerpt from the full technical report, which is written in Norwegian.

The excerpt provides the report's main messages in English.

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Systematic review

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We would like to thank all contributers for their expertise in this project. Norwegian Knowledge Centre for the Health Services assumes final responsibility for the content of this report.

Norwegian Knowledge Centre for the Health Services
Oslo, 2012

Key Messages

All health care professionals have a role in promoting sexual health, knowledge and allowing for questions. Sexual problems are fairly common. People are, however, reluctant to seek help. In this report we aim to answer questions on the effect of sexual therapeutic interventions on people with different sexual problems. Sexual therapeutic interventions overall are effective for people with sexual problems. This was shown for a broad spectrum of both populations and sexual problems.

- In men with erectile dysfunction group therapy had a positive effect alone or as supplement to medical treatment (sildenafil).
- There was a positive effect of sexual therapeutic interventions (as cognitive therapy) for women with loss of sexual desires and orgastic dysfunction. It was unclear if sexual therapeutic interventions had any effect on gynecological pain in women. Sexual function was improved after short sexual therapeutic interventions in women with gynecological cancers.
- For couples with sexual problems there were improvements with couple therapy with communication skills and conflict solving, as a supplement to sexual therapy.
- For people with severe mental illness we found positive effect of different sexual therapeutic interventions to promote sexual health.
- Self help, as information in written or audio/visual material (bibliotherapy) had an overall positive effect for men and women regardless of sexual problem.
- It was not clear if sexual therapeutic interventions had a positive effect on men with cancer. The interventions might be harmful for this group.

The results, however, must be interpreted with caution as the studygroups were small, there are limitations in methodological quality and large variations in what is defined and presented as sexual therapeutic interventions. We can not rule out a possible publication bias in the material which means that studies with a negative effect might not have been published or not identified by us.

The effects of sexual therapy interventions for sexual problems

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Type of publication:

Systematic review

A review of a clearly formulated question that uses systematic and explicit methods to identify, select, and critically appraise relevant research, and to collect and analyse data from the studies that are included in the review. Statistical methods (meta-analysis) may or may not be used to analyse and summarise the results of the included studies.

Doesn't answer everything:

- Excludes studies that fall outside of the inclusion criteria
- No health economic evaluation
- No recommendations

Publisher:

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Updated:

Last search for studies: June 2008. Search for new studies January 2011, studies listed and awaiting assessment.

Executive summary

BACKGROUND

In this report, commissioned by the Directorate of Health in 2006, we aim to examine the effect of sexual therapeutic interventions on people with sexual problems.

World Health Organisation define sexual health in this way: *Sexual health is a state of physical, emotional, 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 of coercion, discrimination and violence. For sexual health to be attained and maintained, the sexual rights of all persons must be respected, protected and fulfilled.*

Sexuality is a core dimention in humanity. It includes sexual actions, gender roles, gender identity, sexual orientation, eroticism, intimity, nearness, confirmation, love and reproduction. Sexuality is experienced or expressed through thoughts, fantasies, longings, wishes, beliefs, attitudes, values, activities, actions, roles or relationships, and is source for happiness and self-realisation as well as health challenges and difficulties for men and women. Life events may reduce sexual function to such a degree that it qualifies for diagnostic criteria for dysfunction, without the individual necessarily regarding it as a problem. It is when the individual finds that something is hindering a wanted sexual activity that it might be a sexual problem.

In 1997 10% of Norwegian *men* reported that they had experienced sexual problems that might have been solved with some help. Of these, 40% said they had a need for professional help, but only 6% had contacted a doctor, psychologist or other health care professionals. The most common sexual problems in men are premature ejaculation and erectile dysfunction. International surveys indicate that the most common sexual problems in *women* are reduced sexual desire (10 to 46%), reduced lubrication (6 to 21%), lack of orgasm (4 to 7%) and pain (3 to 18%). Amongst women in a Norwegian survey on *couples* 26% reported reduced sexual desire. Eight percent of the men and 8% of the couples reported “distress”.

Sexual dysfunction involves difficulties in one or more phases of sexual response in individuals or couples with negative consequences, such as frustration or avoidance. Clinical sexology involves understanding, counseling, helping and treating people with sexual problems and impairment.

This report aims to answer questions on the effect of sexological interventions for people with different sexual problems. We use the term ”sexological interventions” as an overall term for psychological, psychosocial and educational interventions, within the context of information, counseling and treatment for sexual dysfunction. We use the terms used by individual study authors when we summarise the studies in this report. We have limited our report by not including medical or pharmacological treatments, surgery or technical devises, as long as they were not clearly integrated in the sexological intervention.

METHOD

We conducted a systematic review based on systematic searches for literature in 2008 in the following databases: Cochrane Library, Medline, Embase, Cinahl, Psycinfo and Svemed. Two people independently appraised all titles and abstracts. Studies were included or excluded based on set inclusion- and exclusion criteria, but we made some diversion from the protocol. The diversion was that we excluded studies that included a population of people who perform sexual assault. Articles that were found relevant after appraisal in full text were critically appraised concerning methodical quality. This was done by two people independently and we used checklists on systematic reviews or randomised controlled trials published on kunnskapssenteret.no. Some results were pooled in metaanalyses.

As part of the report we made a description of sexological treatment methods and gave an overview of test methods used for the assessement of effect (outcomes) in included studies. In addition we made a glossary. These are found as attachements.

RESULTS

We identified 2805 unique titles in the search in 2008. Titles and abstracts were judged against the inclusion criteria and 320 articles were considered in full text. We appraised the articles against the quality- and inclusion criteria and based this report on nine systematic reviews and 34 randomised controlled trials. We found many new titles in a search update in 2011, references to these 78 possible relevant studies are listed as attachement.

We have results from one systematic review and four randomised controlled trials which evaluated the effect of sexological interventions in *men*. Group therapy had positive effect on erectile dysfunction, five studies (100 men) [Risk Ratio RR 0,40, (95% confidensintervall CI 0.17 to 0.98)]. There was a positive effect of sexological interventions as supplement to medical treatment (sildenafil), three studies (124 men) [RR 1.57 (CI 1.11 to 2.22)].

Results from four systematic reviews and 12 randomised controlled trials showed effect of sexological interventions in *women*. It was positive effect for lack of or loss of sexual desire, three studies (197 women) [RR 4.52 (CI 2.35 to 8.69)]. Three studies with a total of 144 women showed positive effect for women with primary orgastic dysfunction [RR 3.61 (CI 1.36 to 9.59)]. For secondary orgastic dysfunction (123 women) the included studies did not show effect [RR 5.47 (CI 0.63 to 47.59)], but this result is very uncertain. For gynecological pain two studies (104 kvinner) showed no effect of decensitivisation [RR 1.36 (CI 0.60 to 3.04)]. It was unclear if sexological interventions had effect on pelvic/gynecological pain.

Three studies with a total of 242 *couples* all showed positive effect on several sexual outcomes on couple therapy with communication skills and conflict solving supplemented with sexological therapy.

For young men treated for *testicle cancer* one small study with 72 men suggest that cognitive therapy increased anxiety one year after treatment with no change in sexual function. We can not conclude on the effect of sexological interventions on men with *prostate cancer*, results from five randomised trials (801 men) pointed both in positive and negative direction.The different results might be caused by uneven competence in the health care professional. Results from four randomised trials with a total of 212 women showed some effect on sexual function after short sexological interventions on women with *gynecological cancer*. One study showed positive effect of psychosexual therapy for 40 women with *breast cancer*.

We found positive results from small singel studies concerning the effect of sexological interventions for people with *chronic disease* (heart infarction, spinal damage). The same was found for people with intellectual impairment (”dating skill program”). For people with *severe mental illness* one systematic review with 14 studies, five were randomised (total of 1127 people), there were positive effects of various sexological interventions for promoting sexual health.

S*elf help*, as written or audio/visual material *(bibliotherapy*) had an overall moderate positive effect for women and men regardless of sexual problem. Metaanalyses of 12 studies (397 people) showed significant moderate effectsize [ES 0.36 (CI 0.12 to 0.59)].

We did not find any studies on the effect of sexological interventions for people with questions on *sexual identity*.

DISCUSSION

The positive findings in this report are based on studies with very small populations. It is in the nature of the subject that it is challenging to evaluate the effect of sexological interventions in big trials with robust designs. We have, however, mostly as-

sessed the included studies to be of moderate methodological quality. We have pooled results in metaanalyses, but will point to the fact that the total study population is small. For many comparisons it was not possible to pool the results and we could only report from single studies. There was heterogeneity in populations, interventions and outcomes and outcome measures in the meta-analyses. We can not rule out that studies have results affected by risk of type-1 bias (false positive result) or type-2 bias (false negative result). There is an overall positive effect across interventions and populations. However, we can not rule out a publication bias in the material meaning that studies with negative findings might not have been published or not identified by us. Outcome measures on effect in the studies are mostly based on self reporting.

Interventions described in the research literature are not representative for the variety of treatment strategies offered for sexual problems and dysfunctions in men and women.

We did not identify Norwegian effect studies, but cross sectional studies suggest that the prevalence of sexual problems in Norway is similar to that found in other countries. In this report we did not follow the research protocol in that we excluded the population of sexual offenders. On people who have suffered sexual abuse we found many studies, but very limited information on sexual therapeutic interventions or sexual outcomes.

Sexual problems are for the environment and the health care professionals often a hidden problem. If it is not addressed it will stay under-diagnosed, not-acknowledged and not treated.

CONCLUSIONS

Overall, sexual therapeutic interventions are effective for people with sexual problems. This is shown for both a broad spectrum of populations and sexual problems. Self help, as information in written or audio/visual material (bibliotherapy) can be effective in the treatment of sexual problems. The results, however, must be interpreted with caution as the study groups were small, there are limitations in methodological quality and large variations in what is defined and presented as sexual therapeutic interventions. We cannot rule out publication bias.

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