

"No sex please, we're women"

Susan Quilliam

Background

You would agree, surely, that we Journal readers are in the sex business. Whether in the front line fighting sexually transmitted infections or in the back room of academic research, a huge part of our mission is to support women patients in their sex lives.

There's only one problem with that though. Many of them don't actually have a sex life. For while the tabloids assert that everyone swings from the chandeliers every night, in fact a huge proportion of our female client base, even those who are partnered, are not making love regularly. It's difficult to track down a definitive statistic, but it has been suggested that up to 35% of couples, married and non-married, have 'no sex' or 'very low sex' relationships at some time in their lives.

Whatever the truth of those statistics, that figure sounds about right to me. As an agony aunt for several publications, I get letter after letter from 'no sex' women: the mid-twenties reader in a long-term partnership whose love life died a few years ago ... the four times mother in her mid-thirties who has had sex only three times since her first pregnancy ... the menopausal woman so desperate through lack of desire that she feels life is at an end.

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And whilst on the surface the fact that a patient isn't having sex may seem to have nothing to do with her clinician, I would argue that it does. The lack of sex may not only be a symptom of underlying medical or psychological problems for her or for her partner. It is also likely to cause problems, impacting on her self-esteem, her stress levels, her relationship satisfaction – and the ripples will spread out to her family life, her working life and her general physical and mental health. Bottom line: we need to be aware of the possibility that a patient isn't having sex at all – and to remember that possibility in every consultation.

Is there a problem?

First and foremost though, how on earth can we tell? Few patients' opening gambit is: "Hi doctor, I'm not getting enough!". But as an initial sign, markers may be there in the presenting medical problem. If a patient has had a gynaecological 'event', for example, given birth, been through the menopause, had a termination. Or has a chronic illness, particularly one that debilitates or leaves her in constant pain. Or has suffered an accident, bereavement or other sudden trauma. Or has mental illness or problems with drug or alcohol abuse. Or, of course, has a partner with any of these last-mentioned problems. In all these situations there exists the possibility that together with the overt problem, a patient also has a non-existent sex life –

and may be showing signs of wanting to talk about that.

What are these signs? There may be overt statement, albeit said with stuttering hesitation: "I'm not ... that is, we're not ... that is, things aren't too good in the bedroom department". There may be oblique reference to "Chance would be a fine thing", muttered as the speculum goes in during a cervical smear test. There may be anxious body language when frequency of sexual activity is mentioned, or there may be action – such as the pointed refusal of a repeat prescription for the contraceptive pill.

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So, having looked for, and spotted, markers and signs, how to open the door to discussion? We shouldn't phrase the crucial question in a way that makes either of us wince with embarrassment, nor should we ask the question when the woman still has her feet in stirrups! Also, on this issue as much as on any other sexually linked theme, we must make it clear that there's no judgment involved. We must never ever raise an eyebrow, cast a pitying look, or comment that it's only to be expected at 'your age' if a woman admits that, actually, she's not having any right now.

What now?

Having opened the door to discussion, what happens then can, of course, go one of two ways. The fact is that many a woman is perfectly happy with her 'no sex' status and would regard any intervention as interference. If her own desire has died then the whole thing may well become a self-fulfilling prophecy: she doesn't want sex, and so by definition doesn't want to get help, because then she would

Box 1: A ten-point strategy to use with 'no sex' patients

- Be aware of conditions that may signal the patient may not be having sex.
- Be alert to patient verbal and non-verbal attempts to confide.
- Approach the issue in a relaxed and non-judgmental manner. Take your lead from the patient and use her terminology where possible, but also phrase in a way that you are comfortable with, for example: "Are you and your partner having sex at the moment?" A phrase that could help to normalise the question could be: "I'm asking all my patients at the moment...". Avoid wording such as "How often do you and your partner ...", which presuppose that the patient is having sex and so makes it more difficult for her to admit she isn't.
- Review the medical history of the patient and her partner to identify any physiological causes: "Let's look back at your health/medication since before these problems started happening"
- Review possible lifestyle causes: "What do you do in a normal day/week? How stressed do you feel?"
- Ask about recent emotional events: "Has your life changed recently? Did anything important happen in your life just before these problems started happening?"
- Ask about relationship issues: "How are you and your partner getting on right now? How were you getting on before you started having these problems?"
- Ask about specific sexual difficulties: "Was your sex life good before these problems started happening?"
- Refer on with confidence: "There is a way through this ... you need to get support from someone specially qualified in this area ... let me make some suggestions?"
- If possible, maintain patient contact: "I'd like you to come back and see me ... and tell me how the counselling is going."

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FROM OUR CONSUMER CORRESPONDENT

be expected to have sex! Hence if a woman says that she's happy with her situation, that's the point at which the issue rapidly becomes none of our business.

But if the floodgates open, and the patient can not only admit the problem but also requests our support to solve it, we can congratulate ourselves. Because, given that a 2000 survey¹ of British women suggests that only 21% ever seek treatment for sexual problems, any improvement on that number should make us justly proud.

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But what to do with our patient's admission, with her request for support? As with any purely medical diagnosis, the way forward is to find out what's underpinning the problem. Most 'no sex' situations are a tangled knot of physiological and psychological issues. And whilst I'm not suggesting that we aim to solve 'no sex' problems, especially not single-handed, what we can do is usefully untangle that knot a little more by asking sympathetic questions, allowing the woman to talk, by reassuring and holding out hope of help.

Medical causes

The first line of exploration can be medical. This article is not the place to list out in full the possible medical causes for sexual problems, nor am I properly qualified to do so. But as a rough checklist, if a woman or her partner has undergone a medical event recently (particularly one that has affected sexual anatomy), if she has begun a new course of medication that can affect desire, if she has suffered mental illness, particularly depression, then these may well be contributory causes. Appropriate treatment – or a change of treatment – may help, as may specific medical support with problems such as vaginal dryness or hormonal imbalance.

Once strictly medical causes have been ruled out, the next step is to explore lifestyle causes. My postbag reflects with startling clarity the fact that overwork and stress take their toll in the bedroom. My own study, *Women on Sex*,² further suggests that over 55% of women feel that pressure of work is affecting their sex life, and that for 75% of women the strain of bringing up children has dramatically reduced their rate of sexual activity. Plus, of course, all these things can lead to a dangerous reliance on the sort of lifestyle props that undermine sexual performance such as alcohol and drugs. So it's worthwhile asking the patient questions designed to discover whether her lifestyle might possibly be causing problems, then prescribing appropriately or offering appropriate stress reduction or addiction support.

Emotional causes

So far, so good – our role is clear. But, for all the excellent basic counselling training that is now part of professional development, few of us will have been fully trained in sex therapy. So should we, at this stage, simply be showing our patients the door?

I think not. The patient is here in the consulting room. They trust us enough to have begun to confide, possibly for the first time in their lives. So whilst I'm not suggesting that we muscle in and start 'therapising', I do think it's useful to extend the conversation a little beyond the point where medical expertise is relevant.

So, first, has anything happened to affect the patient emotionally? Redundancy, bereavement, termination, an accident or attack: all these events can drain a patient's

Box 2: Resources to help you refer patients on after you have ruled out medical issues

For lifestyle:

- Stress – many unions and professional bodies have stress helplines
- Childrearing – Parentline Plus offers support to anyone parenting a child: 0800 800 2222 (freephone in the UK) or www.parentlineplus.org.uk
- Alcohol addiction – Drinkline is a national helpline providing counselling, support, advice and information: 0800 917 8282
- Drug addiction – Talk to Frank is a national organisation providing free and confidential drugs information and advice: 0800 776600 or e-mail frank@talktofrank.com or www.talktofrank.com

For emotional life events:

- Bereavement – CRUSE Bereavement Care offers counselling, support, information and advice to anyone who has been bereaved, or who has been affected by a bereavement: 0870 167 1677 or helpline@crusebereavementcare.org.uk or www.crusebereavementcare.org.uk
- Termination – the fpa (Family Planning Association) provides confidential information and advice on contraception and sexual and reproductive health (including information on post-abortion support): 0845 310 1334 (local rate call) or www.fpa.org.uk
- Accident or attack – Victim Support is the national charity which helps people affected by crime, both reported and unreported: 0845 303 0900 or www.victimsupport.org.uk

For relationship issues:

- Relate offers a wide range of support, help and advice for people experiencing difficulties in their relationships: 0845 130 4010 (local rate call) or www.relate.org.uk
- The British Association for Counselling and Psychotherapy can provide details of local counsellors and psychotherapists: 0870 443 5252 or www.bacp.co.uk

For sexual problems specifically:

- Relate, the couples' counselling agency, offers not only marital but also sexual counselling: see details above
- The Institute of Psychosexual Medicine can refer patients on to counsellors in their area: 020 7580 0631 or www.ipm.org.uk
- The British Association of Sexual and Relationship Therapy also has a full list of counsellors: 020 8543 2707 or www.basrt.org.uk

Other useful resources:

- Depression – the Depression Alliance provides information and support for people who are affected by depression: 0845 123 2320 (local rate call) or www.depressionalliance.org. Samaritans (0845 790 9090 or jo@samaritans.org) or Saneline (0845 767 8000) can provide crisis support
- Rape – Rape Crisis (www.rapecrisis.org.uk) can provide a list of local rape crisis helplines and centres
- Abuse – the National Association for People Abused in Childhood can provide information and lists of local support groups for victims of childhood abuse: www.napac.org.uk

confidence and their sexual energy. Second, what's happening in the patient's relationship? Unexpressed anger, an inability to be emotionally intimate, a specific triggering issue such as an infidelity: all these drive a wedge between couples and reduce their motivation to make love. Third, are there any specific practical issues around sexuality? Lack of sexual skill, ignorance of what pleases a partner, a tension around conflicting sexual demands: all these can render sex unrewarding and so make partners pull back.

How to refer

For all these causes there's excellent referral help available (Box 1). Granted, sometimes it's a hard choice for a patient to opt for sex or relationship therapy; to agree to explore their psychological problems, to accept that those problems are not necessarily going to be solved with a medical 'fix', is a big step.

But we can help them take that step. We can tell them about what's on offer – self-help books, reputable websites, supportive helplines, face-to-face counselling (Box 2). We can not only talk them through the options but also give them the encouragement that will make them want to take up such resources. And, albeit given the very real constraints of health service resources, we can possibly

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motivate them further by inviting them to come back in a couple of weeks to report on progress.

A final thought. If we are prepared to tackle the 'no sex' issue head on and spend just a little time with patients exploring the issues, then we're not just supporting them to get the help they need. We're also giving them the message that they deserve that help, that their sexuality matters, and that they don't simply have to accept their current 'no sex' status if they want to take action and change it. And actually, in 'no sex' situations, that message – above and

beyond any other intervention we can offer – could just be the most useful thing of all.

References

- 1 Mercer CH, Fenton KA, Johnson AM, Copas AJ, Macdowall W, Erens B, *et al.* Who reports sexual function problems? Empirical evidence from Britain's 2000 National Survey of Sexual Attitudes and Lifestyles. *Sex Transm Infect* 2005; **81**: 394–399.
- 2 Quilliam S. *Women on Sex*. London, UK: Smith Gryphon, 1994.

Editor's Note

Susan's latest book is *Body Language* (£12.99, Carlton Books Limited).

VIEW FROM PRIMARY CARE

PBC: practice-based commissioning or privatisation becoming commonplace?

Jenny Talia

Reform and restructuring

Here we go again, more market reform of the National Health Service (NHS). As if we haven't had enough of the expensive bureaucracy and inequities of general practitioner (GP) fund-holding in the 1990s. And this time they are serious about putting GPs in the driving seat to commission health care services for their community; apparently, this is to enable frontline clinicians to engage in the process of commissioning.

Call me stupid but I thought the whole point of professional executive committees (PEC) in primary care trusts (PCTs) was to 'engage the frontline' and 'shift the balance of power'. If the Government really wanted to strengthen this engagement then it is the role and function of the PEC in the PCT that needs to be strengthened.

GPs might be very good at arguing for their own and their patients' interests, but the experience of fund-holding makes me fear my peers might not necessarily see the 'big picture' to manage the health economy. This time round, you would think a framework would be set for priority setting and resource allocation. Apparently not. All the guidance on PBC from the Department of Health speak of vague aspirations without stipulating any rules or regulations to ensure the process adheres to a framework that addresses the nation's health priorities. Even the primary care organisations – restructured and very downsized by then – would only have control at arm's length; just like the 'high trust and light touch' approach with the Quality and Outcomes Framework (QOF).

The input from a public health practitioner would be paramount to ensure the commissioning process considers the dimensions of equity, cost effectiveness and patient choice. Otherwise services that have public health functions, like most of sexual and reproductive health services, would be seen as less deserving compared with others that offer quick fixes such as operations and therapies. Actually, the contracting and commissioning would be a very small part of PBC; what matters more is the priority setting for resource allocation and the subsequent performance management and outcomes monitoring of contracted services.

The truth and the economics

But here is the real but sinister agenda: this is privatisation of the NHS dressed up in the mantras of 'promoting clinical engagement' and 'patient choice'. Of course, there is nothing wrong with trying to improve efficiency, standards, access and choice; but is creating competition in a health care market the solution?

From a health economist's perspective, the NHS is a monopoly. A technically or economically inefficient monopolist cannot be driven out of business; without competition, the monopolist has no incentive to improve efficiency or improve quality. Introducing competition might encourage firms to improve their products; in this case, better and more responsive health care services. However, a firm doesn't want to reap the same profits as its competitors, so it operates in ingenious ways to get ahead, and in doing so eventually becomes a monopolist. This is the question they are afraid to ask the public: would you prefer a monopolist that is motivated by altruism or one that is driven by profit?

The American nightmare, not a dream

It is becoming clear that Iraq is not the only casualty of the Bush–Blair collaboration: the NHS is under threat. After many trips to the USA, our Prime Minister is brainwashed into thinking the American health care system is what we need. If the Prime Minister really likes it so much, he should stay there. What does the USA have to teach us? The American health care system has the worst population coverage where the poor, black and unemployed are most disadvantaged; it has the highest *per capita* spending on health and yet no better health outcome than the UK; and its teenage pregnancy rate is the highest in the Western world. Even the French, despite their claim to have the 'best health care system in the world', are looking across the Channel to see how we manage to contain health care costs.

PBC and increasing competition are not the solutions to cost effectiveness, choice and quality in a publicly funded health system. The Prime Minister has learnt, rather belatedly, that there is potential for distorted priorities in a populist agenda such as the 48-hour access. After this reform, the winners would be politicians and shareholders of private companies and the real losers would be the consumers. If they get their way, you could walk into any GP surgery in the country and demand a speedy hernia or varicose vein operation from a choice list of ten hospitals; but try to get the rates of teenage conceptions and chlamydia down? Forget it.

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