Sexual Interview: Mental Health and Relationship Issues

9

Francesca Tripodi

9.1 Introduction

The core activities of sexual counselors and sexual therapists are to understand a thorough and accurate appraisal of the client's presenting problems and concerns, and all other information relevant to defining the issues, in order to plan interventions and predicting and evaluating outcomes. A detailed sexual history is the cornerstone for all sexual problem assessments and sexual dysfunction diagnoses. Diagnostic evaluation is based on an in-depth sexual history, including sexual identity (in the four components that constitute it: biological sexual factors, gender and role identity, sexual orientation), sexual activity and function (previous and current one), overall health and comorbidities, partner relationship and interpersonal factors, and the role of cultural and personal expectations and attitudes.

The third committee of the *Fourth International Consultation on Sexual Medicine* (ICSM) has reviewed a large body of publications relevant to the diagnostic evaluation of sexual function in men and women, including the advancement made in specialized testing on male and female sexual dysfunction (SD). The results and recommendations of the SD management committee [1], and of other relevant ICSM committees [2–5] represent the guide for this chapter. Suggestions highlighted in the volumes *The EFS/ESSM Syllabus on Clinical Sexology* [6] and *The ESSM Manual of Sexual Medicine* [7], which to date represent the guidelines for the European curriculum in clinical sexology and sexual medicine, are considered as well.

F. Tripodi (✉)
International Online Sexology Supervisors (IOSS) P.C. - Education and Research Service in Sexology, Thessaloniki, Greece

Institute of Clinical Sexology, Rome, Italy

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9.2 Clinical Evaluation of Sexual Dysfunctions in Psychiatric Population

The SD management committee of the ICSM endorses three basic principles for clinical evaluation and management of sexual problems in men and women [1]. These are briefly as follows:

- *Principle 1*—Adoption of a patient-centered framework, with emphasis on cultural competence in clinical practice
- *Principle 2*—Application of evidence-based principles in diagnostic and treatment planning
- *Principle 3*—Use of a similar management framework for men and women

Taken together, these three principles provide a balanced and integrated approach to clinical evaluation and treatment of SDs. The theoretical framework within which to consider all sexual complaints is the bio-psycho-social model. Therefore, clinicians should differentiate sexual problems bearing in mind a multifactorial assessment where biological, cognitive, emotional and behavioral, contextual, and interpersonal contributing factors and their ongoing interacting relations play a role in the individual's current sexual functioning and satisfaction.

When the client is a psychiatric patient, we face a first problem with the results of the evaluation process. To diagnose a SD according to DSM-5, it is necessary that the symptoms that characterize the disorder occur for at least 6 months, appear in all or almost all sexual episodes (more than 75% of the time), and cause personal distress. The SD should not be a direct consequence of a non-sexual mental disorder, severe relationship distress, or other significant stress factors and should not be attributable to the effects of a substance/drug or other medical conditions; otherwise the diagnosis cannot be made. The DSM-5 suggests to consider, among the etiological factors, the influence of the following that, when present and consistent, should exclude the diagnosis of SD:

(a) *Partner-related factors* (e.g., partner's sexual problems, partner's health status)
(b) *Relationship factors* (e.g., poor communication, discrepancies in sexual desire)
(c) *Individual vulnerability factors* (e.g., negative body image, history of sexual or emotional abuse), psychiatric comorbidity (e.g., depression or anxiety) or stress factors (e.g., job loss, mourning)
(d) *Cultural/religious factors* (e.g., inhibitions related to prohibitions against sexual activity, negative attitudes toward sexuality)
(e) *Medical factors* relevant to prognosis, course or treatment

The readers surely understand that many of these conditions are concurrent with a sexual dysfunction in psychiatric patients: mental disorders, drug intake, severe relationship conflicts, traumatic experiences, substance abuse, etc. That is a reason why many psychiatrists do not take the time to assess the sexual health of their patients, considering it as secondary to all the other health issues and not that important for the overall well-being. To my opinion instead, in psychiatric population when the DSM-5's A-B-C criteria for a SD are met (symptoms, duration, distress), it could be the case to adopt the concept of *double diagnosis*, where the mental syndrome is the main and primary focus of attention, but the sexual disorder is evaluated and treated as well, regardless of criterion D (exclusion through the specifiers abovementioned).

The ICD-11 expands inclusion criteria for the diagnosis of SD [8], including all those etiological factors that can contribute to the onset or maintenance of the symptom, and in fact it is better suited to the diagnostic process on populations with psychiatric comorbidity. First of all, the ICD-11 defines the sexual response as "a complex interaction of psychological, interpersonal, social, cultural, physiological and gender-influenced processes." Any of these factors may contribute to the development of sexual dysfunctions, which are described as syndromes that comprise the various ways in which people may have difficulty experiencing personally satisfying, non-coercive sexual activities. Second, where possible, categories in the proposed classification of SD apply to both men and women, emphasizing commonalities in sexual response, rather than differences as assumed in the DSM-5. Third, "satisfactory" sexual functioning is defined as being satisfying to the individual. If the individual is satisfied with his/her pattern of sexual experience and activity, even if it is different from what may be satisfying to other people or what is considered normative in a given culture or subculture, a sexual dysfunction should not be diagnosed. As a consequence, the diagnosis is not valid also in case of (a) unrealistic expectations on the part of a partner; (b) discrepancy in sexual desire between partners; (c) inadequate sexual stimulation. Last, but not least, the ICD-11 classification uses a system of harmonized qualifiers that may be applied across categories to identify the important clinical characteristics of the sexual dysfunctions. These qualifiers are not mutually exclusive, and as many may be applied as are considered to be relevant and contributory in a particular case. Proposed qualifiers include the following:

(a) *Associated with disorder or disease classified elsewhere, injury or surgical treatment* (e.g., diabetes mellitus, depressive disorders, hypothyroidism, multiple sclerosis, female genital mutilation, radical prostatectomy)
(b) *Associated with a medication or substance* (e.g., selective serotonin reuptake inhibitors, histamine-2 receptor antagonists, alcohol, opiates, amphetamines)
(c) *Associated with lack of knowledge* (e.g., about the individual's own body, sexual functioning, and sexual response)
(d) *Associated with psychological or behavioral factors* (e.g., negative attitudes toward sexual activity, adverse past sexual experiences, poor sleep hygiene, overwork)

(e) *Associated with relationship factors* (e.g., relationship conflict, lack of romantic attachment)
(f) *Associated with cultural factors* (e.g., culturally based inhibitions about the expression of sexual pleasure, the belief that loss of semen can lead to weakness, disease or death)

9.3 The Sexual Interview: The Important Questions

With psychiatric patients, the sexual interview has to follow a thorough mental health assessment, where the specialist has already got medical information focusing on identifying biological factors, comorbidities, and medical treatments that might be contributing to the sexual problem.

For each SD, there are definite questions that must be done to confirm the diagnosis, and those are related to the specific characteristics of the disorder. In short, we should assess the presence of certain symptoms, as described in the DSM-5 (criterion A), the ICD-11, and by the ICSM [2].

Other questions are considered by leading experts to be important and crucial for taking a sexual history [1, 4, 9, 10]. I would like to call them here "the top ten" in sexual interview, and the clinician should introduce them to the patient during the first or second sessions, wording as follows:

- *Can you describe the problem in your own words?*
  - When describing the difficulty, ask for clarification to know if it has appeared before or after other sexual disorders.
- *Has the problem always existed?*
  - If yes, check the psychosexual and relational factors and the awareness of bodily sensations and genital response.
  - If not, ask when it appeared and what, in his/her opinion, could have triggered the problem. Was the onset gradual or acute?
- *Are you sexually active? With or without a partner?*
  - If you are sexually active and on a regular basis, are you satisfied with your sexual activity? Are there differences in your sexual response?
  - Do you like sexual intercourse?
  - Is there sufficient and adequate sexual stimulation?
  - Do you masturbate? If yes, does the problem arise even when masturbating?
- *During sexual activity, do you experience negative thoughts or emotions?*
  - If yes, ask how much these thoughts or emotions impact on the possibility of remaining focused on the pleasurable and arousing sensations of sexual activity. Do you feel distracted, sexually substandard, unsafe, etc.? Do you feel sadness, emptiness, etc. at any point during the sexual activity?

  - Do you distract yourself with negative images related to body image, femininity/masculinity, performance, or others?
- *Is the problem limited to your partner and/or a specific context/situation?*
  - If yes, check the relational and contextual factors.
  - If not, and the problem is generalized, check for individual psychosexual and biological factors.
- *Does your partner have sexual problems?*
  - E.g., low sexual desire, arousal (erection, lubrication) or orgasmic disorders, pain during sexual intercourse? Be aware that the patient may be the "carrier" of the partner's sexual dysfunction.
- *What does the problem mean to you? Does it make you uncomfortable?*
  - Assess the degree of distress. Does it lead to frustration, guilt, shame, or other negative feelings? Examine performance anxiety.
- *What does the problem mean for your partner and for the relationship?*
  - Assess the degree of distress. How much the problem is affecting the relationship?
- *What is "normal" for you in sexuality? What do you expect should happen in a standard sexual encounter?*
  - Assess the presence of rigid sexual scripts, distorted cognitive schemas or dysfunctional thoughts, wrong beliefs, and sexual myths.
- *Is there anything else in your sex life that you think I should know in order to better assess your problem?*
  - The patient would like to add information about his/her previous experiences, his orientation or sexual identity, his/her sexual preferences, or anything else that may not have emerged during the interview.

At the end, collecting these data, we will be able to classify the SD according to the following categories:

- *Lifelong* (present from the beginning of sexual activity) or *acquired* at some point in the sex life (after a period of normal functioning)
- *Generalized* (present in all contexts, with each partner, etc.) or *situational* (only in certain contexts, partners, etc.)
- *Mild*, *moderate*, or *severe*, depending on the severity level of the symptoms

Each of these questions can potentially open the door to further information and inquiry. The main goal of a sexual interview is to define the problem in as much detail as possible, considering the partner's description, if possible. Furthermore, it allows to get some inputs, we would like to deepen more, in order to assess the contributing factors. In general, when there is marked situational variation in the presentation of the problem (e.g., present in some situations but not in others), psychological factors are implicated. Also, if the patient reports sporadic satisfactory

sexual function (even if very rare), then this is suggestive or indicative of psychological factors in the problem. If the complaint is lifelong, ask about masturbation and stressful events (if any) and enquire further about psychosocial factors or influences. If not, then ask when and under what conditions the sexual problem manifested and what might have caused or triggered it, such as unpleasant experiences, sexual intercourse with a new partner, a demanding or intimidating sexual partner, or non-sexual stresses. Question about sexual activity and satisfaction before the onset of the problem. Explore, with empathy and cultural sensitivity, about negative traumatic or humiliating sexual experiences. Assess cultural background and values in relation to sexuality issues. If it is not clear during the first phase of assessment, we should ask the patient *why he/she is seeking for help or treatment right now*. This is a very important answer as it often indicates important triggering factors, above all when the problem is lasting for years.

It is very important to get the real opinion of the patient about possible explanation of the sexual symptom, and we clinicians should guide our patients to think about a few options, at least the following:

(a) The problem occurs despite the right partner, adequate sexual stimulation (in time and approach), and appropriate sexual context.
(b) The problem is a consequence of partner's sexual difficulty.
(c) The problem is a consequence of the quality of the relationship with the partner (the less is the satisfaction in the couple, the less is the sexual function).
(d) The problem is a consequence of the duration of the relationship with the partner (the longer is the relationship, the more the problem persists).
(e) The problem is a consequence of a severe relational discomfort (psychological, physical, sexual partner violence).
(f) The problem is strongly influenced by external factors (family context, lifestyle, presence of stressors, etc.).
(g) The problem is a consequence of a medical condition or intake of substances/drugs.
(h) The problem is due to fantasies or sexual preferences that I do not want/can act.

Not all sexual difficulties can be categorized as a real dysfunction (satisfying all the criteria for a diagnosis); nevertheless, it can cause significant distress for the person or couple experiencing it. In these cases, during the assessment, it is important to elucidate what happens during the sexual response. The sexual response cycle involves a series of emotional and physical changes that occur when a person becomes sexually aroused and participates in sexually stimulating activities, including sexual intercourse and masturbation. Retracing all the phases of the sexual response (desire, excitement, orgasm, resolution) together with the patient and the partner can be useful, identifying any points of interruption or lack of fluidity [10, 11]. For this purpose, it is convenient to investigate the events that occur at the *beginning* of any sexual

activity (thoughts, fantasies, memories, interest, contexts), *during* sexual activity (adequacy of stimulation, genital and extra-genital sensations, subjective excitement, pleasure), not forgetting those *after* sexual activity (relaxation, satisfaction, intimacy, negative feelings such as emptiness, sadness, guilt, or shame). It should also be kept in mind that some people cannot feel satisfied sexually, despite a good level of sexual functioning and regardless the specific sexual activity or quality of performance. Functioning and sexual satisfaction (meant as an emotional state that occurs with the achievement of individual desires in the sexual sphere, different from pleasure and orgasm) are therefore two different variables in the clinical evaluation, both able to affect the motivation to start a sexual activity (ibidem).

After all that done, if we convinced ourselves that the role of other factors, besides the biological ones, is crucial, it may be worthwhile to investigate the psychosocial and relational variables in more detail.

Psychosocial issues. Ask about/assess:

- Daily mood and fatigue
- Body image concerns, especially genital image
- Sense of privacy
- Awareness about sexual rights
- Personality characteristics, self-esteem, self-efficacy, sexual self-confidence, extroversion, perfectionism, etc.
- Previous relationships with men or women
- Social skills, such as flirting or social networking
- Life-stressing factors, such as financial or work or job stresses

Relationship and partner issues. Ask about/assess:

- Relationship satisfaction, love, intimacy, trust, power dynamics, etc.
- Communication skills and whether the patient feels free to communicate the preferred sexual stimulation with partner
- Attraction between partners
- Physical intimacy
- Differences in partners' sexual preferences and potential
- How the couple copes with the problem. Pressure (imposed by patient or by the partner) can exacerbate symptoms
- Partner's attitude and reaction toward the sexual problem
- Each partner's goals and expectations

9.4 Predisposing, Precipitating, Maintaining, and Contextual Factors

Sexual function is typically influenced by a variety of *predisposing, precipitating, maintaining*, and *contextual* factors [11, 12]. Each of these factors contributes to determining the ability to preserve an active and satisfying sex life or the development and maintenance of sexual dysfunctions, both in the individual and in the

couple. The vulnerability of an individual to the onset of sexual dysfunction is determined by the relationship between risk factors and protective factors, as well as by his personal *resilience* (psychological attribute that describes the personal ability to deal with significant adversities). In general, the vulnerability to sexual dysfunctions is greater when there are more risk factors, lasting for longer periods, accompanied by huge forcing, compared to a single negative or traumatic episode. When stressors are greater than protective factors, even resilient individuals can be overwhelmed and develop sexual problems.

The *predisposing factors* are those conditions that precede the onset of the disorder and that make the individual more vulnerable to its trigger. These factors can be more biological in nature, such as a medical condition, or psychological, such as negative or traumatic life experiences. Their presence can diminish the ability to manage stressful events in adult life. The predisposing factors are rarely alone the cause of a sexual dysfunction, but they contribute to constitute a greater vulnerability of the subject (see Table 9.1).

The *precipitating factors* are events and conditions that occur at a certain point in the life of the subject and that can cause sexual difficulties, by themselves or in interaction with the predisposing factors. They include those more immediate factors that can bring a person from an adequate response to an altered one. They are able to trigger sexual dysfunctions or resolve when the "precipitating" situation should end or improve. The course depends on the individual's ability to deal with the problematic event (see Table 9.2).

The *maintenance factors*, instead, are not connected to the onset of the disorder but to the duration or to a greater or lesser ability of the subject or of the couple to overcome the sexual difficulty. They can prolong and exacerbate problems, regardless of the original predisposing conditions or precipitating factors, and are

Table 9.1 Predisposing factors

A.	*Constitutional factors*
	– Anatomical abnormalities (e.g., congenital disorders of sexual development)
	– Hormonal abnormalities
	– Temperament (e.g., shyness, impulsiveness, inhibition/excitability)
	– Physical recovery capacity (lack/low)
	– Personality traits (e.g., obsessive-compulsive, histrionic, borderline, etc.)
B.	*Developmental factors*
	– Problematic attachment and/or negative experiences with parents/caregivers
	– Episodes of physical, psychological, and/or moral violence
	– Surgical interventions/medical conditions
	– Traumatic events and/or trauma processing
	– First sexual experiences
	– Sexual abuse
	– Messages, expectations, and cultural/religious norms

Table 9.2 Precipitating factors

– Use of the condom or other contraceptive
– Stressful contextual situation in the specific sexual episode
– Discrepancy in the sexual repertoire with the partner
– Stressful life events such as divorce, separation, partner loss, infidelity, undesirable effects due to menopause
– Infertility or post-partum experiences
– Humiliating experiences in sexual encounters
– Depression/anxiety
– Relational conflicts
– Substance abuse
– Medical conditions, such as cancer, CVD, diabetes, etc.
– Partner's sexual problem

Table 9.3 Maintaining factors

– Current interpersonal conflicts
– Emotional, work, or personal stress
– Acute/chronic diseases or health problems
– Drugs or substance abuse
– Loss of sexual self-esteem, performance anxiety
– Problems related to body image
– Psychiatric problems
– Inadequate stimulation or foreplay
– Incorrect information on sexuality
– Poor communication between partners
– Fear of intimacy

Table 9.4 Contextual factors

– Fatigue in caring for an elderly parent, children, or sick partner
– Stress and daily challenges related to economic problems, unemployment, legal issues
– Problems related to the context: lack of privacy, time, shifts of work with the partner
– Repeated and unsuccessful attempts at conception, medically assisted procreation procedures

responsible for the conversion of episodic sexual failures into chronic dysfunctions (see Table 9.3).

Contextual factors tend to be temporary and situational and may interfere with sexual activity or maintain a dysfunctional situation. These are often aspects related to daily life, lifestyle, or problems that have led to a chronic change in personal or couple balance (see Table 9.4).

In essence, the assessment of a sexual problem should include an investigation of these factors, which will be useful to clarify the reasons for the current sexual functioning of the patient and the couple. The clinical interview, and/or the administration of questionnaires and scales, will be aimed at providing a temporal path of the patient's difficulties, starting from sexual development up to the current situation, with particular attention to the different life stages (Fig. 9.1).

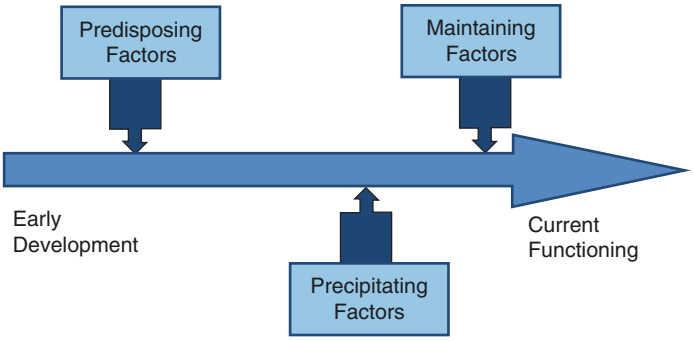

Fig. 9.1 Etiological timeline of sexual dysfunction

9.5 Therapeutic Alliance and Attitude During the Sexual Interview

Extensive research has consistently found a significant relationship between therapeutic alliance with therapy process and outcome [13–17]. Alliance has been found to be one of the most robust predictors of positive psychotherapy outcome regardless of the type of therapy utilized or whether assessed by therapist, client, or independent observer. The perceived psychotherapist's empathy, genuineness, acceptance, and competence are all associated with therapeutic alliance in the first stage of the treatment.

A well-conducted sexual interviewing and assessment can be seen already as a "therapeutic process" itself, which incorporates several specific therapist activities and strategies that have demonstrated promise in fostering positive working alliances. Specifically, in this very early step of treatment, clinicians are committed to:

- Developing and maintaining empathic connections with clients
- Working collaboratively with clients to define individualized objectives (e.g., "What's most important to you right now?" "At the end of therapy what would you most like to be different or have changed?" "How will you know at the end of our work together if treatment has been effective?").
- Sharing and exploring assessment results with clients, expanding the focus ("We've covered a lot of ground today and I've asked a lot of questions, but is there something that we haven't touched on yet that you think is vitally important to knowing you as a person?").

The therapist's ability to form a relationship with the patient during this stage may enhance his/her perception of being understood and aid in feeling more connected to the treatment process. When the ground is a psychiatric condition, and we want to alleviate a sexual distress, it could be very important to explore the *core relational theme*, meaning by that a statement of the patient's wish, an expected, imagined, or actual response from another, and a subsequent response from the self, which includes both the actions/behaviors and the feelings/affect associated with

this response. A common knowledge about these themes allows a better therapeutic focus on collaboration and alliance building.

Keeping in mind that approximately 40–50% of patients terminate therapy prematurely and that the effects of patient and therapist-rated alliance developed during an assessment persist across the course of treatment, the readers can follow why the initial sessions (up to 3) is an important area for clinicians to consider. The application of techniques that convey trust, appreciation, warmth, and understanding will likely increase opportunities to improve alliance levels in an initial session.

It is "never too early" in approaching the patient in the right way. Adopting a collaborative stance toward him/her, such as by exploring the client's perspective of their disorder in an interactive rather than one-sided manner, fosters more involved, depth-oriented interviews and develops early alliances. Therapist's techniques and attributes found to contribute positively to the alliance are summarized in Table 9.5 [13].

It may be necessary for a psychiatric patient to have a positive opinion of the therapist before he/she has enough influence to facilitate therapeutic change. If a patient believes the treatment relationship is a collaborative effort between him/herself and the therapist, he/she may be more likely to invest more in the treatment process and in turn experience greater therapeutic gains.

Which are, instead, therapist's techniques and attributes found to contribute negatively to the alliance? A summary of them is listed in Table 9.6 [13]. Of course, when the clinician does not pay attention to the patient's experience, intervenes in a dogmatic and rigid way, rejects the patient's expression of negative feelings, and does something the patient does not want or need, or his/her focus is off, he/she aggravate alliance ruptures.

Table 9.5 Interventions and attitude improving early therapeutic relationships

Techniques positively related to alliance	Attributes positively related to alliance
– Clarifying sources of distress	– Alert
– Maintaining an active focus on treatment related topics	– Confident
– Providing the patient with new understanding and insight	– Experienced
– Offering psychoeducation on symptoms	– Competent
– Fostering a collaborative treatment process	– Flexible
– Speaking with emotional and cognitive content	– Honest
– Using clear, concrete, experience-near language	– Respectful
– Utilizing open-ended and reflective queries	– Trustworthy
– Exploring in-session process and affect in a non-defensive and non-judgmental manner	– Open – Empathic
– Attending to the patient's unique experience	– Warm
– Facilitating client affect and experience	– Relaxed
– Fostering patient motivation for change	– Understanding
– Active-engaged involvement during the session	– Accepting
– Focusing on the here and now of therapy relationship	– Collaborative
– Providing ongoing feedback to patient	– Helpful

Adapted from: Hilsenroth MJ, Cromer TD, Ackerman S. How to Make Practical Use of Therapeutic Alliance Research in Your Clinical Work. Psychodynamic Psychotherapy Research: Evidence-Based Practice and Practice-Based Evidence 2012; 11:361–380.

Table 9.6 Precipitants to rupture in the alliance

Techniques negatively related to alliance	Attributes negatively related to alliance
– Managing the treatment in inflexible manner	– Rigid
– Over structuring the therapy	– Tense
– Failure to structure the therapy	– Defensive
– Inappropriate self-disclosure	– Self-focused
– Inappropriate use of silence	– Exploitive
– Unyielding transference interpretations	– Distant/detached
– Belittling or hostile communication	– Cold
– Superficial interventions	– Distracted
– Unsupportive confrontation	– Uncertain
– Giving unwanted advice	– Critical
– Missing importance of issues	– Aloof
– Focusing on something the patient does not want or need	– Indifferent

Adapted from: Hilsenroth MJ, Cromer TD, Ackerman S. How to Make Practical Use of Therapeutic Alliance Research in Your Clinical Work. Psychodynamic Psychotherapy Research: Evidence-Based Practice and Practice-Based Evidence 2012; 11:361–380.

9.5.1 Barriers to Discuss Sexual Issues

When talking about sexual interview and assessment, clinicians can meet several barriers to discuss these issues with their patients. Why do healthcare professionals not ask? Sexologists can be scared about the psychiatric condition while psychiatrists about sex. Some reasons could be as follows:

– Someone else will do it.
– Patients never ask about it, so they must not care.
– I don't know how to help or have time.
– I disagree with their lifestyle.
– They should be already happy to manage their psychosocial issues.
– They are too old, sick, young, etc.
– I will offend them by asking.
– I am embarrassed.
– I feel overwhelmed with more urgent healthcare issues.
– I lack specific training in sexual medicine.

That is why, when a psychiatric patient asks for sexological help, the ideal treatment team could be a psychiatrist and a clinical sexologist, and if needed involving other professionals, as urologists, gynecologists, endocrinologists, and physiotherapists. Training and supervision for all of us clinicians should focus on increasing basic/advanced therapeutic qualities, depending on our role in the treatment. That is why modern approaches to training in sexual medicine and sexology, carried out by the most important national and international scientific societies, are in fact educating HCPs capable of conducting a good sexual assessment and treatment, regardless of their specialty of origin. The innovative concept of these courses is to train

professionals from different specialties (and possibly from different cultural background) with the same interest in the field of sexual health and to give a common ground of knowledge, skills, and professionalism within the frame of the biopsychosocial approach to SD. In these contexts, multidisciplinary networking is promoted, but also for the single HCP the competence to see the patient through diverse perspectives when no team is available, which is the case of many countries and clinical environments. The goal of this book goes on the same line, being a useful resource of awareness and inspiration for all the psychiatrists willing to improve their expertise in sexual medicine, but also for the HCPs who need some knowledge about mental health conditions.

9.5.2 The "Good-Enough" Interview

In a "good-enough" interviewing, the clinician interacts in a respectful and nonjudgmental way. This is particularly true when the client is a psychiatric patient. We have to validate information and detect possible issues of secondary gain; provide client with preliminary information and, where relevant, feedback; perform or order from relevant specialist, significant psychometric, and other tests; progressively interpret and apply information to adapt assessment approach; and complete assessment in timely manner appropriate to client's needs.

Interrelationships of presenting signs, symptoms, objective tests, and other relevant features of the client's history and current circumstances will be considered when we will share the results of the assessment process with the patient/couple. Findings have to be interpreted with respect to gender, age, and physical and psychosocial parameters of the client; compared with current knowledge, expectations, and practice for the presenting condition and include or exclude alternative diagnosis; compared with client's expressed goals and aspirations and with cultural and statistical norms. Prioritize client's realistic needs and expectations, acknowledge and address differences between partners, and understand and incorporate into intervention planning the client's cognitive capacities for recognizing/accepting realistic goals, his/her physical capacities for meeting these goals, and cultural, social, religious, and legal issues that may impact on meeting aspirations and targets are essential clinician's tasks.

Working in partnership with the client means also re-evaluate, if required, our hypothesis, recognize and predict likely intervention effects, and—very important—identify areas that are outside our skills and expertise and refer the client appropriately.

9.6 Key Messages

- A detailed sexual history is the cornerstone for all sexual problem assessments and sexual dysfunction diagnoses. It should include sexual identity, sexual activity and function, overall health and comorbidities, partner relationship

and interpersonal factors, and the role of cultural and personal expectations and attitudes.

- Clinicians should differentiate sexual problems through a multifactorial assessment where biological, cognitive, emotional and behavioral, contextual, and interpersonal contributing factors and their ongoing interacting relations play a role in the individual's current sexual functioning and satisfaction.
- The ICD-11 classification seems better suited for the diagnosis of SD on populations with psychiatric comorbidity, where the mental syndrome could be the main and primary focus of attention, but the sexual disorder is evaluated (and treated) as well, when it is a source of distress for the patient.
- With psychiatric patients, the sexual interview has to follow a thorough mental health assessment, where the specialist has already got medical information focusing on identifying biological factors, comorbidities, and medical treatments that might be contributing to the sexual problem.
- Ten questions are considered by leading experts to be important and crucial for taking a sexual history; each of these questions can potentially open the door to some inputs we should deepen more, in order to assess the contributing factors (predisposing, precipitating, maintaining, and contextual).
- Therapeutic alliance has been found to be one of the most robust predictors of positive psychotherapy outcome regardless of the type of therapy utilized. The perceived psychotherapist's empathy, genuineness, acceptance, and competence are all associated with therapeutic alliance in the first stage of the treatment.
- Clinicians can meet several barriers to discuss sexual issues with their patients. Specific training, supervision, networking with specialists from different disciplines, staying update with the prominent publications on evidence-based medicine, and belonging to scientific societies in the field are the best strategies to overcome these barriers and be of help for psychiatric patients.

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