Diabetes in the bedroom: Discussing the psychological element of diabetes-related sexual difficulties

Jen Nash, Shafali Talisa Arya

Sexual dysfunction is a significant comorbidity experienced by many people with diabetes. While physical factors underlie sexual problems in a number of people with diabetes, emotional elements can also complicate sexual relations in any long-term partnership, but this is manageable in many people with diabetes. This article covers psychological factors and other aspects of a relationship that can inhibit a fulfilling sex life. A self-help guide is included for people with diabetes on how to manage the emotional impact of sexual difficulties and outlines the importance of self-esteem through a case study, with a step-by-step guide to cognitive behavioural therapy.

Encountering problems with sexual response is a common experience for both men and women with diabetes. As well as affecting physical aspects involved during intercourse, diabetes may also be associated with psychological factors that interfere with people having a full and rewarding sex life. Psychological approaches that can be used to manage these factors are the focus of this article.

Problems with sexual function can be very distressing, and affect the quality of the person's life and their relationships (De Berardis et al, 2002). Although help is available, many people (both with and without diabetes) find sexual difficulties an embarrassing topic to discuss in the context of a health appointment and, therefore, refrain from being open with their healthcare professional about their difficulties.

This article will describe the different ways the sexual response of people with diabetes may be affected and suggests ways for nurses to start conversations about this sensitive issue during consultation periods.

Sexual dysfunction in both genders

Many physical factors, in addition to diabetes, can contribute to difficulties with sexual response in both men and women with the condition. These include:

- Alcohol.
- Smoking.
- Substance misuse.
- Medications.
- Spinal cord damage.
- Nerve damage (for example, caused by operations to the bladder, bowel or prostate).
- Poor blood supply.

Male sexual dysfunction

Erectile dysfunction is when a man is unable to obtain or keep an erection long enough for sexual intercourse, and this is significantly more common in men with diabetes than those without. A study of 1460 males with diabetes found 34% of this sample reported erectile issues (De Berardis et al, 2002). In practice, this figure may be higher owing to responders' unwillingness to report difficulties with sexual function (Smith et al, 2012). In comparison, about one in 10 men over 40 years have erectile dysfunction, whether they have diabetes or not. In addition to erectile dysfunction and the sexual problems that affect both genders,

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Article points

1. Emotional factors – ranging from stress, anxiety and depression to bereavement and infertility – can cause both men and women with diabetes to encounter problems relating sexually with their long-term partner.
2. This article includes a self-help guide for people with diabetes called "sensate focus" that describes new ways to be intimate with their partner that do not focus on erection or orgasm.
3. Other aspects of sexual relationships are covered, including communication, conflict resolution, and the value of cognitive behavioural therapy, which is illustrated using a theoretical case study.

Key words

- Communication
- Sensate
- Sexual difficulties

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Page points

1. Several factors can contribute to sexual difficulties in men in addition to erectile dysfunction. These include penile injury, hypogonadism and hypertension.
2. Women affected by sexual dysfunction are less likely to know that diabetes may be the cause of these difficulties than men.
3. Investigation of potential physical causes for sexual dysfunction may require laboratory and clinical data, and referral to a hospital specialist.

the following factors can contribute to difficulties with sexual response, specifically in men:

- Penile injury.
- Nerve damage caused by operations (for example, operations to the bladder, bowel or prostate gland).
- Peripheral arterial disease.
- Hypogonadism.
- Hypertension.

Female sexual dysfunction

Women with diabetes are also at increased risk of experiencing difficulties with sexual response, compared to healthy women (Bitzer and Alder, 2009). Although these may not be as visually obvious as those experienced by men, they can be just as upsetting and difficult to manage. Physical reasons for sexual problems in women may be:

- Hyperglycaemia-induced vaginal dryness.
- Proneness to fungal candidiasis, which can cause discomfort during intercourse (Diabetes UK, 2014).
- Loss of skin sensation around the vagina.

Support for the physical side of sex

The starting point of most consultations that consider sexual problems is to investigate the potential role of physical causes. This may require laboratory and clinical data, and referral to a hospital speciality. Once the diagnosis is made, a growing range of treatments and management options can be considered. The range of physical causes and management options are described in detail in a recent review in *Diabetes & Primary Care* (Edwards, 2013). A discussion about the availability on the internet of medicines to treat erectile dysfunction and the possibility that the products may not be genuine can be useful.

As well as the management of specific causes, it can be helpful to mention the following general guidelines for improving sexual response in both men and women:

- Weight loss.
- Smoking cessation.
- Reducing alcohol consumption.
- Improving glycaemic control or changing treatment regimen (Milsten et al, 2010).

It is important to consider glycaemic control if the sexual difficulty coincided with a sudden worsening of glucose control or with starting a different drug.

Emotional factors in sexual dysfunction

In addition to physical problems, emotional factors can cause both men and women with diabetes to encounter problems relating sexually with their partner. Some of these include:

- Stress.
- Depression and low mood.
- Anxiety and worry.
- Relationship conflict.
- Religious and cultural pressures.
- Homosexuality.
- Bereavement.
- Illness.
- Being in an accident.
- Previous abuse.
- Infertility.
- Disability.

It is natural for people to feel embarrassed about discussing sexual problems with healthcare professionals. Setting the scene during annual checks by routinely raising the fact that diabetes can impact sexual performance will allow the individual the opportunity to discuss any issues, when they are ready.

To ease potential awkwardness, it can be helpful to follow the individual's lead in terms of the language they use, or be proactive by enquiring how they would like the difficulty discussed. If no potential physical causes are found during the medical assessment, a shift in focus to psychological strategies can be helpful.

The programme outlined below can be offered to people with diabetes as a self-help guide to work on the sexual relationship with their long-term partner. Alternatively, the following information can be adapted by a nurse for use in consultations with people with diabetes who are having sexual difficulties.

A guide for people with diabetes and sexual dysfunction

How to manage the emotional impact of sexual dysfunction

Enjoyment of sex goes beyond the act of intercourse, which culminates in an orgasm. Enjoyment of the sexual experience involves

a whole range of factors, including your past experiences of sex, your appearance, your confidence physically and sexually and so on. Early traumatic sexual experiences and negative beliefs about sex that stem from family values and attitudes can hinder the sexual experience. The sensate exercises described here can help overcome these stresses and increase your confidence in your own body. Remember that knowing what works for you is crucial to helping your partner learn your tastes.

A plan with sensate focus

The aim of this sensate focus plan (Nash, 2013, adapted from Ford, 2005) is to learn new ways to be intimate together that do not focus on erection, intercourse or orgasm. It is designed as the starting point for all sexual problems (for men and women, and relating to heterosexual and homosexual relationships). It allows you to get out of the trap of sex feeling conflictual, and helps you renew your enjoyment in your own and each other's bodies. This takes the pressure off in the short term, providing a good foundation for better relating. The whole exercise is planned to take five weeks, although it may take longer if you need to allow more time for particular stages. In the first week, you need to plan and find time for three sessions, each lasting approximately 1–2 hours. For best results, it is advisable to agree with each other not to have sex or masturbate outside of these sessions.

Week 1

- Take it in turns to be the "active partner", so decide who will go first.
- The "passive partner" lies down on their stomach on the bed, getting as relaxed and comfortable as possible.
- The exercise is designed to be done in silence so only comment if something is uncomfortable or painful. Remaining quiet helps to avoid embarrassment and also aids your concentration.
- If one or both of you feel embarrassed naked (perhaps because of weight gain or a scar following an operation) then you can wear underwear or a towel when you begin. These items can be removed in future sessions as you become more comfortable.
- It is the role of the active partner to give a massage, but a slightly different massage to the ones you may have given in the past. This one uses more of your senses: sight, sound, smell, taste and touch.
- Start by touching the top of your partner's head. Feel the shape and size, smell the head and hair, run your fingers through the hair, use soft massage strokes all around the head and neck.
- Move down to the shoulder, kneading, squeezing, using whatever strokes you like. Massage the back; run your fingers down the spine; kiss, taste and pummel the skin. For women, you can use your breasts or hair – whatever feels good.
- Next move on to the buttocks, again using whatever stroke feels good. Work down the tops of the legs over the calves and down towards the feet and toes. Firm hand movements are better than soft fluttery ones, which may be ticklish.
- Spend about 15 minutes doing this exercise, and then tweak your partner's big toe to indicate that it is time for them to turn over so they are lying on their back.
- Start again from the top, exploring the face, nose and lips, kissing, gently licking, tasting and touching. Move on to the chest but avoid breasts and nipples as they are off limits for now. Massage the chest and stomach, then the arms and hands. Lick, gently bite and suck the fingers.
- Do not touch the vagina or penis at this stage. Massage the tops of the legs, work down over the knees and shins to the top of the feet. This should take another 15 minutes, taking 30 minutes in total.
- When you have finished, it is time to swap

Box 1. Sensate focus: Questions to ask each other

- What felt good?
- What did you enjoy?
- Were there any difficult parts?
- What have you learned for yourself?
- Which role felt more comfortable?
- Did you feel any pressure in either role?
- Did you feel anxious at all? If so, did the anxiety lessen or increase as the exercise progressed?

"Enjoyment of sex goes beyond the act of intercourse and orgasm, and involves a whole range of factors, including your past experience of sex, your appearance, and your confidence physically and sexually."

Page points

1. The aim of the five-week, sensate focus plan is for people to learn new ways to be intimate together that do not focus on erection, intercourse or orgasm. This can release people from the trap of allowing the topic of sex to feel conflictual.
2. Week 2 of the "sensate focus" plan introduces experimentation with lotions and smells, and feedback on what feels good while the sexual areas of the body are off limits to touch.
3. The basis of the "sensate focus" plan is for the partners to build trust and confidence by talking about each session afterwards.

places; the passive partner becomes active and follows the same routine. When you are done, put on a towel or robe, cuddle up and talk to one another about the experience and your feelings. Consider the "sensate focus" questions in *Box 1*.

Week 2

- Week 2 follows the same pattern as week 1, but incorporates experimenting with lotions, talk, creams, massage oils, food or drink.
- Think about smell. What smells do you like? What feels good? What looks good? It is important that when you are the active partner you use the products you like rather than what your partner likes. You can always wash it off afterwards. Have some fun and be imaginative. Try feathers, chocolate, silky material. Do be careful if you have a skin complaint or allergy.
- You can give feedback (such as "that's nice") but keep talk to a minimum.
- The sexual areas are still off limits during this week.
- Again, attempt to complete three sessions over the week, talking over and recording your findings after each one and, if you need to, taking time for one or two additional sessions so that you are completely comfortable before moving on to week 3.

Week 3

- The following week, repeat again everything you have done so far, but now include the breasts and genital areas.
- Do not pay particular attention to the sexual areas; give them the same amount of attention as you do to the other parts of the body as you make your journey of massage over your partner's body.
- The focus is on building trust and confidence.
- Talk about each session afterwards in the same way as previously, and only move on when you both feel ready.

Week 4

- Week 4 is about learning what each of you enjoys.
- Having completed the massage as before, focus on the sexual areas.
- Take a look at your partner's penis/vagina. Note the colour and texture of the skin, feel the warmth, feel her breasts and his nipples, note the size and colour. Do no more than simply look and gently touch.
- Should you start to feel any anxiety, stop and talk to teach other about what is making you feel uncomfortable. As with any of the stages described above, do not move on to the next stage until you feel comfortable. Once the exercise is complete, discuss it together in the usual way.

Week 5

- Week 5 is about giving and receiving pleasure for mutual enjoyment.
- Repeat all of the steps in week four above, but now tell each other what feels good as it happens.
- Provide feedback about what you are enjoying, such as: "that's nice" or "more of that".

After week 5, the programme changes depending on whether the individual is struggling with erectile dysfunction or orgasmic dysfunction. It may be helpful to tell the person that there is a second phase of the programme and that they should organise a consultation to discuss this when they near the end of the first 5 weeks. Details of weeks 6 to 10 of the programme can be accessed in the literature (Nash, 2013). In addition to the sensate focus, it may be helpful to discuss with the individual other elements that can improve the relationship, such as communication, conflict resolution and new ways of expressing love.

Other aspects of sexual relationships

Communication

The sexual programme will help with how you communicate with your partner. Allow time each day to really communicate with each other. Even 10 minutes a day is a great start. Really listen to what your partner is saying, and empathise with them. Attend to their body language and do not offer solutions or try to solve their problems unless explicitly asked.

Express conflict

Hurts and conflicts that are unvoiced are toxic to a relationship. A mirroring can occur, where conflict is not expressed in daily life, and so sexual love is not expressed in the bedroom.

Plan romantic times

Life is really busy, and it can be difficult to fit in quality time to relate with your partner. It is, therefore, important to make a specific date to do this. Plan to have a relative or friend watch the children and decide what you would like to do: have a meal, see a film, have a walk in the park, or even just stay at home with a DVD, but remove distractions and turn off the phone.

Other ways to give love

We all give and receive love in many different ways, and demonstrating our love is an important way of showing our feelings. Chapman (2010) proposed that we each have our own personal "love language", which is one of the following types of expression that is more dominant for us than the other ones:

- Words of affirmation: Compliments, or hearing the words "I love you".
- Quality time: Giving one's full, undivided attention makes this person feel very loved and special.
- Receiving gifts: Although few people would say they didn't enjoy receiving gifts, for this person it is the thoughtfulness and effort behind the gift that is important.
- Acts of service: Helping with the burden of responsibilities in small and big ways is important for this person.
- Physical touch: While this can mean sexual touching, it can also be tender touching. Holding hands, hugs, pats and touches on the arm or face are other ways to show love.

Think with your partner about which ones you each particularly enjoy and be on the lookout for opportunities when you can engage in each other's love language.

Raise your self-esteem

Sexual dysfunction can knock the confidence of both men and women, so you may need to work on your self-esteem.

- Keep a diary where you record three things you are proud of, have done well, or like about yourself each day. For example, "I had that difficult conversation with my colleague."
- Say something complimentary to yourself every time you look in a mirror, such as: "Your eyes look nice today"; "I feel good today" or "I did that really well".
- Thinking styles are also important in raising self-esteem. Techniques drawn from cognitive behavioural therapy (CBT) can be used to challenge unhelpful thinking styles.

Using cognitive behavioural therapy to resolve sexual dysfunction

The questions in *Box 2* (overleaf) are an example of dialogue between a therapist and a patient during CBT. You may want to discuss CBT as a treatment option if self-esteem is a particular concern. If they are receptive, you may want to print a copy of the case study for them to keep.

Conclusion

Sexual difficulties are very common amongst men and women with both type 1 and type 2 diabetes. Overall, psychological factors can play a role in sexual dysfunction. This article has introduced a self-help programme to provide people with diabetes with the help to move beyond any physical barriers to a fulfilling sex life. Clinicians have an important role to play in educating and normalising this particular impact of diabetes and, in doing so, can support people with diabetes to feel fully expressed in their sexual wellbeing. ■

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Page points

1. The basis of the following case study is to illustrate thinking styles that may be present in people with low self-esteem along with alternative styles that may be encouraged during therapy.
2. People experiencing sexual dysfunction may entertain thoughts that are contributing to the problem, think in "all or nothing" terms, and use language such as "I can't do this" and "I'll never be normal".
3. Cognitive behavioural therapy encourages people to challenge extreme thoughts with questions such as, "What is the evidence for and against this thought", "Is thinking this way helping me?" and "How else could I think about this?"

"Allow time each day to really communicate with each other. Really listen to what your partner is saying, and empathise with them. Attend to their body language and do not offer solutions or try to solve their problems unless explicitly asked to."

Box 2. Case study: Howard

Howard has been struggling with erectile dysfunction for a few months now. Although his partner, Julie, is understanding and supportive, he still notices his mind wandering to negative thoughts about himself and his inability to pleasure her sexually.

Step 1: What is the situation or event?

- Thinking back to a recent sexual experience with Julie that did not go well

Step 2: What do you tell yourself? What thoughts do you notice running through your mind?

- "I can't do this."
- "This is embarrassing."
- "It's not working as it should."
- "Julie will think I don't love her or fancy her any more."
- "I'll never be normal."

Step 3: What is happening in your body and what do you do?

- Mood – fearful, anxious
- Body sensations – heart beating fast, shallow breathing, flushed face due to embarrassment
- Behaviours – avoiding closeness to Julie in case it leads somewhere

Step 4: Challenge your thoughts by asking yourself some helpful questions:

- What is the evidence for and against this thought?
- Is thinking this way helping me?
- Are there other ways of thinking about this situation?
- If a friend told me they were thinking this way, how would I respond?
- Am I thinking in "all or nothing" terms?
- What other points of view are there?
- How would someone else think about this?
- How else could I think about it?
- How would I think about this if I were feeling better?
- What are the facts of the case?
- How can I find out which way of thinking fits the facts best?
- What is the evidence?
- Could I be making a mistake in the way I am thinking?
- Am I thinking straight?
- Am I pressurising myself?
- Am I using the language of the extremist?
- What is the worst thing that could happen?

Step 5: Come up with an alternative, balanced thought

- "I can't do this." Having difficulties with sex is common for people with diabetes.
- "It's not working as it should." I won't always have this struggle.
- "This is embarrassing." I'm following a plan and learning how to enjoy sex again.
- "I'll never be normal." I'm getting control over the problem by implementing this plan. I'm going to ask Julie to compliment me/my appearance when we are in bed together.
- "Julie will think I don't love her or I don't find her attractive any more." I'm going to focus on all the aspects of the sexual experience, the closeness and intimacy with Julie, how good it feels to be touched, how nice it is to be kissed and stroked.