AMORE E PSICHE
AI TEMPI DEL DIABETE

Roma - 24 Marzo 2017
NH Hotel Villa Carpegna
"SALA TIEPOLO"

LA COMUNICAZIONE DI DIAGNOSI: RUOLO DELL'ANDROLOGO E DELLO PSICOSESSUOLOGO UN PERCORSO IN SOLITARIA O DI COPPIA?

Dott.ssa Gilda Ruga, Androloga

Dott.ssa Valentina Rossi, Psicologa e Consulente sessuale

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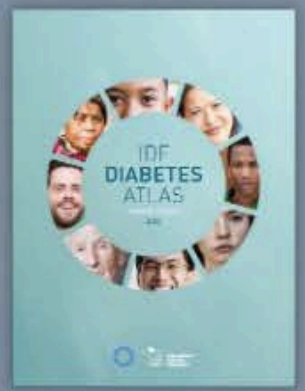
IDF DIABETES ATLAS - 7TH EDITION

International Diabetes Federation

415 million adults have diabetes.
By 2040 this will rise to **642 million.**



Download the 7th Edition of the Diabetes Atlas:

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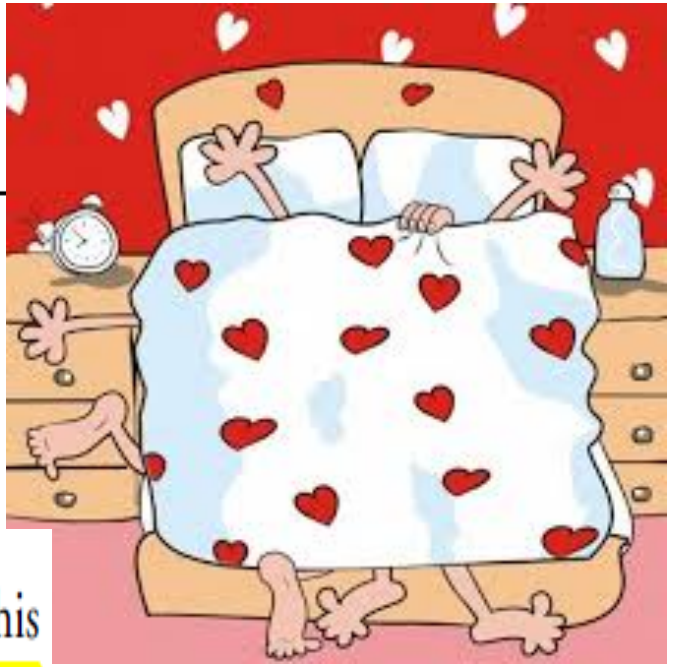
SEXUAL MEDICINE REVIEWS

Sex Med Rev 2016;■:1–7

Diabetes and Sexuality

Fuat Kizilay, MD,[1] Helena Elizabeth Gali, BA,[2] and Ege Can Serefoglu, MD, FECSM[3]



Deterioration in sexual functioning is one of the major and serious complications of diabetes. This common metabolic disorder not only affects sexuality through microvascular and nerve damage but also has psychological aspects. In men, the primary complications are erectile dysfunction, ejaculatory dysfunction, and loss of libido. Women similarly experience sexual problems, including decreased libido and painful intercourse.

Conclusion: Diabetes has detrimental effects on the sexual function of patients. Diabetologists who primarily care for the patient should not only focus on the glycemic control of their patients but also address their sexual complaints, because these problems can significantly impair their quality of life. Urologists, gynecologists, endocrinologists, and psychiatrists should work in a multidisciplinary manner for the treatment of decreased sexual functioning as a result of diabetes.

Summary of the Recommendations on Sexual Dysfunctions in Men

Tom F. Lue, MD,[a] François Giuliano, MD, PhD,[b] Francesco Montorsi, MD,[c] Raymond C. Rosen, PhD,[d] Karl-Erik Andersson, PhD,[e] Stanley Althof, PhD,[f] George Christ, PhD,[g] Dimitrios Hatzichristou, MD,[h] Mark Hirsch, MD,[i] Yasasuke Kimoto, MD,[j] Ronald Lewis, MD,[k] Kevin McKenna, MD,[l] Chris MacMahon, MD,[m] Alvaro Morales, MD,[n] John Mulcahy, MD,[o] Harin Padma-Nathan, MD,[p] John Pryor, MD,[q] Inigo Saenz de Tejada, MD,[r] Ridwan Shabsigh, MD,[s] and Gorm Wagner, MD, PhD[t]

Erectile dysfunction (ED) must be distinguished from other sexual disorders in the male such as early or delayed ejaculation, anejaculation and lack of desire, although these disorders are frequently coexisting.

Erectile dysfunction (ED) is defined as the consistent or recurrent inability of a man to attain and/or maintain a penile erection sufficient for sexual activity.

© Journal of Sexual Medicine 1743 6095
Vol. 1, No. 1, 2004

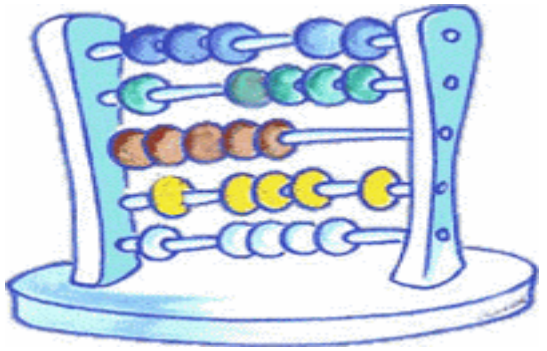
Age-Related Changes in General and Sexual Health in Middle-Aged and Older Men: Results from the European Male Ageing Study (EMAS)

Giovanni Corona, MD,* David M. Lee, PhD, MPH,† Gianni Forti, MD,* Daryl B. O'Connor, PhD,‡ Mario Maggi, MD,* Terence W. O'Neill, MD,† Neil Pendleton, MD,§ Gyorgy Bartfai, MD,¶

3369 uomini
Età 40-79 anni
(media 60±11)

Prevalence of Erectile and Orgasmic Dysfunction

ED (moderate or severe) was reported in 30% of the entire EMAS sample (Table 5). The prevalence of ED was higher in the older age groups, peaking in men 70 years and older (64%).



J Sex Med 2010;7:1362–1380

INCIDENCE OF ERECTILE DYSFUNCTION IN MEN 40 TO 69 YEARS OLD: LONGITUDINAL RESULTS FROM THE MASSACHUSETTS MALE AGING STUDY

THE JOURNAL OF UROLOGY®
Vol. 163, 460–463, February 2000

	No. Incident Erectile Dysfunction Cases	Person-Yrs.	Incidence/1,000
Crude incidence	194	7,475	25.9
Age:			
40–49	39	3,154	12.4
50–59	83	2,749	29.8
60–69	72	1,572	46.4

TABLE 1. *Crude and stratified incidence rates for erectile dysfunction in 847 men 40 to 69 years old from the Massachusetts Male Aging Study (1987 to 1995)*

A total of 194 new cases of erectile dysfunction in 7,475 person-years of followup were detected, for a crude incidence rate of 25.9 cases per 1,000 man-years (95% CI 22.5 to 29.9). The incidence of erectile dysfunction increased with each decade of age and was higher for men with self-reported diabetes (50.7 cases per 1,000 man-years), treated heart disease (58.3) or treated hypertension (42.5) at baseline (table 1). The risk of erectile dysfunction was almost 4 times higher for men 60 to 69 than for those 40 to 49 years old. Incident erectile dysfunction was inversely related to baseline education and income (table 1).

INCIDENCE OF ERECTILE DYSFUNCTION IN MEN 40 TO 69 YEARS OLD: LONGITUDINAL RESULTS FROM THE MASSACHUSETTS MALE AGING STUDY

THE JOURNAL OF UROLOGY®
Vol. 163, 460–463, February 2000

Sono stati analizzati 847 uomini senza evidenza di DE al momento del reclutamento e che hanno completato il follow-up. La DE è stata evidenziata mediante somministrazione di questionari costituiti da 13 domande.

	No. Incident Erectile Dysfunction Cases	Person-Yrs.	Incidence/1,000
Diabetes:			
None	177	7,140	24.8
Treated or untreated	17	335	50.7

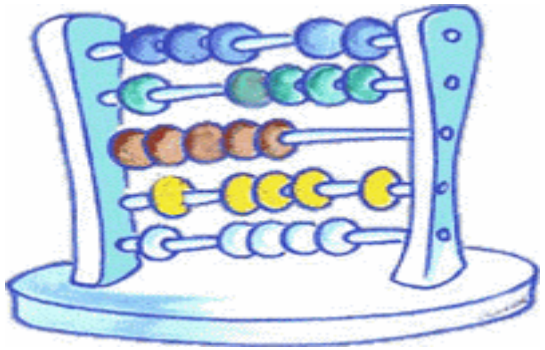
A total of 194 new cases of erectile dysfunction in 7,475 person-years of followup were detected, for a crude incidence rate of 25.9 cases per 1,000 man-years (95% CI 22.5 to 29.9). The incidence of erectile dysfunction increased with each decade of age and was higher for men with self-reported diabetes (50.7 cases per 1,000 man-years), treated heart disease (58.3) or treated hypertension (42.5) at baseline (table 1).

Conclusions:

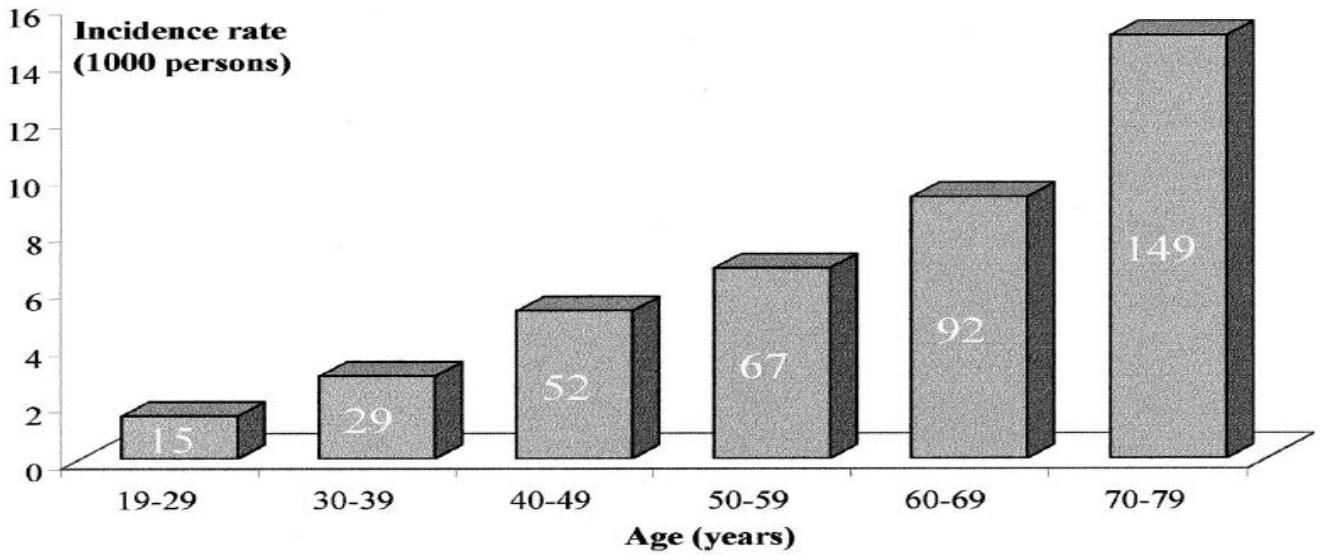
- Indipendentemente dall'età c'è una maggiore incidenza di DE nei *diabetici* rispetto ai *non diabetici*
- Il DE si presenta entro i dieci anni dalla diagnosi di DM

INCIDENCE OF ERECTILE DYSFUNCTION IN ITALIAN MEN WITH DIABETES

THE JOURNAL OF UROLOGY®



Results: Of the 1,010 men 192 (19%) complained of erectile dysfunction. The crude incidence rate of erectile dysfunction was 68 cases per 1,000 person-years (95% confidence interval 59 to 77). The incidence of erectile dysfunction increased with increasing age (10-fold higher for ages 70 to 79 than for 19 to 29 years), duration of diabetes (1.6-fold higher a history of 11 years or greater than for less than 5) and deteriorating metabolic control (1.7-fold higher for hemoglobin A1c greater than 9% than less than 7.5%). Moreover, it was higher in type 2 than in type 1 diabetes (74 versus 45 cases per 1,000 person-years).



Incidence of erectile dysfunction stratified by patient age

TABLE 2. *Incidence of erectile dysfunction stratified by type, duration and control of diabetes, and body mass index*

	Incidence/1,000 Pts. (95% CI)
Diabetes type:	
1	45 (28–62)
2	74 (63–84)
Diabetes duration (yrs.):	
1–5	47 (19–75)
6–10	55 (40–70)
11 or Greater	77 (65–91)
Metabolic control (% hemoglobin A1c):	
Good (less than 7.5)	52 (40–64)
Fair (7.5 to less than 9)	77 (61–93)
Poor (greater than 9)	90 (61–119)
Body mass index:*	
Normal (18.5–24.9)	51 (36–64)
Pre-obese (25.0–29.9)	70 (56–84)
Obese (greater than 30)	92 (68–116)

* No participant was underweight.

D. FEDELE, C. COSCELLI, D. CUCINOTTA, G. FORTI, F. SANTEUSANIO, S. VIAGGI,* G. FIORI,* T. VELONÀ,* M. LAVEZZARI,* AND the MEMBERS OF THE DIADE STUDY GROUP†

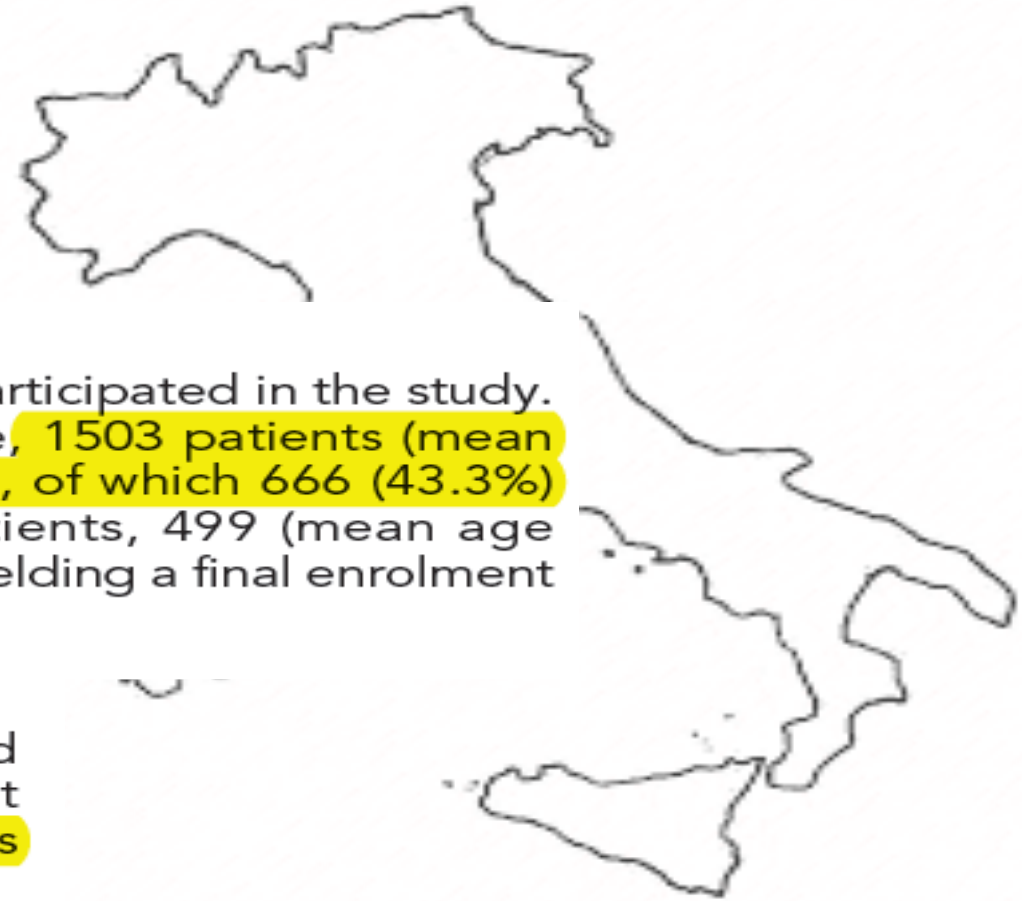
The SUBITO-DE study: Sexual dysfunction in newly diagnosed Type 2 diabetes male patients

J. Endocrinol. Invest. 36: 864-868, 2013

G. Corona[1], C.B. Giorda[2], D. Cucinotta[3], P. Guida[4], E. Nada[5], and the SUBITO-DE study group*

[1]Endocrinology Unit, Medical Department, Azienda USL Bologna, Maggiore-Bellaria Hospital, Bologna; [2]Metabolism and Diabetes Unit, ASL Torino 5, Torino; [3]Policlinico di Messina, Department of Medicine, Messina; [4]Cardiology Unit, Emergency and Organ Transplantation Department, University of Bari, Bari; [5]Chaira Medica Association, Chieri, Italy

Without preliminary selection, all male patients recently (<24 months) diagnosed with T2DM were consecutively interviewed by their attending physician at the diabetes care centers and asked whether they had experienced a change in their sexual function or found it unsatisfactory. Those responding positively were then invited to participate in the study.



RESULTS

In all, 27 diabetes care centers participated in the study. During the cross-sectional phase, 1503 patients (mean age 58±8.9 yr) were interviewed, of which 666 (43.3%) reported ED. Of these 666 patients, 499 (mean age 58.8±8.8 yr) entered the study, yielding a final enrolment rate of 33.3%.

Use of ED medications

About 20% said they had used ED drugs, 2% reported habitual use and less than 10% occasional use. About 50% said they had abandoned therapy because it was either ineffective or costly.

The SUBITO-DE study: Sexual dysfunction in newly diagnosed Type 2 diabetes male patients

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Depressive symptoms

The average CES-D score was 16.1, with a score >24 suggesting clinical depressive symptoms in about 20% of patients.

Over one-third of the patients presented with a CES-D score suggestive of depression. There is an established association between DM and depression (47, 48) and the bidirectional relationship between depression and ED (49). Subsequently, if depressive symptoms at the baseline visit herald the risk of ED at the follow-up visit, ED will increase the risk for developing depressive symptoms

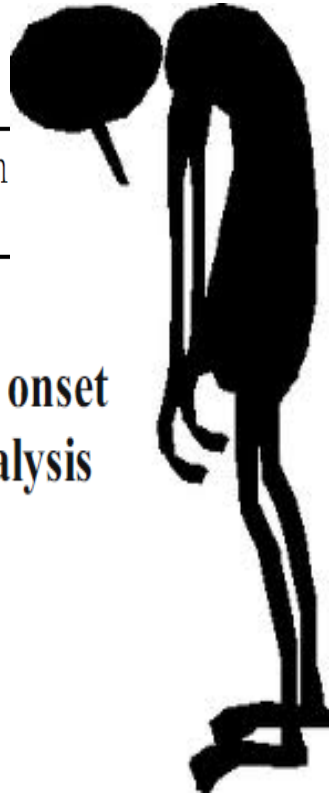
Reviews/Commentaries/ADA Statements

META-ANALYSIS

Diabetes Care 34:752–762, 2011

Prevalence of Depression in Individuals With Impaired Glucose Metabolism or Undiagnosed Diabetes

A systematic review and meta-analysis of the European Depression in Diabetes (EDID) Research Consortium



Type 2 diabetes mellitus as a risk factor for the onset of depression: a systematic review and meta-analysis

Diabetologia (2010) 53:2480–2486
DOI 10.1007/s00125-010-1874-x

Bidirectional Relationship Between Depression and Erectile Dysfunction

THE JOURNAL OF UROLOGY®

RESEARCH ARTICLE

October 5, 2016

Sexual Dysfunction in Type 2 Diabetes at Diagnosis: Progression over Time and Drug and Non-Drug Correlated Factors

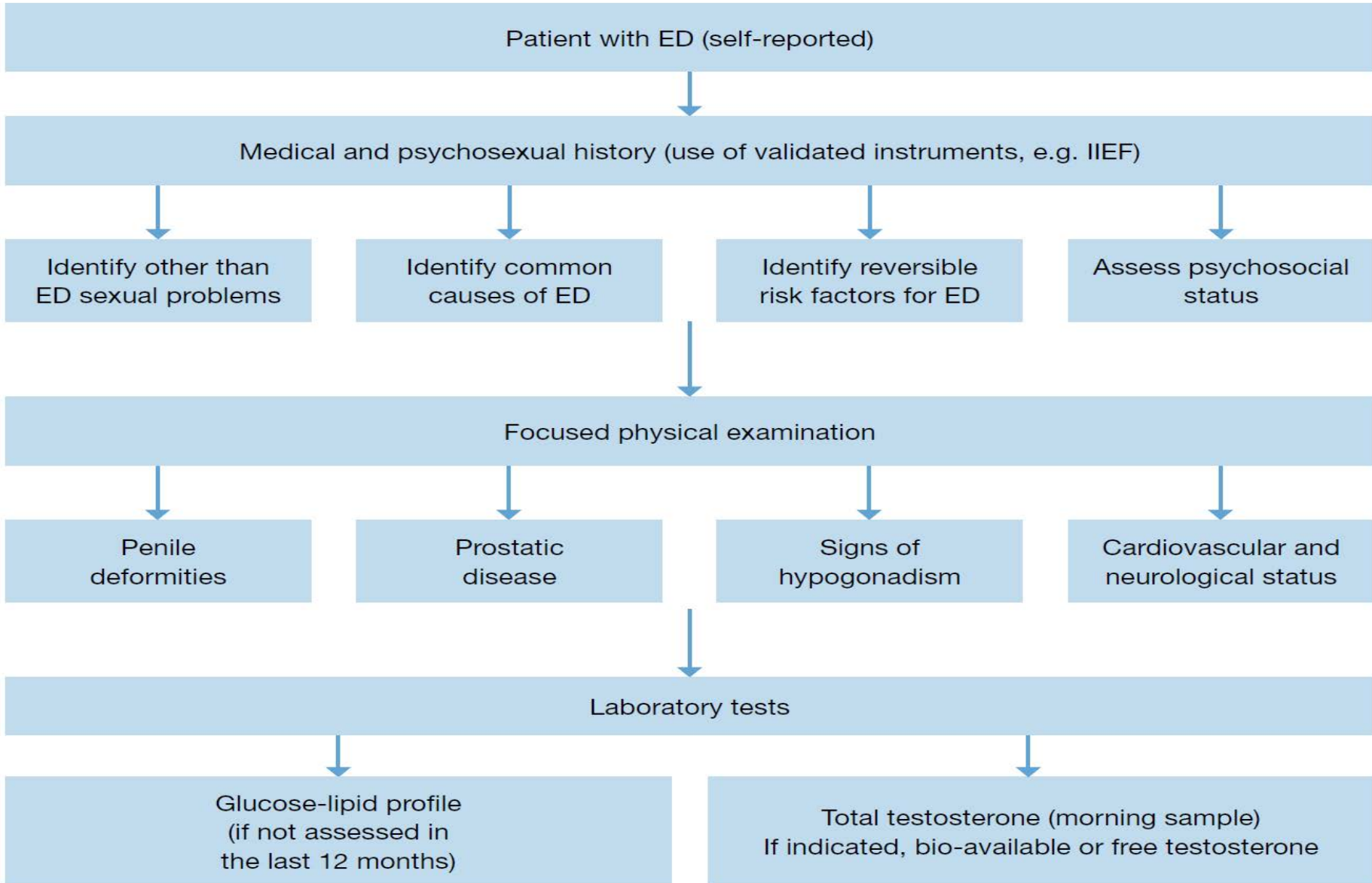
Frequent sexual activity with the same partner may create a better supportive intimate relationship, reduce stress, and increase social support, ultimately enhancing cardiovascular health. Like any other kind of physical exercise, sexual activity may have protective functions.

Involvement of the partner plays a key role in the evaluation and management of patients with ED. [34–35] There is consistent evidence that women engage less frequently in sexual activity after their partner develops ED and that their sex life is less satisfactory when ED is severe. [36–50] Furthermore, women whose partners have ED retrospectively reported a substantial decline in their own sexual desire, sexual arousal, orgasm and satisfaction after their partner had developed ED. [36–50] Of note, however, is that female sexual dysfunction such as dyspareunia or vaginal dryness can exacerbate milder forms of ED.

Guidelines on Male Sexual Dysfunction:

Erectile dysfunction and premature ejaculation

Figure 1: Minimal diagnostic evaluation (basic work-up) in patients with ED



ED = erectile dysfunction; IIEF = International Index of Erectile Function.

2012 International Society for Sexual Medicine

Standard Operating Procedures for Taking a Sexual History

Stanley E. Althof, PhD,*† Raymond C. Rosen, PhD,‡ Michael A. Perelman, PhD,§ and Eusebio Rubio-Aurioles, MD, PhD¶

*Center for Marital and Sexual Health of South Florida, West Palm Beach, FL, USA; †Case Western Reserve University School of Medicine, West Palm Beach, FL, USA; ‡New England Research Institutes, Watertown, MA, USA; §Reproductive Medicine & Urology, New York Weill Cornell Medical Center, New York, NY, USA; ¶Asociación Mexicana para la Salud Sexual, A.C. Profesor de posgrado, Departamento de Psiquiatría y Salud Mental, Facultad de Medicina, Universidad Nacional Autónoma de México, Mexico City, Mexico

Four prospective opening questions

1. Are you presently sexually active?
2. Are you satisfied with the quality of your sexual life? What might make it better? OR—In what ways are you not satisfied with the quality of your sex life?
3. Are there any sexual problems or worries that you would like to discuss with me today?
4. Sometimes people who suffer from _____ (diabetes, hypertension, depression, or are on beta blockers, SSRIs) have sexual issues. Are there any concerns you would like to discuss with me?

E' importante che le domande riguardanti la sessualità vengano poste all'interno del flusso di domande previste normalmente da una valutazione complessiva in modo da non essere percepite dai pazienti come "*invasioni di campo inaspettate*". Nell'uomo, si possono richiedere informazioni sulla vita sessuale mentre si indaga sulla funzione genito-urinaria. Analogamente, nelle donne, informazioni sulla sessualità potrebbero essere richieste insieme a quelle inerenti i cicli mestruali, la menopausa e/o problemi genito-urinari.

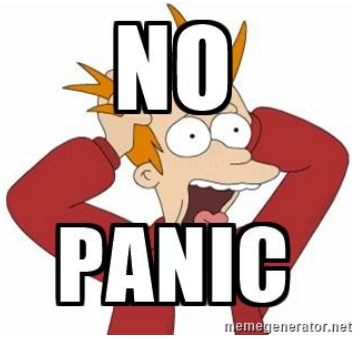


Table 1 Reasons given by patients and clinicians for not taking a sexual history

Patients
Lack of opportunity
Sense of embarrassment and shame
Societal taboo against the open discussion of sexuality
Not feeling optimistic about the outcome of such a discussion
Uncertain whether sexual problems/concerns are part of heath care
Uncertain which specialty treats sexual problems/concerns
Clinicians
Time constraints
Unrealistic fear of offending the patient
Deficits in communication skills
Reimbursement concerns
Lack of available or approved treatments
Growing knowledge gap between developments in sexual medicine and the clinical skills of the clinician
Discomfort about asking sexual questions to a patient of the opposite gender
Discomfort about asking sexual questions to a patient under age 18 or over 65
Inadequate training in sexual health

Questionario IIEF 5

L'International Index of Erectile Function - 5 (IIEF-5) è stato creato allo scopo di fornire un questionario sensibile e specifico per valutare la funzione erettiva. Nel rispondere si deve tener conto della attività sessuale relativa agli ultimi sei mesi

A) Negli ultimi sei mesi come è stata la sua capacità di raggiungere e mantenere l'erezione?
0- praticamente inesistente
1- molto bassa
2- bassa
3- moderata
4- alta
5- molto alta

B) Negli ultimi sei mesi dopo la stimolazione sessuale quanto spesso hai raggiunto un'erezione sufficiente alla penetrazione?
0- non ho avuto alcuna attività sessuale
1- quasi mai o mai
2- poche volte (molto meno della metà delle volte)
3- qualche volta (circa la metà delle volte)
4- la maggior parte delle volte (più della metà delle volte)
5- quasi sempre o sempre

C) Negli ultimi sei mesi durante il rapporto sessuale quanto spesso è riuscito a mantenere l'erezione dopo la penetrazione?
0- non ho tentato di avere rapporti sessuali
1- quasi mai o mai
2- poche volte (molto meno della metà delle volte)
3- qualche volta (circa la metà delle volte
4- la maggior parte delle volte (più della metà delle volte)
5- quasi sempre o sempre

D) Negli ultimi sei mesi durante il rapporto sessuale quanto è stato difficile mantenere l'erezione fino alla fine del rapporto?
0- non ho tentato di avere rapporti sessuali
1- estremamente difficile
2- molto difficile
3- difficile
4- abbastanza difficile
5- facile

E)Negli ultimi sei mesi quando ha avuto un rapporto sessuale quanto spesso ha provato piacere?
0- non ho tentato di avere rapporti sessuali
1- quasi mai o mai
2- poche volte (molto meno della metà delle volte)
3- qualche volta (circa la metà delle volte)
4- la maggior parte delle volte (più della metà delle volte)
5- quasi sempre o sempre

Sommando i punteggi ottenuti (indicati a fianco della risposta scelta), si ottiene il risultato finale.
Da 22 a 25 l'attività sessuale è da considerarsi normale.
Da 17 a 21 siamo in presenza di disfunzione erettiva lieve.
Da 12 a 16 si manifesta una disfunzione erettile lieve-moderata.
Da 8 a 11 si tratta di una disfunzione erettile moderata.
Da 5 a 7 siamo in presenza di una grave disfunzione erettile.

Development and evaluation of an abridged, 5-item version of the International Index of Erectile Function (IIEF-5) as a diagnostic tool for erectile dysfunction.

Rosen RC[1], Cappelleri JC, Smith MD, Lipsky J, Peña BM.

Int J Impot Res. 1999 Dec;11(6):319-26.

International Journal of Impotence Research (2003) 15, 210–220

0955-9930/03 $25.00
www.nature.com/ijir

Structured interview on erectile dysfunction (SIEDY©): a new, multidimensional instrument for quantification of pathogenetic issues on erectile dysfunction

L Petrone[1], E Mannucci[2], G Corona[1], M Bartolini[3], G Forti[1], R Giommi[4] and M Maggi[1]*

Multidomain SIEDY scores

- **Scale 1** = organic domain
- **Scale 2** = marital domain
- **Scale 3** = intrapsychic domain

La SIEDY è l'unica intervista strutturata disegnata e validata in lingua italiana sulla disfunzione erettile e che ha mostrato una sua utilità clinica in molti studi.

Si tratta di un'intervista composta da 15 domande che si distribuiscono su tre scale; ogni scala identifica e quantifica un dominio della DE: la scala 1 quantifica il dominio organico; la scala 2 quello relazionale e la scala 3 quello intrapsichico.

Appendix A. SIEDY Questions Composing Scale 3

2. Are you satisfied with your job/occupation?
   - 0 Very satisfied
   - 1 Fairly satisfied
   - 2 Not very satisfied
   - 3 Unsatisfied

3. Do you ever think of your job out of the working hours?
   - 0 never
   - 1 sometimes
   - 2 quite often
   - 3 often

6. Do you have a difficult relationship with your partner?
   - 0 No, I have normal relationships
   - 1 No, occasional quarrels
   - 2 Yes, frequent quarrels
   - 3 Always

11. Are there any conflicts at home (with children, or other persons living with you?)
   - 0 No, I have normal relationships
   - 1 No, occasional quarrels
   - 2 Yes, frequent quarrels
   - 3 Always

12. Do you have other sexual relationships
   - 0 No
   - 1 Occasionally
   - 2 Another stable relationship
   - 3 Another stable relationship and occasional intercourse with different partners

14. Did you have more or less desire to make love in the last three months? Was your desire increased or reduced when compared to the past?
   - 0 Unmodified or increased desire
   - 1 Desire present but moderately reduced
   - 2 Desire remarkably reduced
   - 3 Desire never present

SIEDY Scale 3, a New Instrument to Detect Psychological Component in Subjects with Erectile Dysfunction

Giovanni Corona, MD, PhD,*§ Valdo Ricca, MD,† Elisa Bandini, MD,* Giulia Rastrelli, MD,* Helen Casale, MD,* Emmanuele A. Jannini, MD,‡ Alessandra Sforza, MD,§ Gianni Forti, MD,¶ Edoardo Mannucci, MD,** and Mario Maggi, MD*

LA SALUTE DELLA COPPIA

LIBRO BIANCO SULLO STATO DELL'ASSISTENZA IN MEDICINA DELLA SESSUALITÀ E IN ANDROLOGIA IN ITALIA

siams
Società Italiana di Andrologia e Medicina della Sessualità

2007 **Consiglio Universitario Nazionale** che riconobbe lo stato delle cose riconoscendo la **figura dell'andrologo** in un ENDOCRINOLOGO con competenze Andrologiche o un UROLOGO con competenze Andrologiche

la prestazione di **visita andrologica** è da sottolineare che nel nomenclatore tariffario del SSN non esiste un codice specifico, essendo associata alla visita urologica anche nella versione dei nuovi LEA in discussione (codice 89.7.C3 "Prima visita urologica/andrologica.

TABELLA 1 - Sintesi e percentuali dell'offerta assistenziale in andrologia e medicina della sessualità in Italia.

Codice specifico di "Visita andrologica" nel nomenclatore tariffario e nei LEA	**Assente**. Codici utilizzati: visita urologica, urologica/andrologica, urologica per fisiopatologia della riproduzione, endocrinologica, endocrinologica per fisiopatologia della riproduzione
Percentuale di offerta di visite specialistiche in ambito di: endocrinologia-andrologia medica urologia	 20% 80%
Codice specifico di "Visita psicosessuologica" nel nomenclatore tariffario	**Assente.** Codici utilizzati: visita urologia, visita ginecologica, colloquio psicologico clinico

Pochissime Regioni possiedono un codice per **visita sessuologica o psicosessuologica**, che viene quindi erogata solo sporadicamente da strutture di eccellenza di andrologia medica e saltuariamente all'interno delle Unità di Urologia, Ginecologia o nei centri PMA.

LA SITUAZIONE NEL LAZIO

3 febbraio 2016

Lo scorso 14 Dicembre 2015 è stato approvato il "Piano per l
20
i t

The different aspects that contribute to quality of life in patients with diabetes mellitus are of great importance for the treatment of this disease. These aspects not only influence the well-being of patients but also influence treatment adherence, therefore affecting the course of the disease.

The Journal of Nursing Research ■ VOL. 25, NO. 2, APRIL 2017 PERSPECTIVE

Psychological Care for Patients With Diabetes — Present and Future

Ruey-Hsia Wang

RN, PhD, Professor & Dean, College of Nursing, Kaohsiung Medical University, Kaohsiung, Taiwan, Adjunct researcher, Department of Medical Research, Kaohsiung Medical University Hospital, Kaohsiung, Taiwan.

American Journal of Therapeutics 23, e159–e171 (2016)

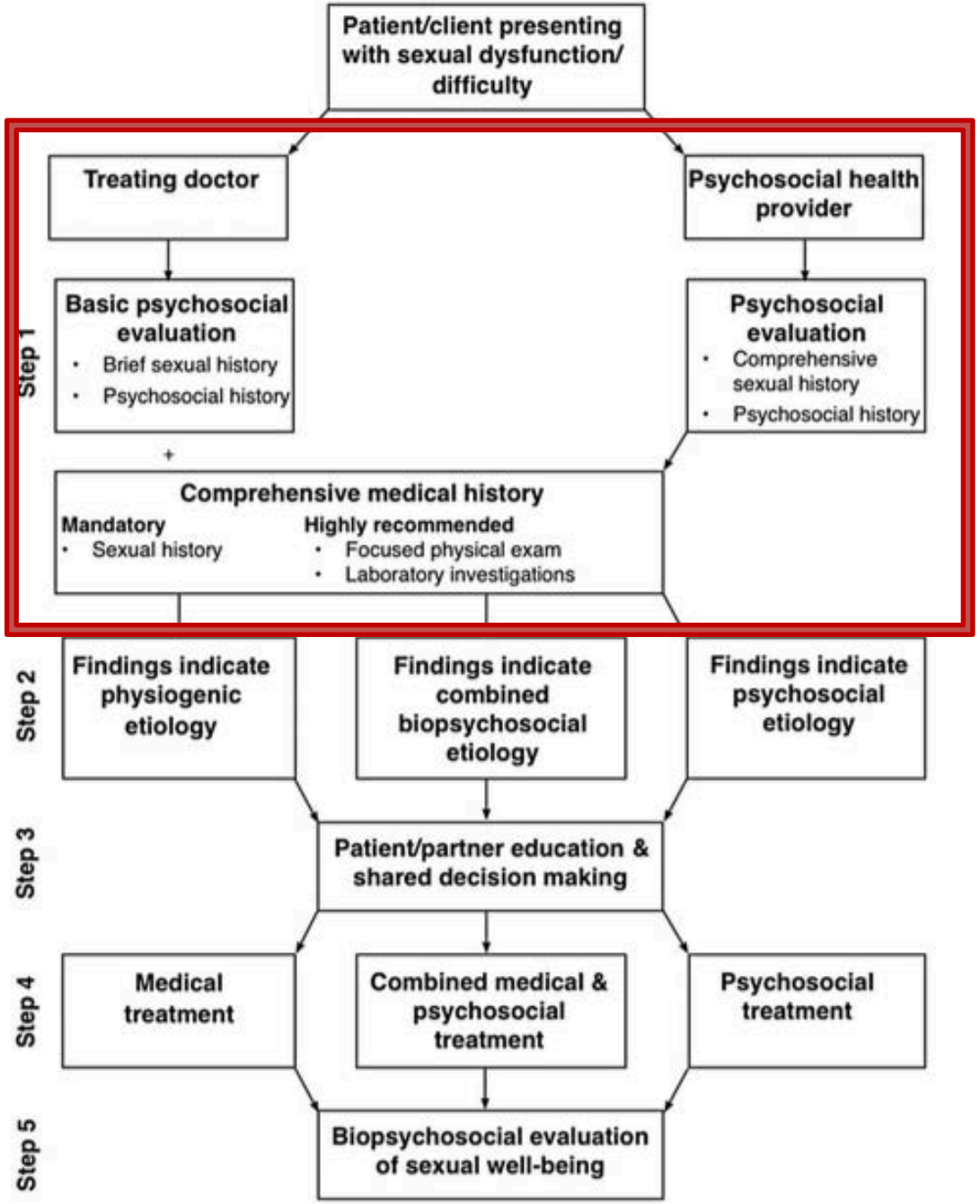
Diabetes and Quality of Life: Initial Approach to Depression, Physical Activity, and Sexual Dysfunction

M. Josefina Pozzo, MD,[1]* Juliana Mociulsky, MD,[2] Esteban T. Martinez, MD,[3] Guido Senatore, MD,[4] Javier M. Farias, MD,[5] Adrian Sapetti, MD,[6] M. Gabriela Sanzana, MD,[7] Patricia Gonzalez, MD,[4] Alberto Cafferata, MD,[8] Andrea Peloche, MD,[9] and Liliana Lemme, MD[4]

Diabetes Care Team

COME PROCEDERE?

Figure 3 Biopsychosocial treatment steps. Adapted from International Consultation on Sexual Medicine, ICSM-5 Diagnostic and Treatment Algorithm [190].



Berry, Berry, *J Sex Med*, 2013

STEP 1 - ASSESSMENT

Comprehensive diagnostic hypothesis					
	Biomedical		Psychological		Social
Predisposing					
Trigger					
Maintaining					

Bitzer

Includono sia elementi costituzionali che esperienze personali precedenti che contribuiscono alla vulnerabilità alle disfunzioni. In ogni caso raramente questi fattori da soli sono sufficienti per causare una disfunzione sessuale

Includono quei fattori che più direttamente possono portare una persona a sviluppare una risposta disfunzionale

Possono prolungare ed esacerbare la problematica originale e sono responsabili della trasformazione di episodi disfunzionali in disfunzioni croniche

Bitzer *et al.*, *J Sex Med*, 2013

FATTORI PSICOLOGICI

THE JOURNAL OF SEXUAL MEDICINE

J Sex Med 2016;13:538–571

Psychological and Interpersonal Dimensions of Sexual Function and Dysfunction

Lori Brotto, PhD,[1] Sandrine Atallah, MD,[2] Crista Johnson-Agbakwu, MD,[3] Talli Rosenbaum, MSc,[4] Carmita Abdo, PhD,[5] E. Sandra Byers, PhD,[6] Cynthia Graham, PhD,[7] Pedro Nobre, PhD,[8] and Kevan Wylie, MD[9]

- Personalità e stili di attaccamento
- esperienze infantili (eventuali abusi)
- Prime esperienze con la sessualità
- schemi cognitivi / credenze rigide sulla sessualità

FATTORI PREDISPONENTI

- Eventi di vita stressanti / passaggio diverse fasi di vita
- depressione
- ansia
- stress

FATTORI PRECIPITANTI / MANTENIMENTO

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FATTORI RELAZIONALI

- INTIMITÀ
- SODDISFAZIONE RELAZIONALE
- DISFUNZIONI SESSUALI DEL PARTNER
- MALATTIE DEL PARTNER
- DISCREPANZA DI DESIDERIO
- LE RISPOSTE DEL PARTNER ALLE DIFFICOLTÀ SESSUALI

FATTORI PSICOSOCIALI LEGATI AL DIABETE

LA COMPONENTE BIOLOGICA DA SOLA NON È SUFFICENTE A FAR SVILUPPARE E MANTENERE UNA DISFUNZIONE SESSU

MOLTO DIPENDE DE

IMPORTANTE CONSIDERARE L'ETÀ!

STRESS DA DIABETE

- DEPRESSIONE
- ANSIA
- BASSA AUTOSTIMA
- PROBLEMI RELAZIONALI
- ISOLAMENTO SOCIALE

DIAGNOSI

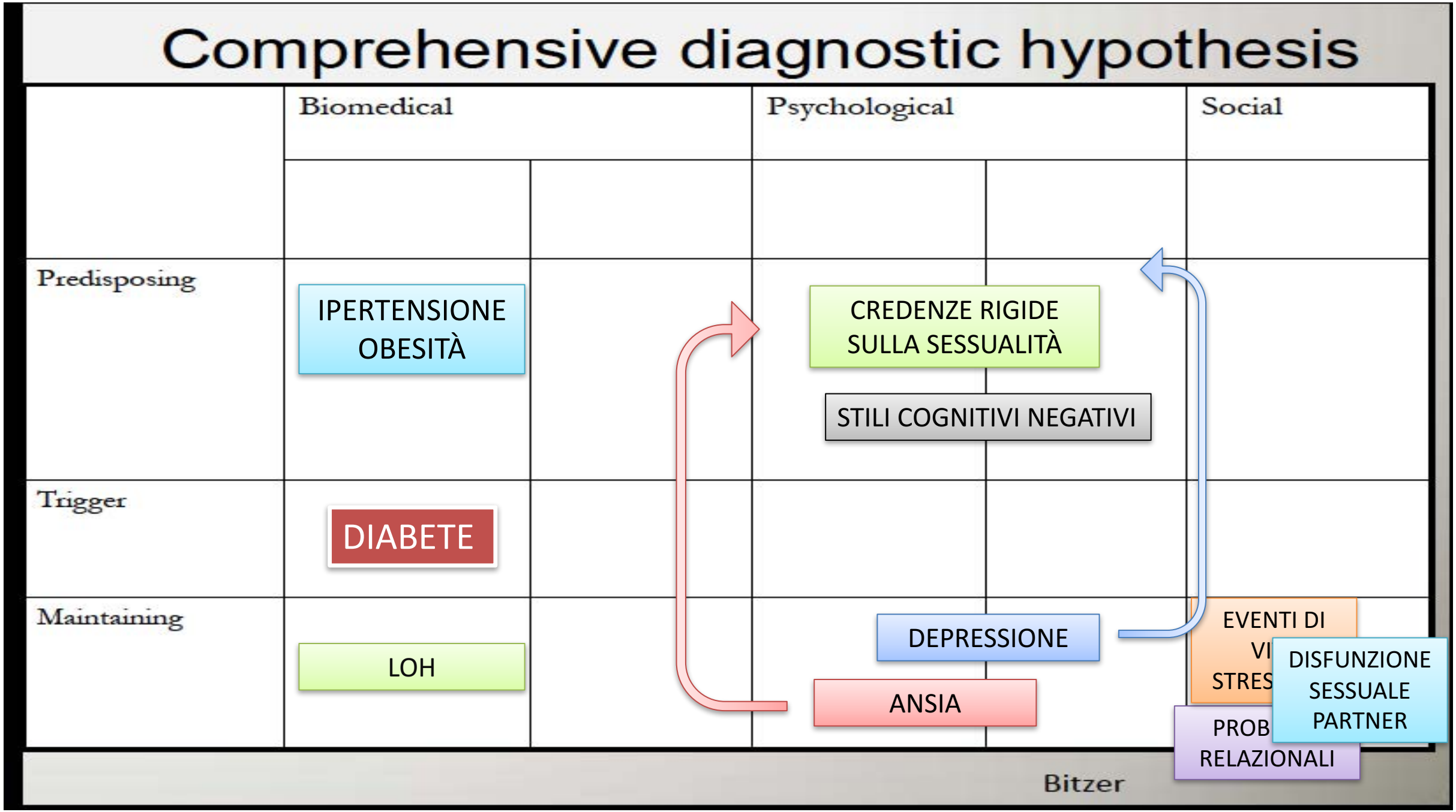
CONVIVERE CON UNA PATOLOGIA CRONICA

CAMBIAMENTI NELLO STILE DI VITA

CAMBIAMENTI NELLA SESSUALITÀ

Feng, Astell-Burt, 2017; Deschênes *et al.*, 2017; *Corona et al., 2016; Gandhi et al., 2016; Mazzilli, 2015*

Comprehensive diagnostic hypothesis

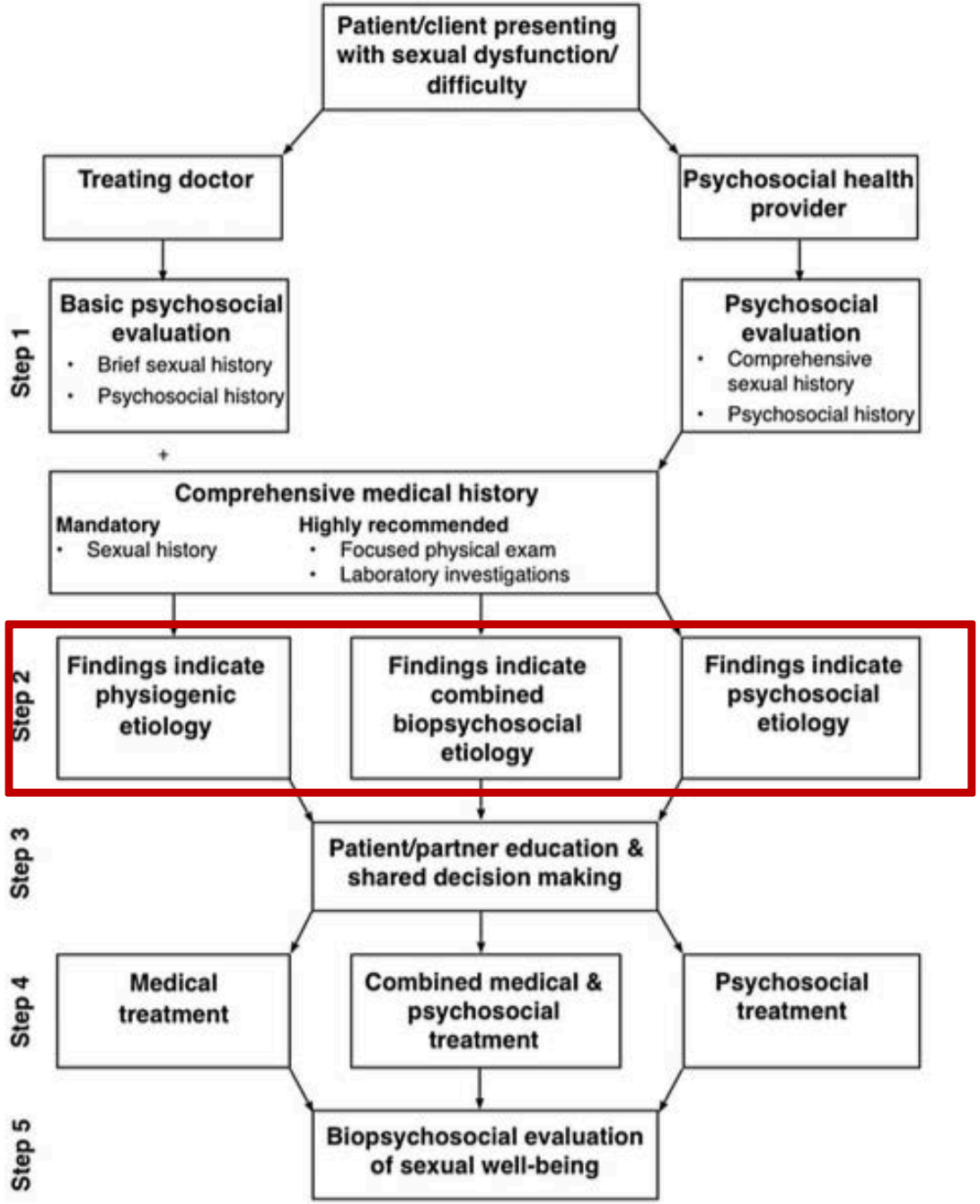


STEP 2 – DISCUSSIONE TRA PROFESSIONISTI

SE SI RAVVISA SOLO UN'EZIOLOGIA ORGANICA?

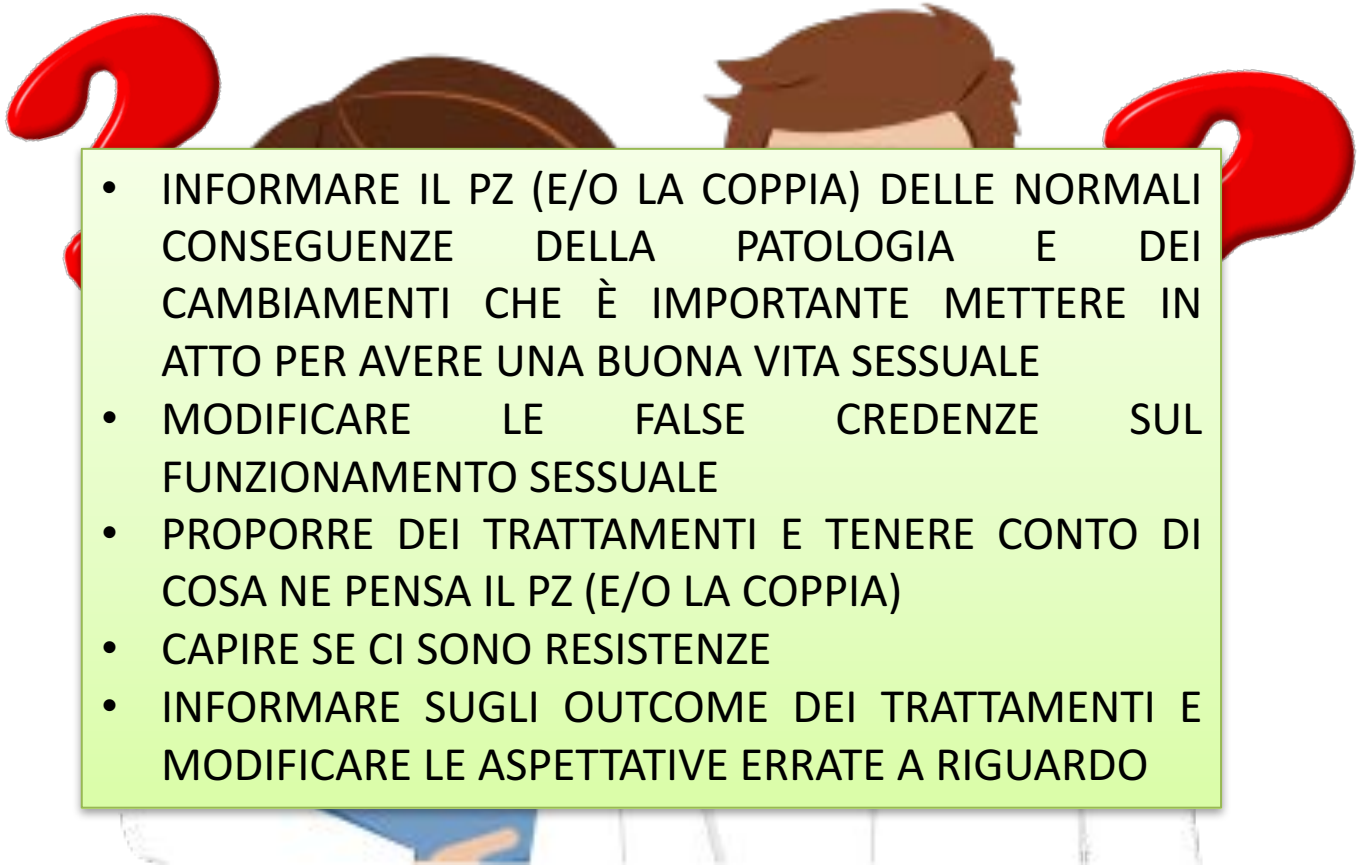
SE SI RAVVISA SOLO UN'EZIOLOGIA PSICOGENA?

IMPORTANTE LAVORARE IN MANIERA INTEGRATA DALL'INIZIO ALLA FINE!



Berry, Berry, *J Sex Med*, 2013

STEP 3



- INFORMARE IL PZ (E/O LA COPPIA) DELLE NORMALI CONSEGUENZE DELLA PATOLOGIA E DEI CAMBIAMENTI CHE È IMPORTANTE METTERE IN ATTO PER AVERE UNA BUONA VITA SESSUALE
- MODIFICARE LE FALSE CREDENZE SUL FUNZIONAMENTO SESSUALE
- PROPORRE DEI TRATTAMENTI E TENERE CONTO DI COSA NE PENSA IL PZ (E/O LA COPPIA)
- CAPIRE SE CI SONO RESISTENZE
- INFORMARE SUGLI OUTCOME DEI TRATTAMENTI E MODIFICARE LE ASPETTATIVE ERRATE A RIGUARDO

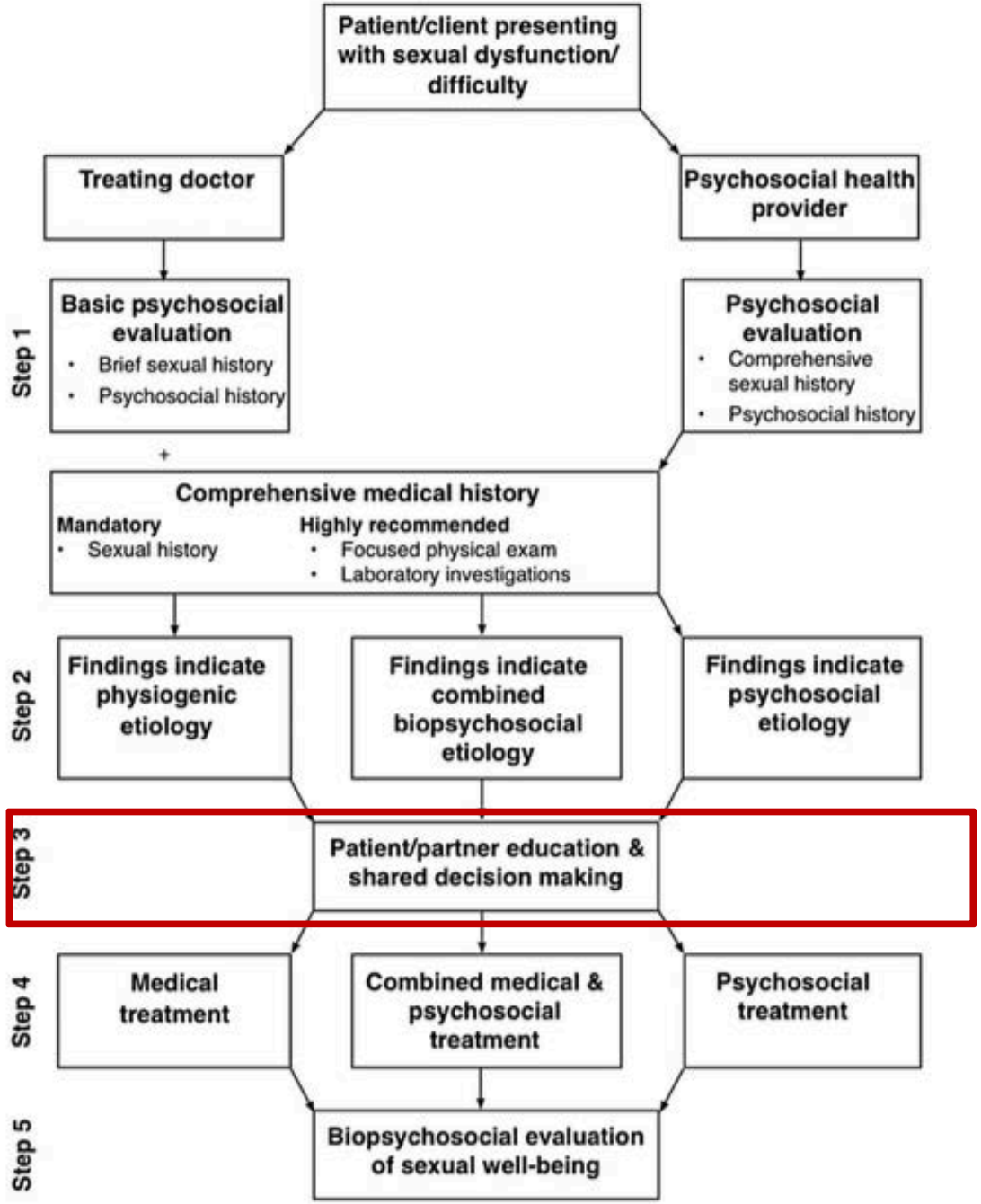


Figure 3 Biopsychosocial treatment steps. Adapted from International Consultation on Sexual Medicine, ICSM-5 Diagnostic and Treatment Algorithm [190].

Berry, Berry, *J Sex Med*, 2013

STEP 4 / 5 – TRATTAMENTO E FOLLOW-UP

IN CASO DI EZIOLOGIA PREVALENTEMENTE ORGANICA CON PROPOSTA DI TRATTAMENTO FARMACOLOGICO, È IMPORTANTE AFFIANCARE SEMPRE UN COUNSELING PSICO-SESSUALE.
BISOGNA VEDERE COME "REAGISCONO" IL PZ E IL/LA PARTNER ALLA PROPOSTA DEL FARMACO.
SPESSO RIFIUTO DELL'AIUTO FARMACOLOGICO

IN CASO DI EZIOLOGIA PREVALENTEMENTE PSICOGENA CON PROPOSTA DI TRATTAMENTO PSICOSESSUOLOGICO, È IMPORTANTE CONSIDERARE COMUNQUE L'USO DI TRATTAMENTI FARMACOLOGICI.
A VOLTE IL FARMACO PUÒ FUNGERE DA SUPPORTO PER RIPRENDERE SICUREZZA E DURANTE IL LAVORO PSI PERMETTERE AL PZ DI VIVERE LA SUA VITA SESSUALE

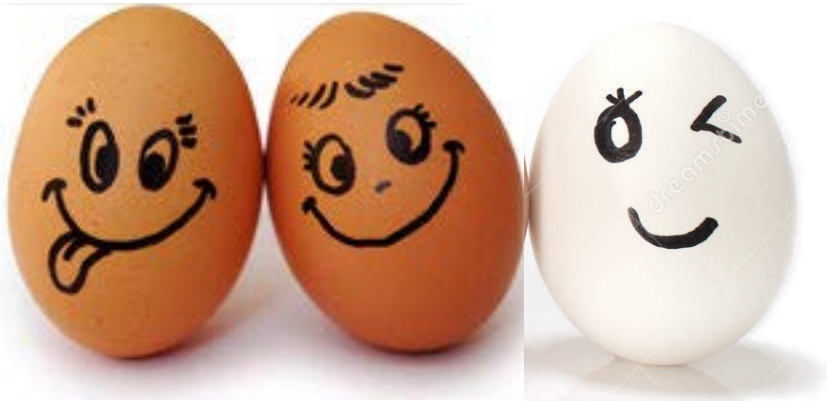
ocial treatment
m International
Consultation on Sexual Medicine, ICSM-5 Diagnostic and Treatment Algorithm [190].

Berry, Berry, *J Sex Med*, 2013

QUANDO COINVOLGERE LA COPPIA?

IN QUALE MOMENTO?

- DA SUBITO E PER TUTTO IL PERCORSO DI CURA



E IN CASO DI RELAZIONI EXTRA-CONIUGALI?!?

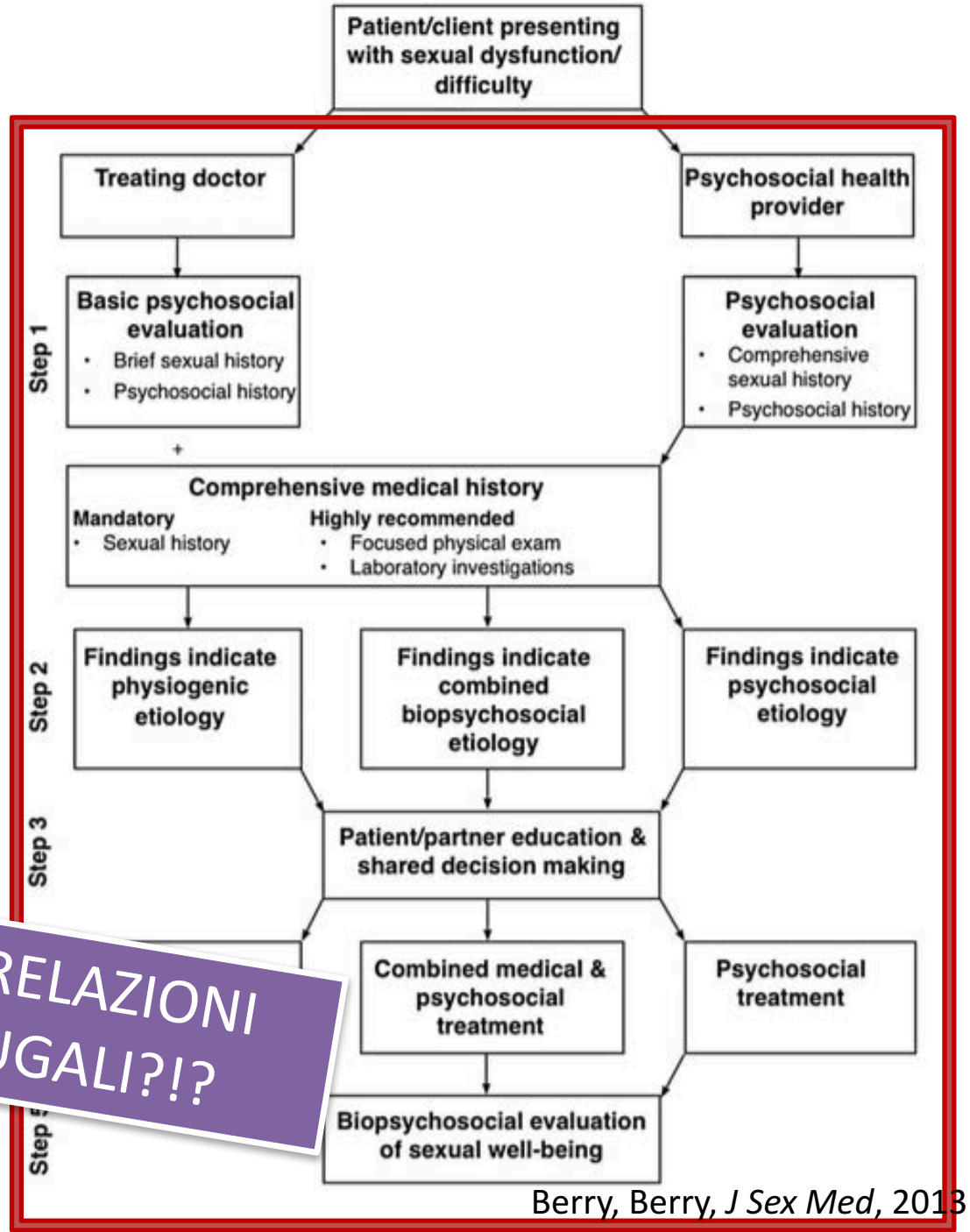


Figure 3 Biopsych… steps. Adapted from Internati… Consultation on Sexual Medicine, ICSM-5 Diagnostic and Treatment Algorithm [190].

Berry, Berry, *J Sex Med*, 2013

Frank Dickens

CALMASUTRA

PER IL SESSO NON È MAI TROPPO TARDI

ZELIG EDITORE