"**Sexual health** **is a state *of physical, emotional, mental and social well-being*** in relation to sexuality; it is not merely the absence of disease, dysfunction or infirmity. Sexual health requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination and violence"

www.who.int/reproductivehealth/gender/sexualhealth.html

Female Sexual Dysfunction: Screening, Diagnosis and Treatment

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Goals and Objectives

- Identify barriers to screening for female sexual dysfunction
- Identify the most prevalent types of female sexual dysfunction
- Discuss diagnostic considerations for female sexual dysfunction and when to begin treatment
- Discuss strategies for female sexual dysfunction

Prevalence of Sexual Dysfunctions

Men N > 90,000	Women N ~ 10,000
▪ Any SD 31% ▪ Low desire 5% - 15% ▪ Anorgasmic 8% ▪ Rapid ejaculation 14% - 30% ▪ Erectile disorder(ED) 18% - 52% ▪ 36% moderate or complete ED ▪ ↑ with age - - 25% of men < 59 yo - 61% of men > 70	▪ Any SD 32% ▪ Low desire 17% - 55% > in surgical menopause ▪ Arousal problems 14% - 35% ▪ Orgasm issues 25% -39% ▪ Pain 2% - 26%

- Sexual problems can be life long or acquired
  - Generalized or situational

- DeRogatis & Burnet. J of Sexual Medicine 2008:5:289-300
- McVary, NEJM 2007:357:2472.
- Shifren, Monz, Russo, et al. Obstet Gynecol 2008:112:970

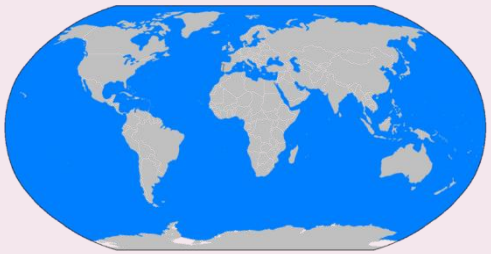
Correlates of Sexual Problems

- **Age**
  - Occurrence of problems ↑ with age
  - Distress ↓ with age
- **Health comorbidities**
  - DM, CVD, HTN, prostate / gyn problems, cancer, obesity, tobacco, alcohol, recreational drug use
- **Medications**
  - Psychotropics, antihypertensives, anticonvulsants..
    - ~ 25% of ED cases are medication related
- **Psychosocial factors**
  - Depr, anx, relationship issues, stress, sexual trauma

- Bacon, Mittleman, Kawachi, et al. Ann Intern Med, 2003:139-161
- Lindau, Schumm, Laumann, et al. NEJM 2007(357)762.

Impact of Sexual Problems

- Global Study of Sexual Attitudes Behaviors
  - Survey of 27,000+, 40-80 y/o



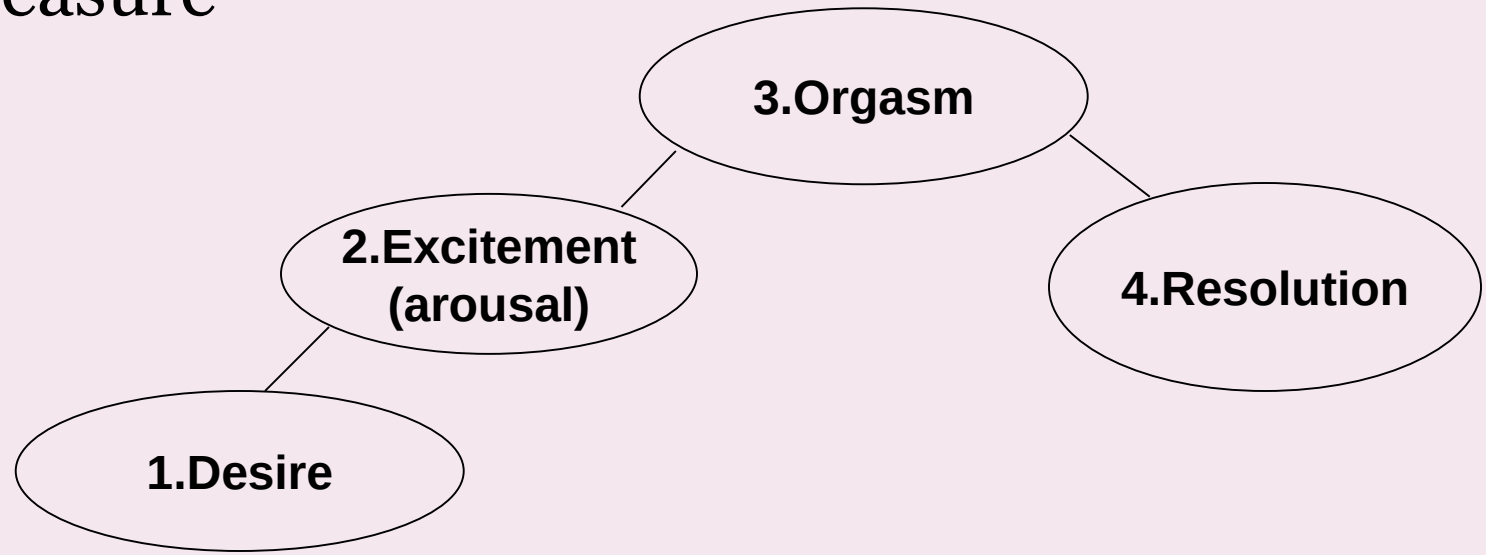
80% of men, 60% of women rated sexual function as a **"moderately to extremely"** important

- Not all pts meet formal diagnostic criteria but the impact of sexual problems is ↑
- Treatment helpful even if a formal dx is not made

Lauman, et al . Int J Impot Res 17: 2005;39-57

DSM-5: Sexual Dysfunctions

- Persistent disturbances in the person's ability to respond sexually or to experience sexual pleasure



DSM-5 - Sexual Dysfunctions

- **Changes to DSM-5**
  - **Distinction between phases of the sexual response cycle was removed**
  - **Gender specific disorders have been added**
  - **Some dx have been combined***
  - **Sexual response is not always a linear, uniform process**

APA 2013

10 Dx – require sxs X6 mos

1. Female orgasmic do
2. Female sexual interest/arousal do*
3. Erectile do
4. Delayed ejaculation
5. Male hypoactive sexual desire do
6. Premature (early) ejaculation
7. Genito-pelvic pain/penetration do*
8. Substance/medication-induced SD
9. Other specified SD
10. Unspecified SD

Emotional Factors and Sexuality

- **Depression**
  - Impacts all aspects of sexual response
    - desire, arousal and orgasm
- **Anxiety**
  - Common in SD - performance anxiety, fear of inadequacy, spectatoring
    - all impede psychophysiological arousal
- **Anger**
  - Impedes communication and intimacy

Besharat M, 2001

Depression and Sexual Dysfunction

- Sexual dysfunction is both:
  - A symptom of depression
  - An adverse effect of many antidepressants & other psychotropics
- Treatment-emergent sexual dysfunction
  - A major cause of noncompliance and drug discontinuation
  - It is a substantial risk factor for relapse or recurrence of a depressive episode
  - Important to assess sexual function in patients with depression before selecting the most appropriate antidepressant medication

Kennedy & Rizvi. J of Clin Psychopharm, 29(2), 2009

Importance of Screening for SD

- Underdiagnosed and Undertreated
  - Don't ask, don't tell..
  - Patients not likely to bring it up unless asked
  - Obstacles for physicians
    - Lack of training
    - Lack of confidence
    - Lack of knowledge regarding treatment options
    - Inadequate time to obtain a sexual history
    - Underestimation of the prevalence of sexual dysfunction

Easy Screening Questions

- Are you sexually active?
- Any pain during sexual activity?
- Are you able to achieve an orgasm?
- Any decreased desire or libido that is troubling for you and your partner?
- Everyone should be screened for domestic violence and sexual abuse during annual visits.

Brief Sexual Symptom Checklist

1. Are you satisfied with your sexual function? □ Yes □ No
If No, please continue.

2. How long have you been dissatisfied with your sexual function?
_____

3a. men/women specific questions…

3b. Which problem is most bothersome (circle) 1 2 3 4 5 6 7

4. Would you like to talk about it with your doctor?
□ Yes □ No

Brief Sexual Symptom Checklist: 3a

For Men (BSSC-M)

3a. The problems with your sexual function is: (mark one or more)

1 Problems with little or no interest in sex

2 Problems with erection

3 Problems ejaculating too early during sexual activity

4 Problems taking too long, or not being able to ejaculate or have orgasm

5 Problems with pain during sex

6 Problems with penile curvature during erection

7 Other :

For Women (BSSC-W)

3a. The problems with your sexual function is: (mark one or more)

1 Problems with little or no interest in sex

2 Problems with decreased genital sensation (feeling)

3 Problems with decreased vaginal lubrication (dryness)

4 Problems reaching orgasm

5 Problems with pain during sex

6 Other : .....

SWP: Most Common Presenting Problems

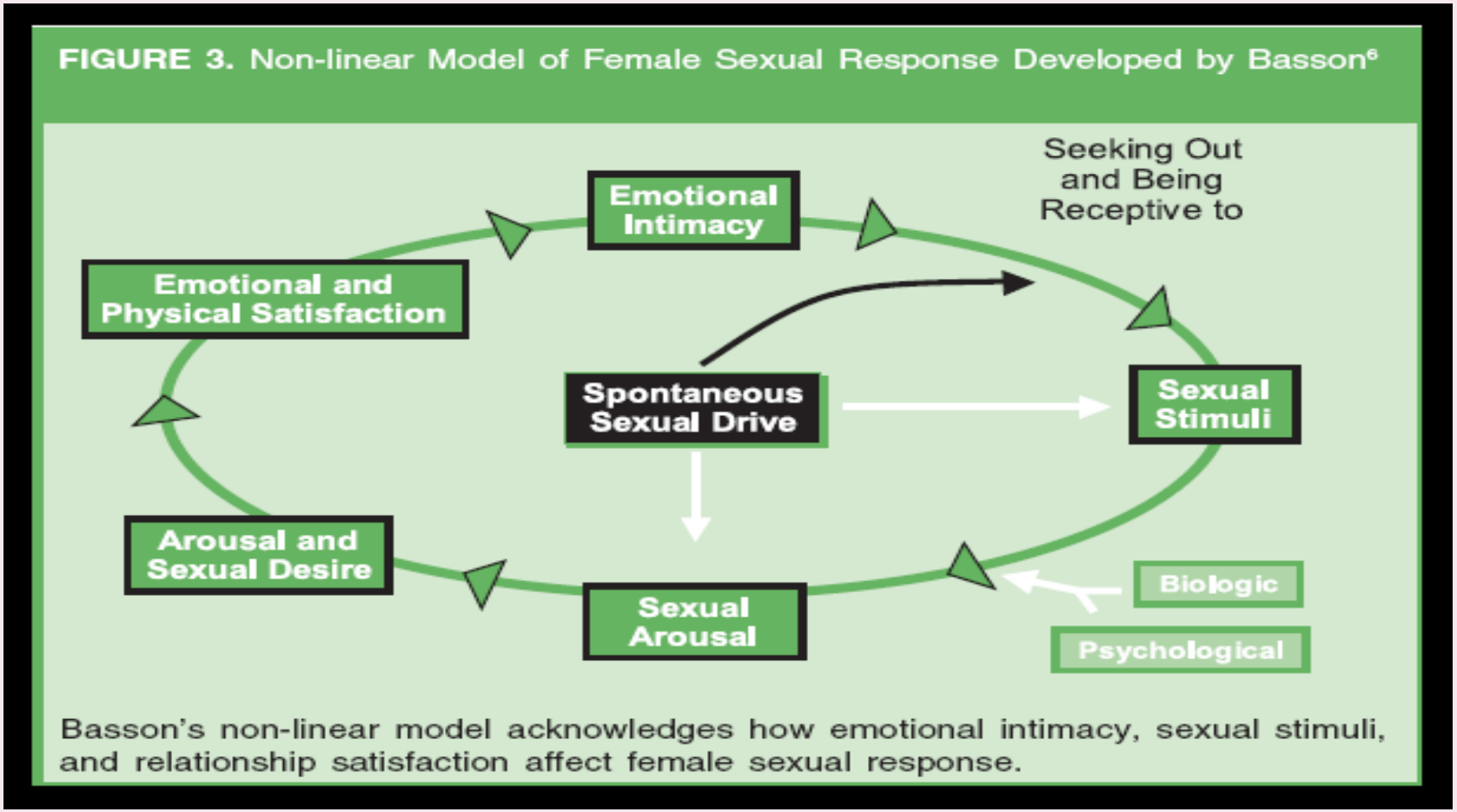
	%
Hypoactive sexual desire	**32.2**
ED	**21.4**
Dyspareunia	**14.3**
Psychosexual dysfunction	**14.3**
Female orgasmic disorder	**10.7**
Premature ejaculation	**7.1**

Female Sexual Interest/Arousal Disorder

- At least 3 of the following:
  - Reduced (or absent) interest in sexual activity
  - Reduced sexual/erotic thoughts or fantasies
  - Reduced initiation of sexual activity, unreceptive to a partner's attempts
  - Reduced sexual excitement or pleasure
  - Reduced sexual interest/arousal in response to sexual cues (e.g., written, verbal, visual)
  - Reduced genital or nongenital sensations
- Freq associated with:
  - Orgasm problems, painful sex, couple-level discrepancies in desire, unrealistic expectations, lack of information about sexuality

Brotto LA, Petkau JA, Labrie F, Basson R:
Predictors of sexual desire disorder in women.
J Sex Med 8(3):742–753, 2011

Basson's Non-linear Model



"I really think you should see a specialist about your lack of libido Sharon."

Treatment

- Biopsychosocial and Educational Approach
  - Focus on the Cause of the Disorder
  - Cognitive-Behavioral Techniques and/or Traditional Sex Therapy.
    - Communication exercises
    - Body image exercises
    - Sensate focus exercises
  - Mindfulness-based treatment
    - Encouraging results
    - Need larger studies
- Pharmacological treatment

Check Medications

- Medications commonly associated with SD
  - Antihypertensives
  - Histamine blockers
  - Oral Contraceptive pills
  - Psychotropic medications
    - SSRIs are most commonly linked to sexual dysfunction
    - Estimated incidence of SSRI-induced sexual dysfunction ranges from approximately 15 to 80 percent
    - Interest/Arousal and Orgasmic disorder are the most common issues

Serretti A, Chiesa A. J Clin Psychopharmacol. 2009 Jun;29(3):259-66.
Baldwin DS, Foong T. Br J Psychiatry. 2013 Jun;202:396-7.

Meds cont..

- Decreasing the dosage may help alleviate some issues
- Switching to another antidepressant may alleviate symptoms, but other antidepressant classes also have been associated with sexual dysfunction.
- A structured treatment interruption may be helpful in some patients, but is not always an option in some other patients.

Flibanserin

- 5-HT serotonin receptor agonist and a dopamine D4 receptor partial agonist.
- Non-Hormonal
- Increases dopamine/noradrenalin and reduces Serotonin
- Hypoactive sexual desire disorder (HSDD) in premenopausal women
- Dose 100mg qhs
- Side effects: fatigue (morning), hypotension
- Take daily and no alcohol use on this medication.

Female Orgasmic Disorder

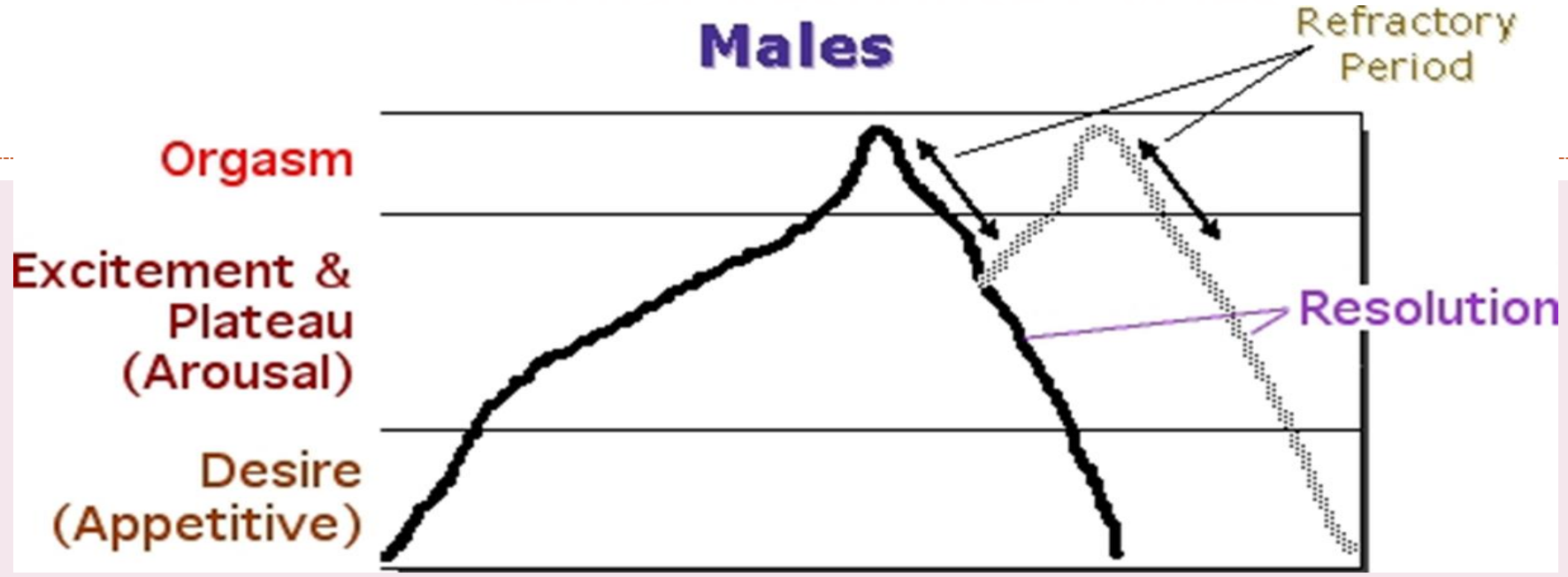
Diagnostic Criteria – for at least 6 months

- Either of the following on 75%–100% during sexual activity:
  - Marked delay in, marked infrequency of, or absence of orgasm.
  - Markedly reduced intensity of orgasmic sensations.
- Causes clinically significant distress
- Not explained by
  - A nonsexual mental disorder
  - A consequence of severe relationship distress (e.g., partner violence)
  - Other significant stressors
  - Not due to the effects of a substance/medication
  - Not due to another medical condition.

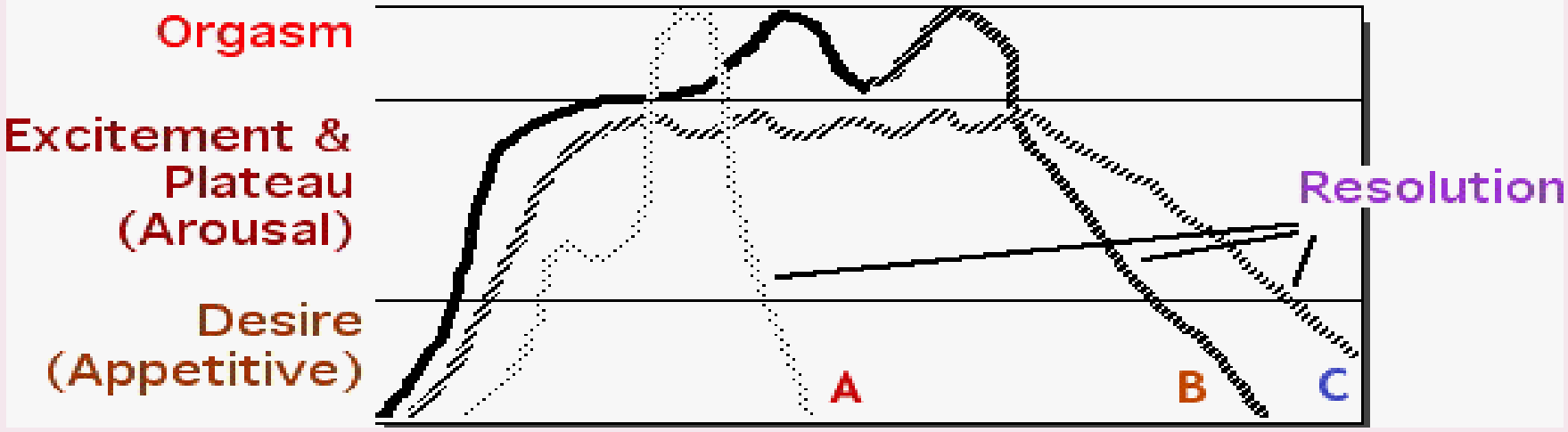
Female Orgasmic Disorder

- Timeline to relating to Orgasmic disorder
  - Ever had an orgasm?
  - Had one with this relationship?
  - Does partner know?
  - Does she engage in self exploration?
- Any comorbid factors (new or old)

Males



Females



Cycle Differences

- 75% of all males→ orgasm is possible within the first 4 minutes after initiation of sexual intercourse

- All women the average time to reach orgasm is between 10 and 20 minutes

Treatment:

- Focus on being comfortable your body and self exploration is encouraged.
- Directed self exploration exercises with clitoral stimulation:
  - encourage patience and persistence with at least three weekly sessions in a good setting
- Transfer of self exercises to "couple"
  - Allow partner to first observe then engage in self exploration exercises. Consider your sexual needs first over your partners.
- Bibliotherapy (see erotic reading list also)
  - The G spot or The science of orgasm
- Lubricants
  - Zestra – stimulating gel (otc)

Genito-Pelvic Pain/Penetration Disorder

- Sxs highly comorbid (need 1 of 4 to dx)
  - Difficulty having intercourse
  - Genito-pelvic pain
  - Fear of pain or vaginal penetration
  - Tension of the pelvic floor muscles

- Behavioral avoidance of sexual situations and of gyn exams is common
  - Avoidance pattern is similar to phobic disorders

Causes of Dyspareunia

- Atrophy
  - Leading cause of dyspareunia due to decreased estrogen
  - Causes:
    - Menopause
    - Premature Ovarian Failure
    - Hypothalamic Amenorrhea (excessive exercise or rapid weight loss)
    - Postpartum/Breastfeeding
    - Low Estrogen Contraceptives
    - Radiation or Chemotherapy (Tamoxifen).

Atrophy

Treatment:

- Hormone-free Lubricants (water-base or silicon):
  - With intercourse
  - Free of Parabens and Glycerin
- Hormone-free Moisturizers
  - Every third night
- Local estrogen therapy: cream, tablet or vaginal ring.
  - If history of breast cancer – discuss with oncologist prior to use.
- Pelvic floor physical therapy (dilators if necessary)
- Relaxation training.

Vaginismus

- Prevalence rates ranging from 1% to 6%
- Cannot consummate intercourse because vaginal penetration is not possible
  - Involuntary spasm of perineal/levator muscles
  - Vaginal muscle contractions occur as an automatic defense to vaginal penetration
  - For some women it is only limited to vaginal exams, but intercourse is possible and comfortable.
- Diagnosed by eliciting muscle spasm by depressing the levators

Treatments cont..

- Relaxation and desensitization techniques
  - Deep muscle relaxation techniques to use during exercises
  - Using dilators
    - Starting with the smallest one that is comfortable
    - Gradually over time increasing diameter of the dilator as tolerated.
    - Goal is to desensitize a woman to her fear that vaginal penetration will be painful
    - Enable her to gain a sense of control over a sexual encounter or a pelvic examination
- Pelvic floor physical therapy
- Vaginal valium (compounded into a suppository) may be helpful.

SWP – 6 Weekly 2.5 Hour Sessions

1. Tx team meeting 30 m

2. Couple didactics

- Various topics, 20-45 m

3. Couple's session ~ 60 m

- Sexual hx taking (wk 1)
- Identifying problems to be addressed
- Setting goals (for program; wk X wk)
- Sexological exam (wk 2)
- Review and processing of the past week
- In session exercises
- Home assignments
  - E.g., sensate focus, "sexy surprise", Qs, readings (Couple's handbook, etc)

4. Therapist wrap up

Sex Therapy

- Type of psychotherapy that uses a range of interventions known to effectively treat male and female sexual dysfunctions
- Treatment format
  - Individual, couples or group format
  - Choice depends upon the presenting problem, the judgment of the therapist, and patient / partners' preference

Sexual Medicine: Sexual Dysfunctions in Men and Women
Eds. MONTORSI, R. BASSON, G. ADAIKAN:2010

Sex Therapy

- Incorporates cognitive & behavioral, psychodynamic, systems relationship and educational interventions
  - e.g., readings, DVDs, anatomical models
- Treatment focused only on the SD is likely to fail if underlying emotional and relationship dynamics are ignored
- Comprehensive treatment is biopsychosocial and multidisciplinary
  - Psych, gyn, uro, endo, family practice, internists, cards, SW, NPs, PA, PT…

Leiblum 2001: *Principles and practice of sex therapy*

Integrative Treatment Models

- **PLISSIT** Model (Annon, 1976)
  - **P**ermission – for the pt to discuss the issue
  - **L**imited **I**nformation – education about the psychophysiology of sexual arousal and normal sexual functioning
  - **S**pecific **S**uggestions – e.g., communication skills, relaxation skills, sensate focus
  - **I**ntensive **T**herapy - refer for additional treatment as needed

- **Brief Sexual Counseling** (Schover & Jensen, 1988)
  - Sex education
  - Restructure maladaptive beliefs about sexuality
  - Help the pt stay sexually active (e.g., sensate focus, identify mutually satisfying sexual experiences)
  - Address conflict resolution and communication skills

Sex Therapy – Patient Centered

- Starts with psychosexual evaluation:
  - Assessment of the pt's / couple's PP and sexual history
  - Current sexual practices
  - Relationship quality
  - Emotional health
  - Contextual factors (e.g., chr illness, stressors, etc)
  - Psychosexual & developmental history
  - Review of relevant medical and biological factors
    - Physical exam / sexological exam
  - Mutual goal setting by pt/partners

Treatment Components

- Education about sexual anatomy and function is essential
- Communication / relationship skill building
  - Using “I” statements
  - Empathic listening exercises
  - Respectful communication
  - Expressing desires / minimizing criticisms
  - Learning to have compassion for each other
  - Becoming open / vulnerable

SWP: Didactics

- Female and male sexual functioning
- Communication skills
- Creating intimacy
- Emotional vulnerability
- Stress management & yoga
- Biochemistry of love
- Nutrition
- Sexual aids
- Maintaining behavioral change

Treatment Components

- Body image exercises
- Sensate focus
  - 5-step exercise for sensual/sexual intimate touch
- Anxiety management
  - Relaxation training, systematic desensitization to feared stimuli
- Bibliotherapy - erotic reading
  - The Busy Couples Guide to Great Sex (McAllister & Rallie)
  - The Art of Kissing (Cane)
  - Fantasy reading

SWP Assessments

- **Clinical interview** - Self-report hx form paired w/clinical interview
  - Person, problem(s), pt-partner responses
- **Assessment – pre- & post tx, 6 months**
  - PHQ-9
  - Dyadic Adjustment Scale - 32-item self report
  - PROMIS - Sexual Functioning Profile
    - interest, satisfaction, frequency, orgasm, physical discomforts, erectile function; 6 & 10-item self report for M/F
  - International Index of Erectile Function, 15-item self report

Take Home Points

- Roughly 1/3 of patients have Sexual Dysfunction
- It is important to Screen for it Annually
- The Most Common Types of dysfunction are:
  - Hypoactive sexual desire disorder (decreased libido)
  - Anorgasmia
  - Genito-pelvic pain disorder (dyspareunia)
- Treatment will usually start with Behavioral Modifications and Education
- Pelvic Floor Physical Therapy can be very helpful for Dyspareunia.

References

- Clayton A, Pradko J, Croft H, et al. Prevalence of sexual dysfunction among newer antidepressants. J Clin Psychiatry. 2002;63:357-366.
- Kennedy, Sidney H. MD, FRCPC*†; Rizvi, Sakina HBSc. Sexual Dysfunction, Depression, and the Impact of Antidepressants. Journal of Clinical Psychopharmacology. Lippincott Williams & Wilkins, Inc. Volume 29(2), April 2009, pp 157-164
- http://fsfi-questionnaire.com/FSFI%20questionnaire2000.pdf
- Hatzichristou D, Rosen RC, et al. J Sex Med. 2004;1:49-57
- Sensate focus Protocol adapted from Loyola Sexual Wellness Patient Handbook 2013.
- Erotic Reading list adapted from: The Pelvic & Sexual Health Institute, Philadelphia (Copyright 2006)
- Brotto LA, Petkau JA, Labrie F, Basson R: Predictors of sexual desire disorder in women. J Sex Med 8(3):742–753, 2011
- Cartoonstock.com

References

- Annon Tx. The behavioral treatment of sexual problems, vol 1, Bret Therapy, Enabling systems, Honolulu, 1974.
- Basson R et al. Summary of the recommendations on sexual dysfunctions in women. J of Sexual Medicine 2004:1:24-34.
- DeRogatis LR, & Burnett AL. The epidemiology of sexual dysfunctions. J of Sexual Medicine 2008:5:289-300.
- Dunn KM, Croft PR, Hackett GI. Association of sexual problems with social, psychological, and physical problems in men and women: A cross sectional population survey. J of Epidemiol Community Health 1999:53:144-148.
- Hatzichristou D et al. Clinical evaluation and management strategy for sexual dysfunction in men and women. J of Sexual Medicine 2004:1:49-57.
- Leiblum SR. Principles and practice of sex therapy (4th Ed.). NY: Guilford Press, 2007.
- Renshaw D. Seven weeks to better sex (3rd Ed.). Redondo Beach, CA: Westcom Press, 2004.

Thank You!