“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

<table>
<thead>
<tr>
<th>Men \ N &gt; 90,000</th>
<th>Women \ N ∼ 10,000</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Any SD 31%</td>
<td>- Any SD 32%</td>
</tr>
<tr>
<td>- Low desire 5% - 15%</td>
<td>- Low desire 17% - 55%</td>
</tr>
<tr>
<td>- Anorgasmic 8%</td>
<td>- &gt; in surgical menopause</td>
</tr>
<tr>
<td>- Rapid ejaculation 14% - 30%</td>
<td>- Arousal problems 14% - 35%</td>
</tr>
<tr>
<td>- Erectile disorder (ED) 18% - 52%</td>
<td>- Orgasm issues 25% -39%</td>
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<tr>
<td>▪ 36% moderate or complete ED</td>
<td></td>
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<tr>
<td>▪ ↑ with age -&lt;br&gt;   - 25% of men &lt; 59 yo&lt;br&gt;   - 61% of men &gt; 70</td>
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</table>

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

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

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

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

Importance of Screening for SD

Underdiagnosed and Undertreated

- Obstacles for patients
  - 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
<table>
<thead>
<tr>
<th>For Men (BSSC-M)</th>
<th>For Women (BSSC-W)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>3a. The problems with your sexual function is:</strong> (mark one or more)</td>
<td></td>
</tr>
<tr>
<td>1 Problems with little or no interest in sex</td>
<td></td>
</tr>
<tr>
<td>2 Problems with erection</td>
<td></td>
</tr>
<tr>
<td>3 Problems ejaculating too early during sexual activity</td>
<td></td>
</tr>
<tr>
<td>4 Problems taking too long, or not being able to ejaculate or have orgasm</td>
<td></td>
</tr>
<tr>
<td>5 Problems with pain during sex</td>
<td></td>
</tr>
<tr>
<td>6 Problems with penile curvature during erection</td>
<td></td>
</tr>
<tr>
<td>7 Other :</td>
<td></td>
</tr>
<tr>
<td><strong>3a. The problems with your sexual function is:</strong> (mark one or more)</td>
<td></td>
</tr>
<tr>
<td>1 Problems with little or no interest in sex</td>
<td></td>
</tr>
<tr>
<td>2 Problems with decreased genital sensation (feeling)</td>
<td></td>
</tr>
<tr>
<td>3 Problems with decreased vaginal lubrication (dryness)</td>
<td></td>
</tr>
<tr>
<td>4 Problems reaching orgasm</td>
<td></td>
</tr>
<tr>
<td>5 Problems with pain during sex</td>
<td></td>
</tr>
<tr>
<td>6 Other : ..........</td>
<td></td>
</tr>
</tbody>
</table>
Integrative Treatment Models

- **PLISSIT Model** (Annon, 1976)
  - Permission – for the pt to discuss the issue
  - Limited Information – education about the psychophysiology of sexual arousal and normal sexual functioning
  - Specific Suggestions – e.g., communication skills, relaxation skills, sensate focus
  - Intensive Therapy - 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

- 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
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

"I really think you should see a specialist about your lack of libido Sharon."
Basson’s non-linear model acknowledges how emotional intimacy, sexual stimuli, and relationship satisfaction affect female sexual response.
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

• 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:
  o Marked delay in, marked infrequency of, or absence of orgasm.
  o Markedly reduced intensity of orgasmic sensations.
• Causes clinically significant distress
• Not explained by
  o A nonsexual mental disorder
  o A consequence of severe relationship distress (e.g., partner violence)
  o Other significant stressors
  o Not due to the effects of a substance/medication
  o 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)
Sexual Response Cycles

Males

- Orgasm
- Excitement & Plateau (Arousal)
- Desire (Appetitive)

Females

- Orgasm
- Excitement & Plateau (Arousal)
- Desire (Appetitive)

Resolution
Refractory Period
• 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.
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

- Sensate focus Protocol adapted from Loyola Sexual Wellness Patient Handbook 2013.
- Erotic Reading list adapted from: The Pelvic & Sexual Health Institute, Philadelphia (Copyright 2006)
- Cartoonstock.com
References

Thank You!

“How was it for you?”