Evidence Based Approach to Low Libido in Women

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AASECT Certified Sex Therapist
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OHSU Center for Women's Health
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Objectives:

- Identify Neurobiological etiology of libido in women, particularly in the female psychiatric patient.
- List at least 3 behavioral approaches that can improve libido in women.
- List at least 3 pharmacologic treatments that can improve libido in women
Why Sexual Health?

**Sexual Health Impacts Medical Health**

- Often necessary for reproduction
- Most common reason for stopping antidepressants
- Decreased BP and cardiovascular risk (men) (NO, NE, 5HT, DHEA, ?)
- Important component in stress reduction (OXT, ?)
- Increased intimacy/Bonding- generosity, nurturing behavior (OT)
- Improved self esteem and weight management (EPI, NE, DA)
- Improved sleep and pain tolerance (Endorphins)
- Elevated Immune system (IgA)
- Improved bladder control, decreased prostrate CA (men) (NO, muscle strengthening)

Light, K. Biological Psychology, April 2005.
Charnetski, C. Psychological Reports, June 2004.
Mulhall, J. Journal of Sexual Medicine; online Feb. 8, 2008.
Meston, C. Archives of Sexual Behavior, August 2007.
Typical patient treated in a Sexual Medicine Clinic

- Pre and post menopausal sexual pain conditions
- PTSD from Sexual Trauma
- Sexual Dysfunction in Psychiatric Patient
- Sexual Dysfunction from complications of childbirth, infertility
- Ambiguous genitalia from chromosomal abnormalities
- Vulvar, breast and endometrial cancer survivors
  - Clitoridectomy
  - S/P radiation
  - Tamoxifen
- Females trying to conceive but unable to have penetrative sex
Sexual Medicine Clinic

Gynecologic Provider (MD/NP/DO)–
– Minor surgeries
– Gynecologic Evaluation/Localized Treatment
– Hormonal Treatment

Behavioralist
– Sex Therapy – AASECT certified?
– Marital Therapy
– Non hormonal medication management

Physical Therapist – pelvic floor muscle specialist
– Biofeedback

Menopause and Sexual Medicine

If you are going through menopause and also have concerns about your sexual health, this clinic can help. You will see both a gynecologist and a psychiatrist in the same day. The clinic also treats menopausal women with complex medical conditions or who are not responding to other treatments.

This clinic is led by Karen Adams, M.D., a gynecologist and North America Menopause Society certified menopause expert, and Nicole Cirino, M.D., a psychiatrist and ASSECT-certified sex therapist.
## Prevalence of Female Sexual Dysfunction (PRESIDE)

<table>
<thead>
<tr>
<th>Sexual Complaint</th>
<th>Sexual Problem</th>
<th>Sexual Problem Plus Distress</th>
</tr>
</thead>
<tbody>
<tr>
<td>Desire</td>
<td>38.7%</td>
<td>10.0%</td>
</tr>
<tr>
<td>Arousal</td>
<td>26.1%</td>
<td>5.4%</td>
</tr>
<tr>
<td>Orgasm</td>
<td>20.5%</td>
<td>4.7%</td>
</tr>
<tr>
<td>Any Dysfunction</td>
<td>44.2%</td>
<td>12.0%</td>
</tr>
</tbody>
</table>

Low desire was the most common of the three sexual problems among women of all ages.

PRESIDE = Prevalence of Female Sexual Problems Associated with Distress and Determinants of Treatment Seeking
Case- Mary (outpatient psychiatric clinic)

• 54 year old female h/o HTN, NIDDM and Depression. When asked about any medication side effects in the last 5 minutes of the session she says:

• “I don’t know...I read that there could be sexual side effects. For me, if I could never have sex again then I’d be just fine. But Mark, he feels pretty upset about it and I guess maybe I do to, I’m not sure.”
Barriers to Addressing Sexual Health

- Research has identified a few common barriers to addressing sexual health with patients:
  - Embarrassment
  - Feeling ill-prepared
    - Uncertainty on how to follow up on any problems identified through screening
  - Belief that sexual history is not relevant to the chief complaint
  - Time constraints

Nusbaum & Hamilton (2002)
Case: Mary  “I don’t know…I read that there could be sexual side effects. For me, if I could never have sex again then I’d be just fine. But Mark, he feels pretty upset about it and I guess maybe I do to, I’m not sure.”

Sexual Problem Assessment

- Nature of the problem
- Phases affected and pain
- Single vs. combined (sequence)
- Lifelong vs. acquired (timeline)
- Generalized vs. situational
- Sudden vs. gradual (predisposing, precipitating, maintaining factors)
- Contributing factors (psychological, biological, socio-cultural, lifecycle)
- Depression, anxiety, trauma, substances
- Impact & distress
- Exacerbating and alleviating factors
- Partner response/related issues
- Treatments and their efficacy
- Motivation for therapy (why now?)

Biopsychosocial model of Female Sexual Health

- Biology (e.g., physical health, neurobiology, endocrine function)
- Psychology (e.g., performance anxiety, depression)
- Sociocultural (e.g., upbringing, cultural norms and expectations)
- Interpersonal (e.g., quality of current and past relationships, intervals of abstinence, life stressors, finances)
Etiology of Female Sexual Dysfunction

- Androgens
- Estrogens
- Medications
- Illness
- Fatigue

- Stimulation
- Partner dysfunction

- Relationship discord
- Absence of emotional intimacy

- Past history of disappointing sex

- Lack of privacy
- Safety
- Emotional rapport

- Trauma (sexual, physical, medical)
- Depression
- Negative emotions (anxiety, fear, shame, guilt)

Created by: Sandra Leiblum, PhD
Sexual Problems/Distress in US Women: Prevalence and Correlates*

Recent data suggest prevalence same in women who identify as lesbian or bisexual

Shifren, Jan; Monz, Brigitta; Russo, Patricia; Segreti, Anthony; Johannes, Catherine: Obstetrics & Gynecology. 112(5):970-978, November 2008
Central Effects of Neurotransmitters and Hormones on Sexual Functioning

Desire
- Testosterone
  +

Subjective excitement
- Opioids
  -
- Progesterone
  +
- Norepinephrine
  +
- 5-HT_{2+3} (serotonin)
  -

Orgasm
- Oxytocin
  +
- 5-HT_{2+3} (serotonin)
  -

Estrogen
- Testosterone
  +

Melanocortins
- Dopamine
  +

Prolactin
-
Effects differ based on receptor subtype:
- $5\text{-HT}_{2A}$ stimulation = negative effects
- $5\text{-HT}_{1A}$ stimulation = positive effects
Traditional Model of Sexual Response

Sexual Excitement/Tension

Desire

Plateau

Arousal

Orgasm

Reduction

Masters & Johnson

Time

Helen Singer Kaplan
Female Sexual Desire: Basson Model

- Emotional Intimacy
- Emotional and Physical Satisfaction
- Arousal & Sexual Desire
- Sexual Stimuli
- Sexual Arousal
- Orgasm

Emotional Intimacy
- Motivates the sexually neutral woman
- To find/be responsive to

Hormonal drive

Psychological and biological factors govern “arousability”
# Changes from DSM-IV to DSM-V

<table>
<thead>
<tr>
<th>DSM-IV</th>
<th>DSM-V</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hypoactive sexual desire disorder (HSDD)</td>
<td>Female sexual interest/arousal disorder (FSIAD)</td>
</tr>
<tr>
<td>Sexual aversion disorder</td>
<td></td>
</tr>
<tr>
<td>Female sexual arousal disorder</td>
<td></td>
</tr>
<tr>
<td>Female orgasmic disorder</td>
<td>Female orgasmic disorder</td>
</tr>
<tr>
<td>Dyspareunia</td>
<td>Genito-pelvic pain/penetration disorder</td>
</tr>
<tr>
<td>Vaginismus</td>
<td></td>
</tr>
<tr>
<td>Sexual dysfunction due to a general medical condition</td>
<td>Substance/medication-induced sexual dysfunction</td>
</tr>
<tr>
<td>Substance-induced sexual dysfunction</td>
<td></td>
</tr>
<tr>
<td>Sexual dysfunction NOS</td>
<td>Other specified sexual dysfunction</td>
</tr>
<tr>
<td></td>
<td>Other unspecified sexual dysfunction</td>
</tr>
</tbody>
</table>
Hypoactive Sexual Desire Disorder (HSDD)

Manifests as *any* of the following:

- Lack of motivation for sexual activity as manifested by either:
  - Reduced or absent spontaneous desire (sexual thoughts or fantasies)
  - Reduced or absent responsive desire to erotic cues and stimulation or inability to maintain desire or interest through sexual activity
- Loss of desire to initiate or participate in sexual activity, including behavioral responses such as avoidance of situations that could lead to sexual activity, that is not secondary to sexual pain disorders
- AND is combined with clinically significant personal distress that includes frustration, grief, incompetence, loss, sadness, sorrow, or worry.
### Decreased Sexual Desire Screener (DSDS)

<table>
<thead>
<tr>
<th>Question</th>
<th>No □</th>
<th>Yes □</th>
</tr>
</thead>
<tbody>
<tr>
<td>In the past, was your level of sexual desire/interest good and satisfying to you?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Has there been a decrease in your level of sexual desire/interest?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Are you bothered by your decreased level of sexual desire/interest?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Would you like your level of sexual desire/interest to increase?</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Please check all the factors that you feel may be contributing to your current decrease in sexual desire/interest:**

- An operation, depression, injuries, or other medical condition
- Medications, drugs or alcohol you are currently taking
- Pregnancy, recent childbirth, menopausal symptoms
- Other sexual issues you may have (pain, decreased arousal, orgasm)
- Your partner's sexual problems
- Dissatisfaction with your relationship or partner
- Stress or fatigue

**Clinical assessment of patient answers is required.**

- On average, the DSDS took < 15 minutes to complete in a clinical study (N = 921)
- DSDS had a sensitivity of 0.836 (84%) and a specificity of 0.878 (88%) (N = 263)
<table>
<thead>
<tr>
<th>Medical Condition</th>
<th>Desire</th>
<th>Arousal</th>
<th>Orgasm</th>
<th>Pain</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Coronary artery disease</td>
<td>−</td>
<td>−</td>
<td>−</td>
<td>−</td>
<td>None</td>
</tr>
<tr>
<td>Hypertension</td>
<td>+</td>
<td>−</td>
<td>−</td>
<td>−</td>
<td>Impact of hypertension or treatment is unclear; one study found an association with low desire</td>
</tr>
<tr>
<td>Diabetes</td>
<td>+</td>
<td>−</td>
<td>−</td>
<td>−</td>
<td>Low desire may relate to depression and relationship status</td>
</tr>
<tr>
<td>Metabolic syndrome</td>
<td>+</td>
<td>+</td>
<td>+</td>
<td>−</td>
<td>None</td>
</tr>
<tr>
<td>Hypothyroid</td>
<td>−</td>
<td>+</td>
<td>+</td>
<td>−</td>
<td>Increased problems with lubrication and orgasm</td>
</tr>
<tr>
<td>Pituitary tumor/hyperprolactinemia</td>
<td>+</td>
<td>−</td>
<td>−</td>
<td>−</td>
<td>None</td>
</tr>
<tr>
<td>Urinary incontinence</td>
<td>+</td>
<td>+</td>
<td>−</td>
<td>−</td>
<td>None</td>
</tr>
<tr>
<td>Renal failure</td>
<td>−</td>
<td>−</td>
<td>−</td>
<td>−</td>
<td>Dialysis associated with sexual dysfunction</td>
</tr>
<tr>
<td>Spinal cord injury/multiple sclerosis/</td>
<td>+</td>
<td>+</td>
<td>+</td>
<td>+</td>
<td>Direct impact on sexual response; indirect effect on desire may be mediated by arousal disorders/pain</td>
</tr>
<tr>
<td>neuromuscular disorders</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Parkinson disease/dementia/head injury</td>
<td>+</td>
<td>−</td>
<td>−</td>
<td>−</td>
<td>Desire may be increased or decreased</td>
</tr>
<tr>
<td>Arthritis</td>
<td>−</td>
<td>−</td>
<td>−</td>
<td>+</td>
<td>Decreased mobility and chronic pain may impair sexual function</td>
</tr>
<tr>
<td>Dermatological conditions (vulvar lichen</td>
<td>−</td>
<td>−</td>
<td>−</td>
<td>+</td>
<td>None</td>
</tr>
<tr>
<td>sclerotic, vulvar eczema, psoriasis, Paget disease)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Gynecologic conditions (genitourinary syndrome of</td>
<td>−</td>
<td>−</td>
<td>−</td>
<td>+</td>
<td>None</td>
</tr>
<tr>
<td>menopause, sexually transmitted infections, endometriosis, chronic pelvic pain, childbirth, pelvic organ prolapse)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Malignancy and treatment (breast, anal, bladder,</td>
<td>+</td>
<td>+</td>
<td>+</td>
<td>+</td>
<td>Sexual function may be directly or indirectly impacted by cancer diagnosis and treatment. Factors include cancer diagnosis, disease itself, treatment (surgery, radiation, chemotherapy), and body image</td>
</tr>
<tr>
<td>colorectal, and gynecologic cancers)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Major depression</td>
<td>+</td>
<td>+</td>
<td>−</td>
<td>−</td>
<td>None</td>
</tr>
</tbody>
</table>

*+ = affected; − = not affected.
*Data from references 50-52.
*Adapted from Am Fam Physician, 13, with permission.
Substance/Medication-Induced Sexual Dysfunction

- Alcohol
- Sedative/hypnotic
- Opioids
- Amphetamine/Cocaine
- (Oral Contraceptives)
- Other: SSRI’s, TCA’s MAOI Antipsychotics Propanolol

*intox or withdrawal

<table>
<thead>
<tr>
<th>TABLE 4. Medications Associated With Female Sexual Dysfunction</th>
</tr>
</thead>
<tbody>
<tr>
<td>Substance/Medication</td>
</tr>
<tr>
<td>-----------------------</td>
</tr>
<tr>
<td>Anticholinergics</td>
</tr>
<tr>
<td>Antihistamines</td>
</tr>
<tr>
<td>Antidepressants</td>
</tr>
<tr>
<td>Cardiovascular and antihypertensive medications</td>
</tr>
<tr>
<td>Antihypertensives</td>
</tr>
<tr>
<td>Beta-blockers</td>
</tr>
<tr>
<td>Clonidine</td>
</tr>
<tr>
<td>Digoxin</td>
</tr>
<tr>
<td>Spironolactone</td>
</tr>
<tr>
<td>Methyldopa</td>
</tr>
<tr>
<td>Hormonal preparations</td>
</tr>
<tr>
<td>Danazol</td>
</tr>
<tr>
<td>GnRH agonists</td>
</tr>
<tr>
<td>Oral contraceptives</td>
</tr>
<tr>
<td>Antiandrogens</td>
</tr>
<tr>
<td>Tamoxifen</td>
</tr>
<tr>
<td>GnRH analogues</td>
</tr>
<tr>
<td>Ultraslim contraceptive pills</td>
</tr>
<tr>
<td>Narcotics</td>
</tr>
<tr>
<td>Psychotropics</td>
</tr>
<tr>
<td>Antipsychotics</td>
</tr>
<tr>
<td>Barbiturates</td>
</tr>
<tr>
<td>Benzodiazepines</td>
</tr>
<tr>
<td>Lithium</td>
</tr>
<tr>
<td>SSRI’s</td>
</tr>
<tr>
<td>TCA</td>
</tr>
<tr>
<td>MAO inhibitors</td>
</tr>
<tr>
<td>Venlafaxine</td>
</tr>
<tr>
<td>Other</td>
</tr>
<tr>
<td>Histamine 2 receptor blockers and promotility agents</td>
</tr>
<tr>
<td>Indomethacin</td>
</tr>
<tr>
<td>Ketoconazole</td>
</tr>
<tr>
<td>Phenytoin sodium</td>
</tr>
<tr>
<td>Aromatase inhibitors</td>
</tr>
<tr>
<td>Chemotherapeutic agents</td>
</tr>
</tbody>
</table>

GnRH = gonadotropin-releasing hormone; MAO = monoamine oxidase; SSRI’s = selective serotonin reuptake inhibitors; TCA = tricyclic antidepressant; + = yes; − = no.
Adapted from Ferri et al. (4) with permission from Elsevier.
Case - Mary 54 year old female h/o HTN, NIDDM and Depression

- Sx. began 5 years ago with “discomfort” with penetration. Desire decreased for the past 4 years. Can still orgasm with masturbation. Now any physical touch from her partner she avoids. No sexual contact for 18 months. She no longer feels as close to her HB but she loves him. Feels guilt, shame and sadness. No h/o trauma.
- Meds: Inderal, Metformin, Prozac 40mg (2 years), Ambien PRN
- SocHx: Married 20 years, Daughter recently moved home with Grandchild, works FT as RN, Wt. gain 10 pounds. HB has Erectile Dysfunction
- PE: BMI 27, constricted affect, PHQ9= 15. GU: Atrophic changes (mild)
Etiology - Exercise

- Androgens
- Estrogens
- Medications
- Illness
- Fatigue
- Stimulation
- Partner dysfunction
- Relationship discord
- Absence of emotional intimacy
- Past history of disappointing sex
- Lack of privacy
- Safety
- Emotional rapport
- Trauma (sexual, physical, medical)
- Depression
- Negative emotions (anxiety, fear, shame, guilt)

Created by: Sandra Leiblum, PhD
Etiology of Female Sexual Dysfunction

Mary

- Androgens
- Estrogens
- Medications
- Illness
- Fatigue

- Past history of disappointing sex
- Painful sex

- Stimulation
- Partner dysfunction

- Lack of appropriate stimuli

- Expectation of negative outcome

- Lack of privacy
  - Safety
  - Emotional rapport

- Biological Hormonal

- Interpersonal

- Contextual

- Trauma (sexual, physical, medical)
- Depression
- Negative emotions (anxiety, fear, shame, guilt)

- Relationship discord
- Absence of emotional intimacy

Created by: Sandra Leiblum, PhD
SSRI Induced FSD

- 1 in 6 women in the US are on an antidepressant
- Women are rarely asked about FSD prior to treatment
- Depression itself causes FSD in 50-70% of patients
  - 30-70% report low desire
- Onset of FSD 1-3 weeks after onset of AD use. (Onset of AD effects 2-6 weeks)
- Overall Rate of AD induced FSD 40% versus 14% placebo
  - Complaints: Sexual Desire 72% Arousal 83% Orgasm 42%

AD use more strongly associated with sexual dysfunction among women with unresolved symptoms of depression.
The disruption of sexual functioning through a medication change or new onset depressive episode may be a key factor.
FDA Approves Female-Libido-Enhancing Man

WASHINGTON—In an effort to address the needs of women suffering from a lack of sexual desire, the FDA announced Tuesday that it had approved a new female-libido-enhancing man, which is expected to be made available to the general public by year's end. "After conducting numerous trials on hundreds of female subjects with low sex drives, we determined that this man significantly increased sexual interest among women of all ages," said FDA representative Jane Newlon, who noted that using the 75kg man, known as Gabriel, every day had been shown to activate the regions of the brain associated with pleasure, increase blood flow to the genitals, and boost instances of orgasm by almost 40 percent. "We observed a sharp rise in libido immediately after the man is introduced, with stimulative effects lasting for up to four hours at a time. In a marketplace dominated by male-libido-enhancing products, it is a significant milestone to finally have a safe, effective option for women who want to increase their arousal, and that is exactly what this man offers." Newlon went on to warn consumers that when mixed with alcohol, the man becomes much less effective.
What type of treatment for this?
What is Sex Therapy?

Locate an AASECT Certified Professional

Search for a sexuality educator, sexuality counselor or sex therapist in your area.

<table>
<thead>
<tr>
<th>Location</th>
<th>Name</th>
<th>Title</th>
<th>Specialization</th>
</tr>
</thead>
<tbody>
<tr>
<td>Eugene</td>
<td>Wendy L. Mattz, MSW</td>
<td>Diplomate of Sex Therapy</td>
<td>Co-Director</td>
</tr>
<tr>
<td>Florence</td>
<td>Mathew Clarkson, MSW, LCSW, CST</td>
<td>Supervisor of Sex Therapy, Diplomate of Sex Therapy</td>
<td>Psychotherapist, Body Psychology, Sex Therapist/Sex Coach</td>
</tr>
<tr>
<td>Portland</td>
<td>Ange Dunn, LCSW CST</td>
<td>Sex Therapist</td>
<td>Licensed Clinical Social Worker, Certified Sex Therapist in Private Practice</td>
</tr>
<tr>
<td>Portland</td>
<td>Maegan D. Meggison, MA, LMFT, LPC</td>
<td>Sex Therapist</td>
<td>Licensed Marriage and Family Therapist, Licensed Professional Counselor</td>
</tr>
<tr>
<td>Portland</td>
<td>Heather Brooks Remshart, LCSW</td>
<td>Sex Therapist</td>
<td>Licensed Clinical Social Worker</td>
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<tr>
<td>Portland</td>
<td>Mark Henry, MA, LPC</td>
<td>Sex Therapist</td>
<td>Licensed Professional Counselor</td>
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<td>Portland</td>
<td>Nicole Harrington Gilroy, MD</td>
<td>Sex Therapist</td>
<td>Psychiatrist</td>
</tr>
<tr>
<td>Portland</td>
<td>Kate McNulty, Kate McNulty</td>
<td>Sex Therapist, Supervisor of Sex Therapy</td>
<td>Private Practice</td>
</tr>
<tr>
<td>Portland</td>
<td>Karlin A Brooke, PsyD</td>
<td>Sex Therapist, Supervisor of Sex Therapy</td>
<td>Clinical Psychologist</td>
</tr>
<tr>
<td>Portland</td>
<td>Roger Carlson, PhD, MDiv</td>
<td>Sex Therapist</td>
<td>Psychologist</td>
</tr>
</tbody>
</table>
Empirically Tested Sex therapy
(Heiman and Meston 1997)

• Trained, licensed therapists that seek additional 2-4 years of training
• “Clothes on” Licensed, office based
• Brief, solution focused 5-20 sessions – with or without partner present
• Alters dysfunctional emotions, cognitions and behaviors
• Educational component - Bibliotherapy
• Home work (behavioral)
• Treats sex as the legitimate problem not as a symptom of underlying pathology
Objectives:

- Identify Neurobiological etiology of libido in women, particularly in the female psychiatric patient.
- List at least 3 behavioral approaches that can improve libido in women.
- List at least 3 pharmacologic treatments that can improve libido in women
1\textsuperscript{st} and 2\textsuperscript{nd} Line treatment- Office Based Education/ “Counseling”

a. Normal Sexual Functioning - Basson Model
b. Spontaneous versus Responsive desire
c. Impact of stress on sexual desire
d. Importance of adequate sexual stimulation – (erotica menu)
e. Impact of pleasurable sexual experiences on desire
f. Influence of age and relationship duration
g. Bibliotherapy – i.e. Come as You Are - Emily Nagaski
Evidence Based Behavioral Interventions: Low Libido

- Office Based “Counseling”: Education/Behavioral Therapy
- Scheduled Sex
- Exercise
- Sensate Focus
- MBgCT  
  (mindfulness based group CT)
Scheduled Sex as treatment for Low Libido – Behavioral Activation

- Positive behavioral feedback loop raises levels of testosterone
- Committing to regular sexual activity breaks a pattern of avoidance
- Decrease anxiety on non sexual days
- Timing natural periods of elevated libido, more energy

1. Dabbs JM Male and female salivary testosterone concentrations before and after sexual activity. Physiol Behav. 1992
2. Lorenz Depress Anxiety. 2014
Sensate Focus – Masters and Johnson (1970)

Hypothesis: Main force of Sexual stimulation are three fold:
- 1) Your touching
- 2) You being touched
- 3) Your partner’s arousal

If words are the currency of poetry, and color is the currency of art, touch is the currency of sex.
Sensate focus- Behavioral Intervention

What?
• “Simple series of touching exercises with profound results.”
• Each partner touches for self and focuses on his or her own sensory experience without regard for the partner or ones own pleasure.
  – temperature, pressure and texture.
• Start with non genital touch and slowly move forward.
• Avoid debriefing with partner. Self reflect, journal and bring to session.

Why?
• Sexual response is a natural function – and not under our direct voluntary control.
• Deemphasizes cognition and emphasizing mind body connection.
• Recognize Spectatoring – to get at neutrality “here and the now”.

Therapeutic techniques used:
• Behavioral –scheduled and manualized
• Cognitive Behavioral therapy: -in vivo desensitization (feared situation is mastered by breaking into discreet steps)
• Interpersonal –Handriding
• Mindfulness –

Masters WH & Johnson VE 1970 Human Sexual Inadequacy
MBgCT—Mindfulness Based group Cognitive Behavioral Therapy

- Sex Therapy
- Cognitive Behavior Therapy
- Mindfulness Based Intervention
- Group Support

Basson Model - Mindfulness

- Emotional Intimacy
- Regain Neutrality
- Motivates the sexually neutral woman
- Sexual Stimuli
  - Mindful of sensual pleasure
- Low Libido Adaptations
  - Mindfulness of arousal
  - Lubrication
  - Arousal & Sexual Desire
    - Maintain responsive desire
  - Emotional and Physical Satisfaction
    - Orgasm
- Emotional and Physical Satisfaction
  - Mindfulness of arousal
Other Behavioral Treatments for FSD

Exercise (on SSRIs or not)
- 52 women with reduced desire and other sexual side effects while on SSRIs
- Effects of exercise on sexual function 1) Anytime 2) 30 minutes prior to sex
- Orgasm improved in both groups
- Desire improved in the group that exercised 30 minutes prior to sex

Sleep
- Insufficient sleep (1 hour) can decrease both desire and arousal

Objectives:

- Identify Neurobiological etiology of libido in women, particularly in the female psychiatric patient.
- List at least 3 behavioral approaches that can improve libido in women.
- List at least 3 pharmacologic treatments that can improve libido in women
Biological Approaches for Low Desire

- Increase androgens (locally and systemically)
- Increase dopamine
- Increase norepinephrine
- Modulate serotonin
- Melanocortins

“CNS Agents”
Flibanserin (addyi)- “CNS Agent”–2015 FDA approved HSDD in Premenopausal Women

- 227 RX filled in the first two months compared to 1 million of Viagra
- Non hormonal -5HT1a agonist*, 5-HT2a** antagonist and D4 antagonist
- MOA: Increased DA and NE, transient decrease of 5-HT
- Over 20 clinical studies 11,000 patients (average age 36 – Long term monogamous heterosexual)
- 13% discontinuation rate -dizziness, nausea, anxiety, fatigue

*buspirone, vilazodone, aripiprazole, ziprasidone
**trazodone, nefazodone, quetiapine
## Viagra vs. Flibanserin

<table>
<thead>
<tr>
<th></th>
<th>VIAGRA</th>
<th>FLIBANSERIN</th>
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</thead>
<tbody>
<tr>
<td>Mechanism of action</td>
<td>Blood flow to penis</td>
<td>Central (brain chemistry)</td>
</tr>
<tr>
<td>Onset</td>
<td>Almost immediately - PRN</td>
<td>Effect seen at 4 weeks, maximal at 8 weeks – Daily use</td>
</tr>
<tr>
<td>Effectiveness</td>
<td>Almost all men</td>
<td>Est. 2/10 women w desire disorders (over placebo)</td>
</tr>
<tr>
<td>Degree of response</td>
<td>Robust</td>
<td>Modest</td>
</tr>
</tbody>
</table>

SIDE EFFECTS: nausea, dizziness, syncope esp if combined with alcohol
Flibanserin Trials: Satisfying Sexual Events

Statistically significant separation from placebo in 4-8 weeks (*p < 0.05)

Overall Response rate of 50% and 2.5 SSE / month (including placebo)
Compared to placebo: Increase of 0.5-1.0 SSE over 4 weeks
Flibanserin – REMS Program

- Must become a certified prescriber
  - Providers/pharmacies MUST participate in Risk Evaluation and Mitigation Strategy (REMS)
- To mitigate the increased risk of hypotension and syncope due to alcohol use
- To become a certified prescriber go to:
  - www.AddyiREMS.com
    - Read the prescribing information and complete training program
    - Complete an assessment
    - Enroll
Other “CNS agents”

- **Buspirone**: Reduces serotonin inhibition 5HT1a agonist*, D2 agonist
- **Bupropirion**: Increased Dopamine and NE
- **Vilazodone**: Serotonin reuptake Inhibitor plus reduces serotonin inhibition 5HT1a agonist*
- **Bremelanotide 2019**: melanocortin receptor agonist –Increases DA
Testosterone in Women

• Several RCTs show efficacy for desire, arousal and orgasm in women
• Modest effect (1 SSE increase versus placebo).

Systemic Testosterone for Treatment of Low Libido

Randomized, placebo controlled trials consistently show benefits of transdermal testosterone vs. placebo for sexual desire and arousal, orgasm, pleasure, satisfaction, and pain.

• Surgically postmenopausal women on E (A)
• Naturally postmenopausal women on E & P (A)
• Postmenopausal women on no other HT (A)
• Premenopausal women in late reproductive years (B)
• Treatment emergent SSRI/SNRI antidepressant induced SD (B)
• POF/POI with HSDD (expert opinion, clinical principle)
• No RCT data: Premenopausal women on COCs

• Lack of RCT data supporting use of systemic DHEA

• Safety has not been established.

Testosterone Monitoring: ICSM, NAMS

• Annual breast and pelvic exams
• Annual mammography
• Evaluation of abnormal bleeding
• Evaluation for acne, hirsutism, androgenic alopecia, voice changes, clitororomegaly
• Monitor testosterone by mass spectrometry (SHBG, calculated free T)
• Goal: not to exceed normal range for reproductive-aged women
• Lipid profile, LFTs, CBC - baseline, 6 mos, annually
• Use for > 6 months contingent on clear improvement and absence of adverse events

Shiffren JL. Menopause 2015;10:1147-1149
Case - Mary (Treatment)

• Modifiable factors: Medication changes? Treat acute depression (Add buproprion), referral for HB to urology, Treatment of Sexual Pain (Lubricant, vaginal moisturizer)
• Office based education/counseling: Responsive desire, Scheduled sex, Erotic Stimulation, Exercise/Stress
• Sex Therapy intervention: MBgCT class: 8 weeks
• Sex therapy intervention: Sensate Focus with partner present
• Next step: Add testosterone or flibanserin
Sexual Medicine - Resources

ISSWSH Fall Course and Certification
International Society for the Study of Women's Sexual Health

SSTAR
Society for Sex Therapy and Research

AASECT Certification
American Association Sexual Educators Counselors and Therapists


AMSA Sexual Health Leadership Course

Menopause and Sexual Medicine

If you are going through menopause and also have concerns about your sexual health, this clinic can help. You will see both a gynecologist and a psychiatrist in the same day. The clinic also treats menopausal women with complex medical conditions or who are not responding to other treatments.

The clinic is led by Karen Adams, M.D., a gynecologist and North America Menopause Society certified menopause expert, and Nicole Cirino, M.D., a psychiatrist and ASSECT-certified sex therapist.
Making Sex Fun Again Reading List


Sexual Pain

1. When Sex Hurts by Goldstein, A and Pukall, C
2. Healing Pelvic Pain by Amy Stein
3. The V Guide by Elizabeth Stuart
4. Managing Pain before it Manages You by Caudill, M. (General Pain management)
5. Vulvodynia Survival Guide by Glazer and Rodke

Anorgasmia (Difficulty achieving orgasm)

2. Vibrator: Hitachi Magic Wand

Childhood Sexual Abuse Survivors

B Rothschild - "The body remembers"
Stacie Hines - "Survivors guide to sex"
Mike Lew - "Victims No Longer"