Presentation Objectives

1. Participants will be able to have a better understanding of the major diagnostic features of DSM-V sexual disorders.

2. Participants will be able to explain and gain a better understanding of pharmacological interventions used in the treatment of sexual disorders.

3. Participants will be able to conceptualize a more integrative approach to treating sexual disorders.


"Neurosexology" – Sexual Circuitry

A word about Hormones…
**Linear Model of Sexual Response (Masters & Johnson, 1966)**

**Circular Model of Female Sexual Response (Whipple & Brash-McGreer, 1997)**

**Circular Sexual Response**

More arousal and pleasure & positive outcome emotionally and physically

R. Basson Journal of Sex & Marital Therapy, Jan. 2000
Sexual Response

The sexual response of both men and women is generally considered to consist of:

- DESIRE
- AROUSAL
- ORGASM


DSM-V Disorders

<table>
<thead>
<tr>
<th>Delayed Ejaculation</th>
<th>Premature (Early) Ejaculation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Erectile Disorder</td>
<td>Female Orgasmic Disorder</td>
</tr>
<tr>
<td>Female Sexual Interest/Arousal Disorder</td>
<td>Genito-Pelvic Pain/Penetration Disorder</td>
</tr>
<tr>
<td>Male Hypoactive Sexual Desire Disorder</td>
<td>Substance/Medication Induced Sexual Dysfunction</td>
</tr>
<tr>
<td>Paraphilias</td>
<td>Other Specified SD</td>
</tr>
<tr>
<td>Gender Dysphoria</td>
<td>Unspecified SD</td>
</tr>
</tbody>
</table>

Common Sexual Issues

- Anxiety about sex
- Erectile and ejaculatory difficulties
- Lack of sexual desire
- Anxiety or uncertainty about orientation/identity
- Conflicting sexual desires between partners
- Recovery from sexual abuse or assault
- Loneliness
- Body image
- Sexual impulses or compulsions that cause distress
Sexual Desire

- Begins in the brain
- The experience of sexual fantasies, thoughts, and wanting to engage in or be involved in sexual activity.
- Desire includes being responsive or receptive to sexual advances by a partner and of wanting to continue the activity once physical contact begins.

Kaplan H.S. Hypoactive sexual desire. Journal of Sex & Marital Therapy, 1979;5:3-9

Sexual Desire Disorders

Hypoactive Sexual Desire Disorder

- The persistent or recurrent deficiency (or absence) of sexual fantasies/thoughts, and/or desire for or receptivity to sexual activity
- The disturbance causes marked personal distress

Specify:
- Lifelong or acquired type
- Generalized or situational type

Low or Absent Sexual Desire is the Most Frequent Complaint of Couples

In couple relationships:

- When sexuality is dysfunctional or non-existent, it plays an inordinately powerful role, 50% - 75%, draining the relationship of intimacy and vitality.

- When sexuality functions well in a relationship, it is 15% - 20% of the relationship, creating special feelings and energizing the bond.

Sexual Arousal Disorders in Men and Women

- Varies as a function of **PHYSICAL** factors (i.e. hormones, medication, vascular, neurologic) and **PSYCHOLOGICAL** factors (i.e. inability to focus, history of trauma, motivation, relationship variables, performance anxiety)

Types of Arousal Problems in Women

- Genital Arousal Disorder
- Subjective Arousal Disorder
- Combined Genital/Subjective Arousal Disorder
- Persistent Sexual Arousal Disorder

**Specify:**
- Situational vs. Generalized
- Acute vs. Chronic
- Severity

Mechanical Enhancement of Arousal

- Vibrators – *come in all sizes, shapes and styles!*
- Eros® clitoral vacuum device
Erectile Disorders

- Persistent or recurrent inability to attain, or maintain erection adequate for the completion of sexual activity (*except for Priapism*).
- Approximately 85% of the cases of erectile dysfunction are psychogenic in men <50; organic in men >50.

Treatment for Erectile Dysfunction

- Sensate focus
- Identify anti-sexual thoughts & fantasies
- Couple work, especially communication
- Anxiety elimination
- Vacuum and other devices
- Medication
  - Oral, intracavernosal, intraurethral

Orgasm

- Wide variability in orgasmic ease
- Wide variability in type or intensity of stimulation needed to trigger orgasm
- Vulnerable to psychological inhibition, anti-depressant medications and lack of effective stimulation
Types of Orgasm Dysfunction

- **Primary Orgasmic Dysfunction (POD)**: Inability to achieve an orgasm ever with any type of stimulation.
- **Secondary Orgasmic Dysfunction (SOD)**: Lost the former ability to experience an orgasm with any type of stimulation.
- **Situational Orgasmic Dysfunction**: Can experience orgasm only with certain kinds of stimulation; with certain partners; with particular fantasies, etc.

Male Ejaculation Disorders

- Rapid ejaculation
- Delayed ejaculation
- *Retrograde ejaculation*
- Inhibited orgasm/ejaculation

Factors Associated with Orgasm Problems

- Performance anxiety
- Negative sexual beliefs or misconceptions
- Ignorance about genital sensitivity/poor technique
- Anxiety about “letting go” – need to control
- Lack of trust, feelings of safety
- High religiosity negatively correlated with orgasm; high education positively correlated with orgasm.
Differential Diagnosis of Orgasmic Problems

- Primary or secondary?
- Acute or chronic?
- Situational or generalized?
- Mild, moderate, or severe?
- Comorbid disorders?
  - Anxiety
  - Depression: Differentiate from HSDD
  - Partner issues
  - Contextual issues

SEX THERAPY integrates...

- Cognitive Therapies
- Behavioral Therapies
- Psychodynamic Therapies
- Practical Applications
- Medication / Hormones

Focus of Sex Therapy Treatment

- Giving the couple or individual a feeling of permission to enjoy sexual activity
- Resolving conflicts and alleviating anxiety about intimacy
- Educating the couple or individual about sexual response and understanding their unique patterns
- Assigning specific behavioral tasks involving touch and communication to be practiced by the couple or individual in the privacy of their home.

Focus of Sex Therapy Treatment
PLISSIT Model
Permission (P)
Limited Information (LI)
Specific Suggestions (SS)
Intensive Therapy (IT)

Focus of Sex Therapy Treatment
Pharmacotherapy for Sexual Dysfunction
Low Desire
Differential diagnosis is essential prior to recommending pharmacotherapy for low libido. A number of psychiatric, medical, and pharmacological factors can cause low desire.

Psychosocial Factors Associated With Low Libido
- Anxiety Disorders
- Mood Disorders
- Relationship Discord
- Religious Prohibitions

Medical Factors Associated With Low Libido
- Alcohol and drug abuse
- Hypothyroidism
- Oophorectomy
- Pituitary tumors
- Hyperprolactinemia
- Low Testosterone
- Opiate use
- Renal Insufficiency/dialysis

Pharmacotherapy for Sexual Dysfunction
Low Desire - Female
HORMONAL
Systemic
- Conjugated Estrogen
- Estrogen + Androgen combination
- Medroxyprogesterone
Local
- Premarin cream
- Testosterone (transdermal)
- Intrinsa*
Pharmacotherapy for Sexual Dysfunction

Low Desire - Female

NON-HORMONAL

PDE-5 Inhibitors (Viagra, Levitra, Cialis)*
Alprostadil (topical, intravaginal cream)
Aomorphine*
Phentolamine
L-Arginine*
Yohimbine*
Bupropion

* While often recommended, there is no data on usefulness, and NONE have been FDA approved.

Pharmacotherapy for Sexual Dysfunction

Low Desire - Male

Testosterone

1. Oral androgens associated with hepatotoxicity
2. Intramuscular preparations produce supraphysiological levels followed by subnormal levels
3. Transdermal delivery systems are preferred

Pharmacotherapy for Sexual Dysfunction

Erectile Dysfunction

Clinical Recommendations regarding prescriptions of PDE-5is:

1. ABSOLUTELY contraindicated in patients taking nitrate drugs (combined or within 24 hrs of nitrate use).
2. Caution and extreme care when prescribing PDE-5is to patients taking multiple antihypertensive agents, with unstable angina, or retinitis pigmentosa (also inhibits PDE-6).

SYMBOLIC MEANING OF SEXUAL ACTIVITY TO THE PATIENT AND PARTNER SHOULD BE EXPLORED PRIOR TO DRUG PRESCRIPTION.
Pharmacotherapy for Sexual Dysfunction

Erectile Dysfunction - Other Treatments

- Apomorphine
  - Investigational, off-label

Intraurethral Treatments

- MUSE - alprostadil (prostaglandin E-1)

Intracorporeal Injection Treatments

- Papaverine, phentolamine, prostaglandin E-1
- Compliance issues, side effects

Pharmacotherapy for Sexual Dysfunction

Orgasm Disorders - Male

- SSRIs
- Dapoxetine (Priligy)*
- Desensitizing Agents/Anesthetics
  - Sildenafil + dapoxetine (P-Force)*

* Not available by Rx in USA,
  But HUGE business online!

Mechanisms of Drug-Induced Sexual Side Effects

- Antiandrogenic effects (steroidal, non-steroidal)
- Anticholinergic effects (parasympathetic inhibition)
- Antiestrogenic effects (also aromatase inhibitors)
- Alpha-Adrenergic effects ($\alpha-1,2$)
- Beta-Adrenergic effects ($\beta-1,2,3$)
- Dopaminergic effects
- Hyperprolactinemia
- Inhibition of NOS
- Serotonergic effects
- Suppression of Gonadotrophin release
Even in the absence of “sexual side effects”…

Adverse events associated with the use of Korlym® may include, but are not limited to, the following:

- nausea
- fatigue
- headache
- decreased blood potassium
- arthralgia
- vomiting
- peripheral edema
- hypertension
- dizziness
- decreased appetite
- endometrial hypertrophy

Drug Therapies Associated With Low Desire

Psychiatric Drugs
- Antipsychotics
- Benzodiazepines
- MAO inhibitors
- SSRIs
- Stimulants
- Tricyclic antidepressants

Other Drugs
- Alpha-2 agonists
- Anticonvulsants
- Beta-blockers
- Ca channel blockers
- Digitalis
- Diuretics
- Guanethidine
- Hemodialysis
- Methyldopa
- Ophthalmic solutions (containing β-blockers)
- Oral contraceptives
- Reserpine
- Tamoxifen

Drugs Known To Cause Priapism

<table>
<thead>
<tr>
<th>Antidepressants</th>
<th>Antipsychotics</th>
<th>Antihypertensives</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>Trazadone</td>
<td>Chlorthalidone</td>
<td>Hydralazine</td>
<td>Cocaine</td>
</tr>
<tr>
<td>Clomipramine</td>
<td>Clozapine</td>
<td>Prazosin</td>
<td>Papaverine</td>
</tr>
<tr>
<td>Olanzapine</td>
<td>Phenotolamine</td>
<td>Quanethidine</td>
<td></td>
</tr>
<tr>
<td>Risperidone</td>
<td>Thioridazine</td>
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<td></td>
</tr>
</tbody>
</table>

* mifepristone
Commonly Prescribed Medications That Can Have Sexual Side Effects

- Antidepressants
- Anxiolytics
- Stimulants/Adrenergics
- Cardiovascular agents
- Antipsychotics / Mood Stabilizers
- Narcotic (opiate) analgesics
- Over-the-Counter Medications
  - Antihistamines
  - Decongestants
  - "Thermogenics"

Over-the-Counter Drugs

- Antihistamines
- Decongestants
- Gastrointestinal (esp. antacid drugs)
- Thermogenics

Herbs, etc.

- Schizandra
- Ginseng Root
- Cinnamon Bark
- Stinging Nettle
- Yohimbe
- Polygonum
- Deer Antler
- Saw Palmetto
- Damiana
- Hawthorn Berry
What is an Integrated Practice?

• A holistic approach to treating the whole person (or the relationship!)
• Uses an inter-disciplinary team
• Can include physicians, nurses, psychologists, physical therapists, and clinical sexologists (sexuality educators, sex therapists)
• A natural fit for urology, gynecology, urogynecology, but also relevant for endocrinology, oncology, obstetrics, cardiology, psychiatry, gerontology, gastroenterology, and virtually ANY surgery.

Medical Factors Underlying Sexual Dysfunction

- Chronic medical illness
- Medications
- Pelvic trauma or surgery
- Neurological illness
- Endocrinological illness
- Infection/sexually transmitted diseases
- Depression/ Major mental illness

Altman A, Asner L. "Making love the way we used to... or better," Chicago: Contemporary Publishing Group. 2002.
Psychosocial Issues in Sex Therapy
Assessment
- Lifelong or acquired
- Symptom or situational
- Unresolved history of sexual abuse or trauma
- Body image/self-esteem issues
- Psychiatric history
- Stress, anxiety, sadness
- Relationship conflict
- Partner sexual dysfunction

Berman, L. UCLA Women’s Sexual Health Conference, 2002

Sample Model: SMWC, Omaha
REFERRAL PROTOCOL

Female Sexual Dysfunction
- Desire
- Arousal
- Orgasm
- Pain
- Medical: Gyn or Urogyn
- Sex Therapy
- Physical Therapy

Sexual Dysfunction, individually or relationship
Case Studies

- Key issues
- Diagnostic direction
- Role of the psychologist
- Medical referral?
- Possible pharmacological treatment?

Case Study #1

- Rick and Tina had been together for three years but rarely had penetrative sex. They both felt they had a good relationship but sex had always been painful for Tina. She describes how sore she became during intercourse and gradually lost all desire to be sexual with Rick who, in turn, found it more difficult to get an erection.

Case Study #2

- Cheryl, 34, enters therapy because she is feeling attracted to women. She reports being happily married to a man, and is at various times ashamed, excited, confused, anxious, and overwhelmed by these new attractions. She is not sure whether to tell her husband or act on these impulses secretly.
Final Points

- Obtain baseline level of sexual functioning prior to patients’ drug use.
- Differentiate between sequelae of psychiatric disorders and effects of medication.
- Questions about libido, erection, lubrication, orgasm, ejaculation, or sexual pain should be specific. (Patients tend to answer negatively to general questions.)
- Seek further education on pharmacology and interdisciplinary approaches.

ANY PHARMACOTHERAPY FOR SEXUAL DYSFUNCTION SHOULD OCCUR WITHIN THE CONTEXT OF SEX AND RELATIONSHIP THERAPY.

Final Points

Before thinking of which drugs to change or add...

- Understand sexually functional vs. sexually normal
- Holistic health (Diet/nutrition, exercise, sleep)
- Social connections, fun & laughter
- **Sex as medicine and relief vs. burden and more pain**