Female Sexual Issues in Clinical Practice

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Most Common Female Issues Presenting in [my] Practice

- Hypoactive Sexual Desire Disorder (HSDD) aka Female Sexual Interest Arousal Disorder (FSIAD)
  - Removed from DSM IV and Adjusted in V
- Cancer and Sexuality
- Infertility
- Anorgasmia
- Vaginismus (Genito-Pelvic Pain/Penetration Disorder)
- Infidelity
- Sexual Abuse
- Post-Partum and Intimacy
A Multi-Modal Referral Sources

- Ob/Gyn
- Oncologist
- Reproductive Endocrinologist
- General Practitioner

- Urologist
- Cardiologists
- Other Therapists
- Internet
- Word of mouth

HSDD/FSAID

Defined: HSDD is a persistent/recurrent absence or deficiency of sexual desire or receptivity to sexual activity that causes marked distress or interpersonal difficulty.
FSAID

- Additional criterion
- Requires absence, reduction or lack of at least three of the following for ≥6 months:
  - sexual activity
  - sexual/erotic thoughts/fantasies
  - initiation of sexual activity or unresponsive to initiation by partner
  - excitement or pleasure during sexual activity
  - response to sexual or erotic cues
  - and/or genital or nongenital sensations during sexual activity.

FSAID continued

- Additionally, sexual desire disorders cannot be the result of coexisting medical/psychiatric conditions, relationship problems, or concomitant medications or other drug substances

- BEEN NOTED in META REVIEWS OF LITERATURE THAT FEMALE DESIRE IS COMPLEX AND HARD TO FIT IN RESEARCH DESIGNS
Prevalence – varied reports

- The prevalence of low desire associated with sexually related personal distress peaks in women aged 45 to 64 years 12.3%; however, women 18 to 44 years old are also affected 8.9%

- American College of Obstetricians and Gynecologists (ACOG) has recognized HSDD as a condition and notes its prevalence to be 5.4% to 13.6%. *** conservative figure?

When to refer?

Assess patients to determine when referral to a psychological specialist is indicated, and provide appropriate resources.
### The Assessment Process

- Challenging for MDs because often dealing with other overarching issues
  - Illness (cancer, arthritis, physical disability)
  - Pain
  - Medication/Vitamin Regimen
  - Drugs and Alcohol
  - Fertility Goals
  - Diet/Caffeine/Nicotine
- Primary Error: Failure to Assess
- Employ the PLISSIT Model

### Potential Patient Self-Reporting Issues

**Physiological Reports:**
- Decreased sex drive
- Vaginal Dryness
- Vaginal Tightening
- Pain during intercourse
- Medication Side-effects
- Fatigue

**Psychological Reports:**
- Decreased interest
- Stress
- Embarrassment / Guilt
- Body Image Issues
- Lack of Knowledge
- Avoidance
- Depression
- Infidelity
- Infertility

**all opportunities for assessment dialogue**
Common Patient Non-Verbal Reporting

- Difficulty with pelvic/gyn exam
  - Due to emotional or physical pain
- Discomfort being examined in general –
  - Stress/anxiety/shame around being touched –
- Unusual Bruising
- Teary
- Heightened / Stressed gag reflex
  - Dental exams, throat/tonsil exams

The PLISSIT Model

<table>
<thead>
<tr>
<th>Description</th>
<th>Sample</th>
</tr>
</thead>
<tbody>
<tr>
<td>Permission</td>
<td>Allows a woman to discuss sexuality by providing an opportunity to address the topic. “Your body is going through many changes right now, and some of those changes may affect your sexuality. Many women have questions about sex during and after pregnancy. Do you have any concerns you’d like to discuss?”</td>
</tr>
<tr>
<td>Limited Information</td>
<td>Gives the woman just enough information to help improve her sexual functioning. A woman may wonder if she is still attractive, or just feels “off” post partum and whether she can have intercourse. The physician can explain that this is a normal feeling and many women experience an adjustment in their sexual identity and desire.</td>
</tr>
<tr>
<td>Specific Suggestions</td>
<td>Provides counseling or a referral specific to the woman’s condition rather than general counseling. If a woman is experiencing symptoms that are very specific, treatment that targets those symptoms should be recommended or provided.</td>
</tr>
<tr>
<td>Intensive Therapy</td>
<td>Refers to conditions that require treatment by a physician, specialist, or therapist. A woman experiencing severe mood disorders may need to be seen by a psychiatrist. Women with FSAID post partum may need to see a Sex Therapist.</td>
</tr>
</tbody>
</table>

Permission Statements
Integral to Assessment

- SOCIAL DESIRABILITY BIAS
- Shame, Embarrassment, Guilt, Culture are all impediments to obtaining a clear picture
- Statements the include:
  - It’s entirely normal…
  - It’s not uncommon
  - I see this often…
  - I have no judgment, so feel free to bring up any concerns…

Check YOUR Comfort Levels

- Neutral Tone
- Normalizing subject and incoming information
- Permission

Are you assessing for sexual issues?
- Check in with your own comfort levels of sexual topics
- At what point do you feel awkward?
PROBE… not just with your Speculum

- Inquire in a few different ways…

**NORMALIZE and Neutralize**
- Do you climax?
- When you do is it usually from clitoral or external stimulation? Oh that’s very normal.
- When you say you don’t have an orgasm, do you mean with your partner or ever? Like if you mastx (touch yourself) do you?
- Tell me about your desire…

Specific Populations

- Cancer
- Infertility
- Vaginismus (Genito-Pelvic Pain/Penetration Disorder)
- Infidelity
- Post-Partum and Intimacy
- Menopause
- Depressive Ptx
- High Stress Professionals
- Overweight
**Inclusion in Overall PTX Assessment**

**eg. 8 week PP**

- How is breastfeeding going?
- Getting much sleep?
- How is the baby?
- Are you feeling back to “normal”?
- Intimacy and sex life slowly returning?
- Finding any time to exercise?
- Any other questions for me?

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**Inclusion in Overall PTX Assessment**

**eg. Annual Exam of Type A Professional**

- How is have you been, how are the kids?
- Everything looks good, will have PAP results in about ten days.
- Any concerns? “Trouble sleeping/anxious”
- How long has it been, level of stress?
- **HOW** (THE HOW IS KEY) is it effecting your marriage and intimacy?
Inclusion in Overall PTX Assessment eg. Breast Cx Post Mastectomy pre Reconstruction

- How are you feeling, you look good?
- When are you scheduled for next treatment/surgery?
- How are you feeling about it?
- Medical discussion
- How are things at home? This must all be hard on Jon too
- Have you guys been able to make time for intimacy or is that the last thing you are thinking about?
- A lot of women report having a difficult time with this. Let me know if you want the name of a therapist to talk further; I know it can be private and hard to bring up—but its an important part of quality of life/marriage too.

Factors that Contribute to FEMALE Desire and Arousal

- Body Image
- Sexual Knowledge
- Relational Health before, during, after sexual obstacle
- Anxiety, Depression
- Medications
- Pain
- Diet
- Hormones
- Feeling desired by partner
- Feeling accepted by partner
- Stress Levels
- Masturbatory Habits
- Sexual History
- Aging
- New Baby
- Drugs/Alcohol
Brain is the Primary Sex Organ

- Women need to be relieved from stress
- Women need to intellectually/emotionally decide something is erotic before they engage
- Women need to feel connected and relaxed
- Depression, anxiety, poor body image/knowledge and stress are correlated to low desire

The Two Heterosexual Dilemmas

Sex for men is a stress reliever
Vs.
Sex for women requires relief from stress

Men: Sex = Love
Vs.
Women: Love = Sex
Sexual Response Cycle

- Desire
- Arousal
- Plateau
- Orgasm
- Resolution

Updated Female Response Cycle

[Diagram of Female Sexual Response Cycle]

Female Desire Talking Points

- Challenge their preconceived ideas that are causing anxiety/inadequacy
  - Women usually don’t experience spontaneous desire at the same rate or frequency as men
  - Majority of women require clitoral stim for orgasm
  - Women usually don’t enter sex from a point of desire
  - Body Image, Stress, and Connectivity are closely connected to desire

The Two Ps in Treatment: Psychological and Pharmacological

- Psychological
  - Individual Counseling
  - CBT
  - Sex Therapy
  - Couples Counseling
  - Communication Training
  - Psycho-Education
  - Support Groups
The Two Ps in Treatment: Psychological and Pharmacological

- Pharmacological
  - Research has been lagging historically
  - Viagra → increased blood flow → increased blood flow =/= increased desire
  - Flibanserin → 1 extra desire day per month
  - Testosterone (post menopausal)
  - Estrogens (?)
  - L-Argenine

HSDD / FSAID and Therapy

- Psycho-educate
- Facilitate a sexual script
- Body exploration
- Masturbation
- Fantasy Development
- Sexual Identity Creation
- Couples Work – Sensate Focus
So...how effective is therapy?

Therapeutic Efficacy

- Data exists for multiple psychological interventions in HSDD/FSAID, and though the data are limited, a benefit has been demonstrated. Limited date largely due to difficulty quantifying desire.
- These psychological interventions may still be preferred because significant AEs would not be expected.
- **SEX THERAPY IN GENERAL YIELDS HIGH LEVEL OUTCOMES**
WHAT IS SEX THERAPY

A focused – often brief – combination of behavioral, psychodynamic, educational, and cognitive counseling. It address sexual dysfunctions, sexual feelings, and other issues as they pertain to an individual and/or couple's sexuality.

Clinical Sex Therapy NEVER involves sexual interaction with the therapist and patients will never perform any sexual activities within the office.
TYPES OF THERAPIES

1. Intimacy Based Model
2. Behavioral Therapy
3. Cognitive Behavioral Therapy
4. Couples Therapy

Intimacy Based Model

**Goals**
- Mutual pleasure
- Enhanced self esteem
- Intimacy
- Satisfaction

**Viewpoint**
- Intercourse and orgasms as choices, not requirements
- Sex-as-experience model not a work/performance model

**Success**: defined as creating erotic pleasure with outcomes of:
- Intimacy
- Satisfaction
- Mutual pleasure
- Self esteem
Couples Therapy

- Clients who have a reciprocal relationship between interpersonal conflict and sex problems
- Usually Combined with CBT
- Techniques:
  1. Reduce sexual and performance anxiety
  2. Education and Cognitive Interference
  3. Script Assessment and Modification
  4. Conflict Resolution and Relationship Enhancement
  5. Relapse Prevention Training

Behavior Therapy

Define
- Based on behaviorism and learning theory, focus on problem behavior and how it can be changed or modified

Goals
- Eliminate goal oriented sexual performance
- Use therapy techniques to decrease anxiety from spectating and feeling like a failure

Techniques Used
- Sensate Focus
- Systematic Desensitization
- Education
DILATORS

Cognitive Behavioral Therapy

Combines Behavioral Therapy and Cognitive Therapy

Technique: Cognitive Restructuring

• Challenge negative attitudes
• Restructure thoughts to be more positive
• Reduce cognitive interference
References


