Psychotherapy and Behavioral Approaches for Treating Female Sexual Dysfunctions

Sheryl Kingsberg, PhD

Chief, Division of Behavioral Medicine
University Hospitals Case Medical Center
MacDonad Women's Hospital

Professor, Departments of Reproductive Biology and Psychiatry Case Western Reserve University School of Medicine

Cleveland OH, USA

Disclosures

- Consultant, Advisory Board member or Investigator for: Apricus, NovoNordisk, Palatin, Pfizer, Shionogi, Sprout, Trimel, Viveve, SST, Metagenics, Emotional Brain, TherapeutixMD, Teva

Objectives

- To develop counseling skills that allow for discussing and treating female sexual dysfunctions
- To review non-pharmacologic treatment options for female sexual problems

How can it be 26 v 0?

PDE5's (Marketed for Erectile Dysfunction)		
Viagra	Cialis	Levitra
Stendra	Staxyn	

Testosterone (Marketed for Low Libido & Erectile Dysfunction)		
Androderm	Depo-Testosterone	Testoderm TTS
Androgel	Ditate - DS	Testopel
Androgel 1.62%	Fortesta	Testosterone Cypionate
Android	Metandren	Testosterone Cypionate – Estradiol Cypionate
Android 5	Methyltestosterone	Testosterone Enanthate
Android 10	Natesto	Testosterone Enanthate – Estradiol
Android 25	Oreton	Testosterone Proprionate
Aveed	Oreton-Methyl	Testred
Axiron	Striant	Virilon
Delatestryl	Testim	Vogelxo
Depo-Testadiol	Testoderm	

Prostaglandins & Combos (Marketed for Erectile Dysfunction)		
Muse	Caverject	Edex

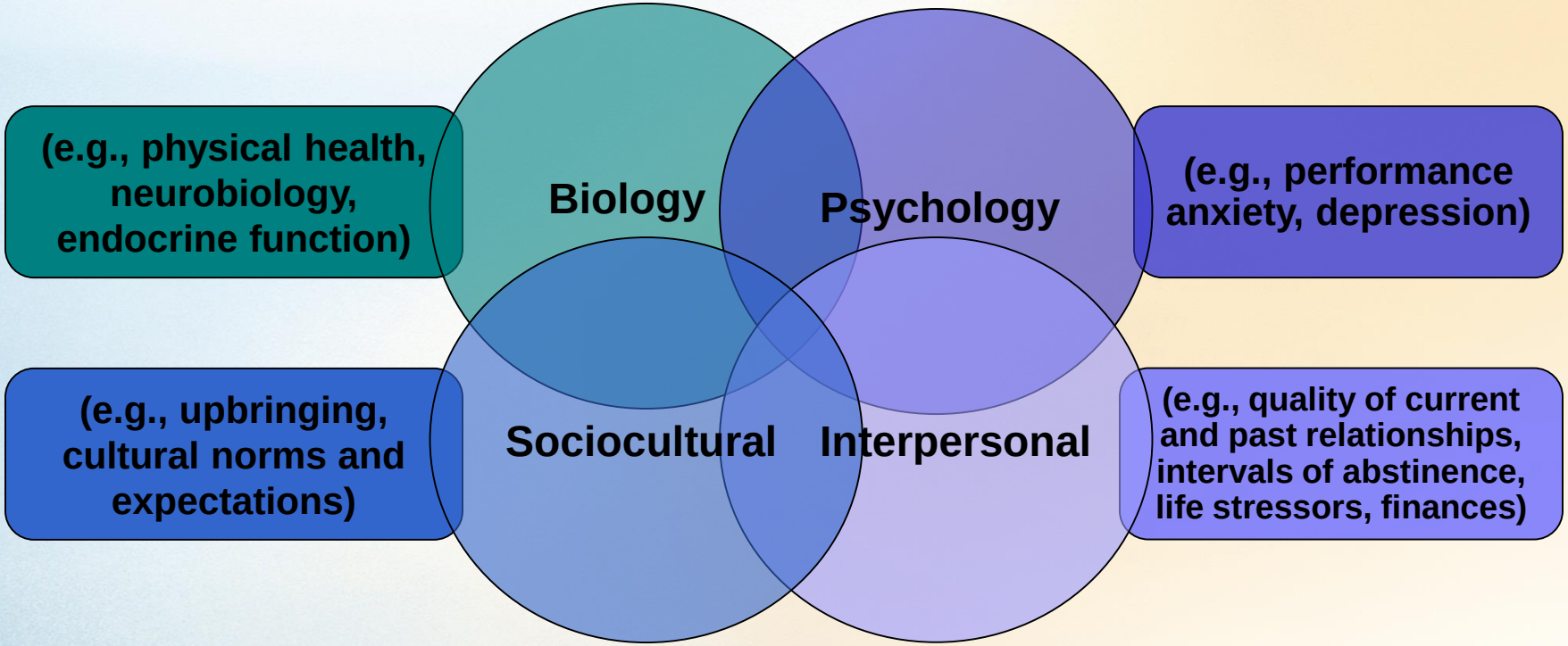
Collagenase (Marketed for Peyronie's Disease)
Xiaflex

*Premarin Vaginal Cream & Osphena approved for pain during sex secondary to VVA in post-menopausal women

Genitourinary Syndrome of Menopause (GSM)

- A collection of symptoms and signs associated with decreased estrogen and other sex steroids
  - Can involve changes to labia majora/minora, vestibule/introitus, clitoris, vagina, urethra, and bladder
  - Symptoms include, but are not limited to, dryness, ***pain with sex that may lead to subsequent sexual dysfunction***, bladder and urethral symptoms, frequent urinary tract infections, burning, itching, and irritation that are bothersome or distressing.
- Symptomatic vulvovaginal atrophy (VVA) is one component of GSM
  - Treatment of symptomatic VVA may improve all components of GSM

Biopsychosocial Model of Female Sexual Response



Rosen RC, Barsky JL. *Obstet Gynecol Clin North Am.* 2006;334:515-526.
Althof SE, Leiblum SR, Chevret-Measson M, et al. *J Sex Med.* 2005;26:793-800.

Female Sexual Disorders:DSM 5

Female Orgasmic Disorder	302.73 (F52.31)	Presence of either of the following on all or almost all (75%-100%) occasions of sexual activity: 1.Marked delay in, marked infrequency of, or absence of orgasm. 2.Markedly reduced intensity of orgasmic sensations

Symptoms persisted a minimum of 6 months and not better explained by a nonsexual mental disorder or consequence of severe relationship distress or other significant stressors and not due to effects of substance/medication or other medical condition

Female Sexual Disorders:DSM 5

Female Sexual Interest/Arousal disorder	302.72 (F52.22)	Lack of, or significantly reduced, sexual interest/arousal as manifested by 3 of the following: 1.Absent/reduced interest in sexual activity 2.Absent/reduced sexual/erotic thoughts or fantasies 3.No/reduced initiation of sexual activity and unreceptive to partner's attempts to initiate 4.Absent/reduced sexual excitement/pleasure during sexual activity in almost all or all (75%-100%) sexual encounters 5.Absent/reduced sexual interest/arousal in response to any internal or external sexual/erotic cues (written, verbal, visual) 6Absent/reduced genital or nongenital sensations during sexual activity in almost all or all (75%-100%) sexual encounters

Symptoms persisted a minimum of 6 months and not better explained by a nonsexual mental disorder or consequence of severe relationship distress or other significant stressors and not due to effects of substance/medication or other medical condition

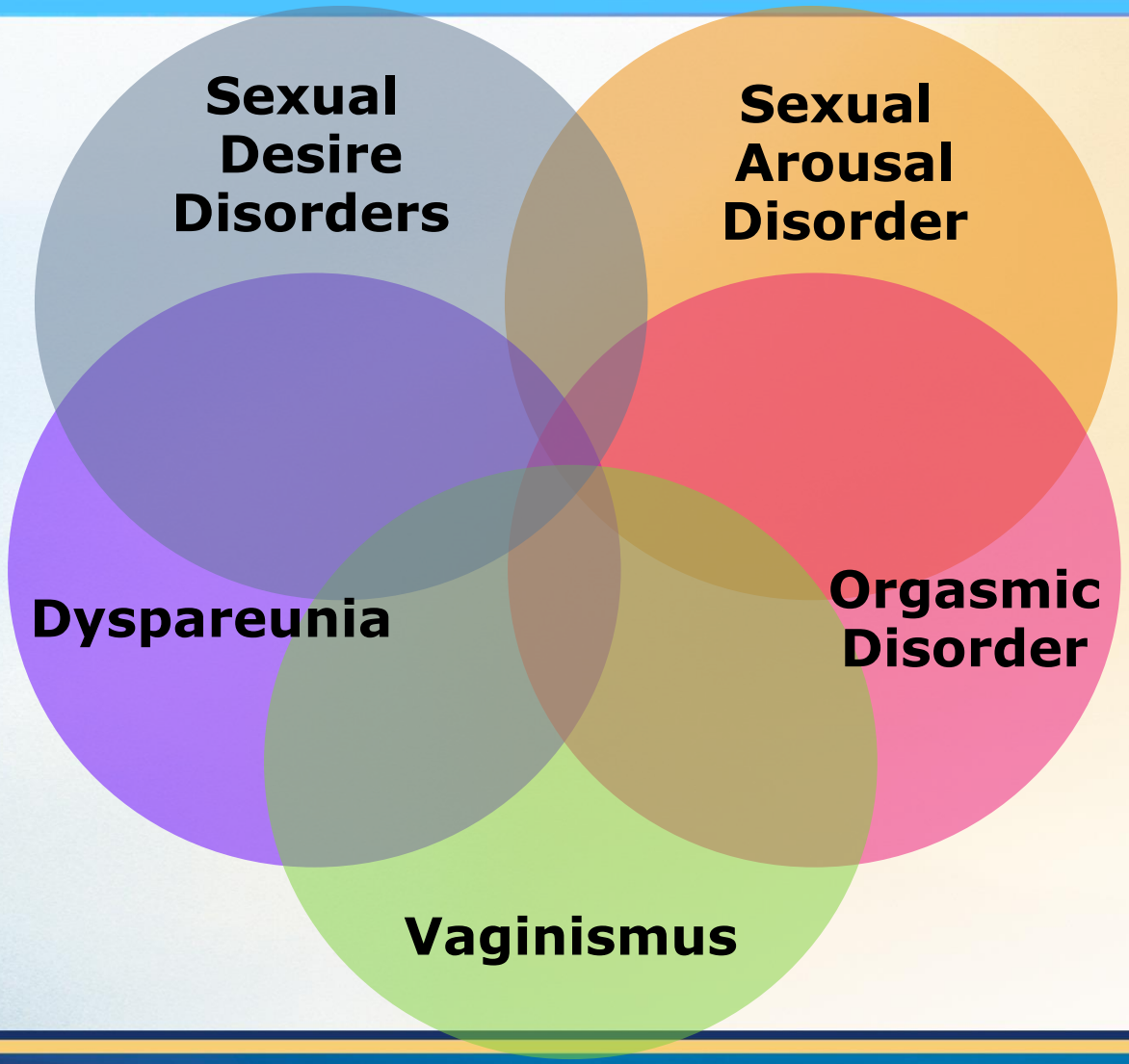
American Psychiatric Association, DSM 5, 2013

Female Sexual Disorders:DSM 5

Genito-Pelvic Pain/Penetration Disorder	302.76 (F52.6)	Persistent or recurrent difficulties with 1 or more of the following: 1.Vaginal penetration during intercourse 2. Marked vulvovaginal or pelvic pain during intercourse or penetration attempts 3.Marked fear or anxiety about vulvovaginal or pelvic pain in anticipation of, during, or as a result of vaginal penetration 4.Marked tensing or tightening of the pelvic floor muscles during attempted vaginal penetration.

Symptoms persisted a minimum of 6 months and not better explained by a nonsexual mental disorder or consequence of severe relationship distress or other significant stressors and not due to effects of substance/medication or other medical condition

Overlap of Female Sexual Disorders



Basson R, et al. *J Urol*. 2000;163:888-893.

Educate!

The Sexual Response
Models of Normal Sexuality

Excitement
Plateau
Orgasm
Resolution

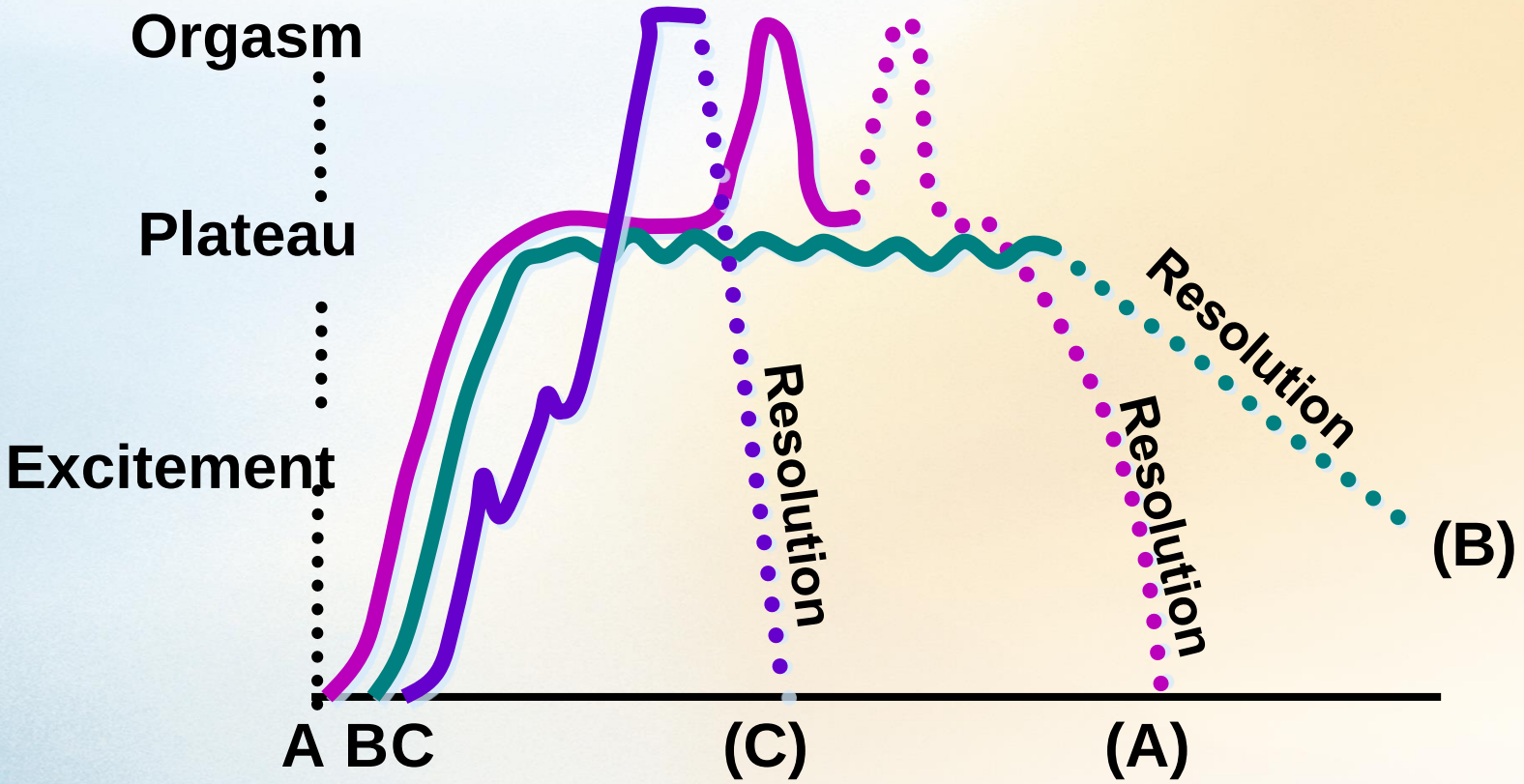
Masters and Johnson

Desire
Arousal
Orgasm

Helen Singer Kaplan
Harold Leif

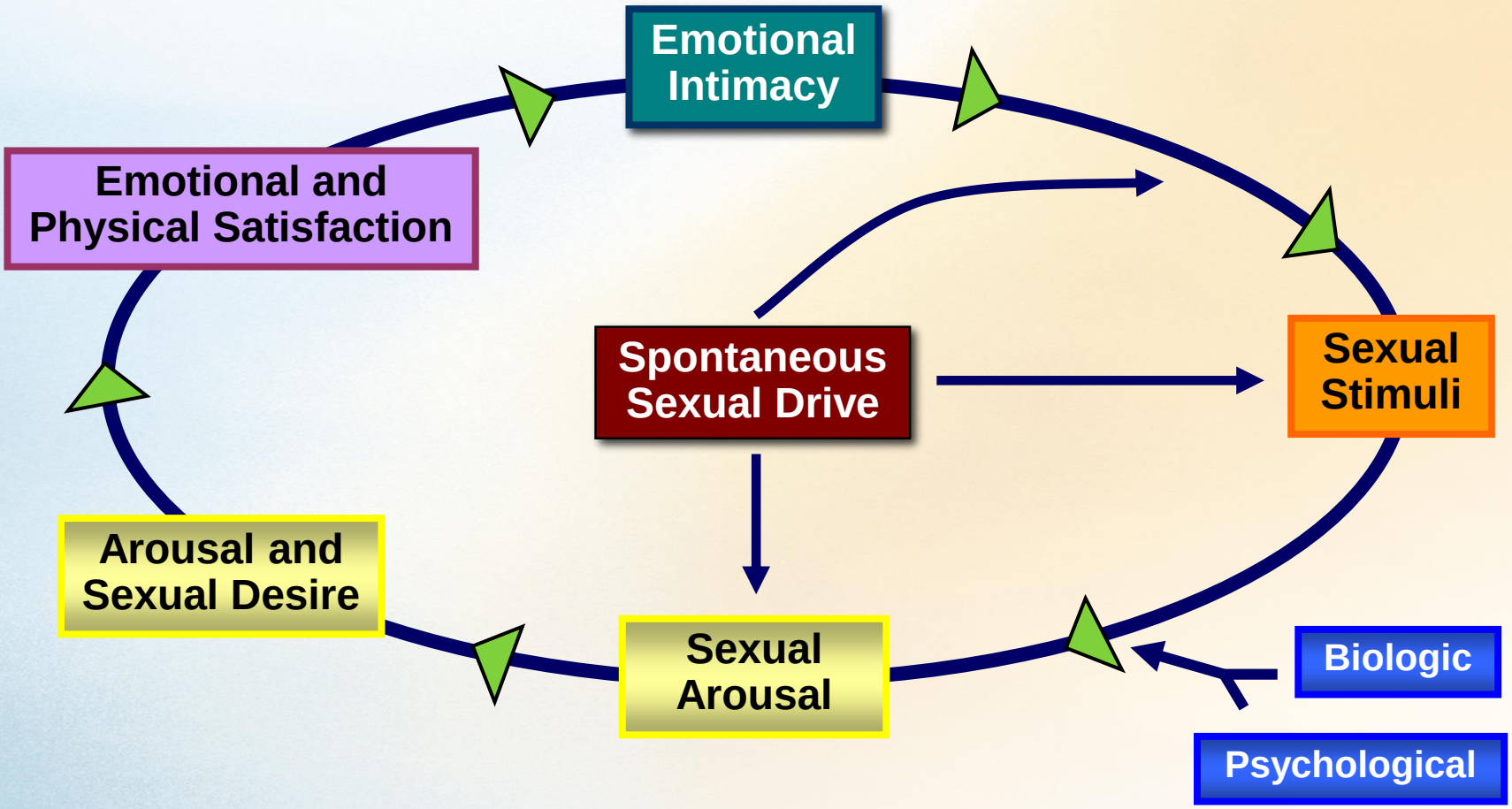
Masters WH, Johnson VE. *Human Sexual Response*. Boston, Mass: Little Brown;1966.
Kaplan HS. *The New Sex Therapy*. New York: Brunner/Mazel,1974 .

Educate!
Female Sexual Response Cycle



Adapted from Masters WH, Johnson VE. *Human Sexual Inadequacy*. Little Brown; 1970.

Educate!
Female Sexual Response Cycle



Basson R. *Med Aspects Hum Sex.* 2001;1:41-42.

Office Based Counseling for Sexual Problems: Follow PLISSIT Model

Permission to talk about sexual issues, reassurance and empathy

Limited **I**nformation

e.g., education about genital anatomy or educational resources

Specific **S**uggestions

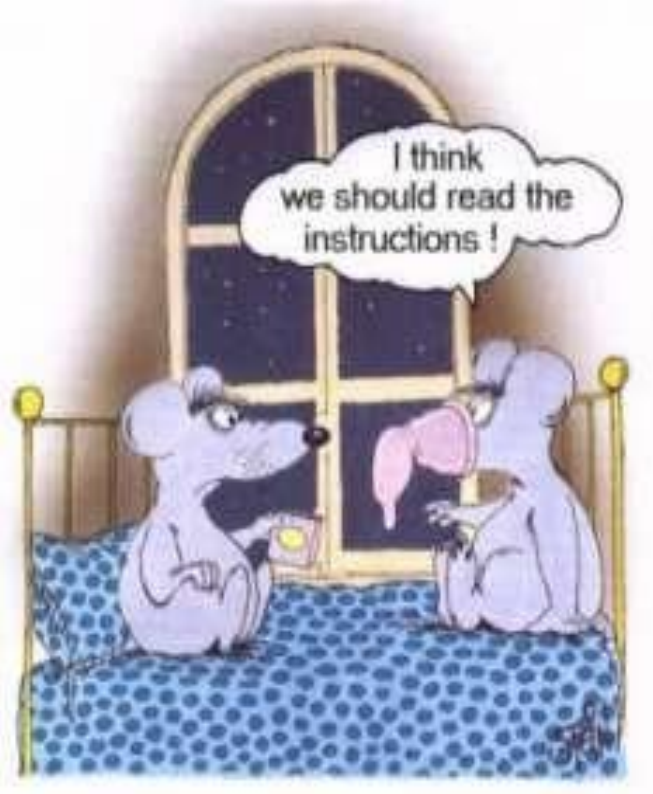
e.g., use of lubricants, altering position

Intensive **T**herapy

e.g., referral for psychotherapy/sex therapy

Annon, 1976

Validate and Encourage Patients to Ask for Advice



Types of Interventions

- Psychotherapy: Individual or Couples
- Physical therapy
- Pharmacologic therapies
- Adjunctive and alternative therapies

Kingsberg SA, Janata, JW, 2007; Simon et al, 2008

Therapeutic Targets in Female Sexual Disorders

First determine relevant factors:

- Biologic (drive)
- Cognitive (expectations, beliefs, and values)
- Motivational (emotional/interpersonal)

Sexual Counseling/Therapy

- Psychotherapy with a chief complaint of a sexual problem
  - Based on principles of learning and cognitive processing as the mechanism of change

- Although the stated goal is to correct a sexual problem, sex therapy often does not focus solely on sexual function

Heiman JR, 2002; Barlow D, 1986

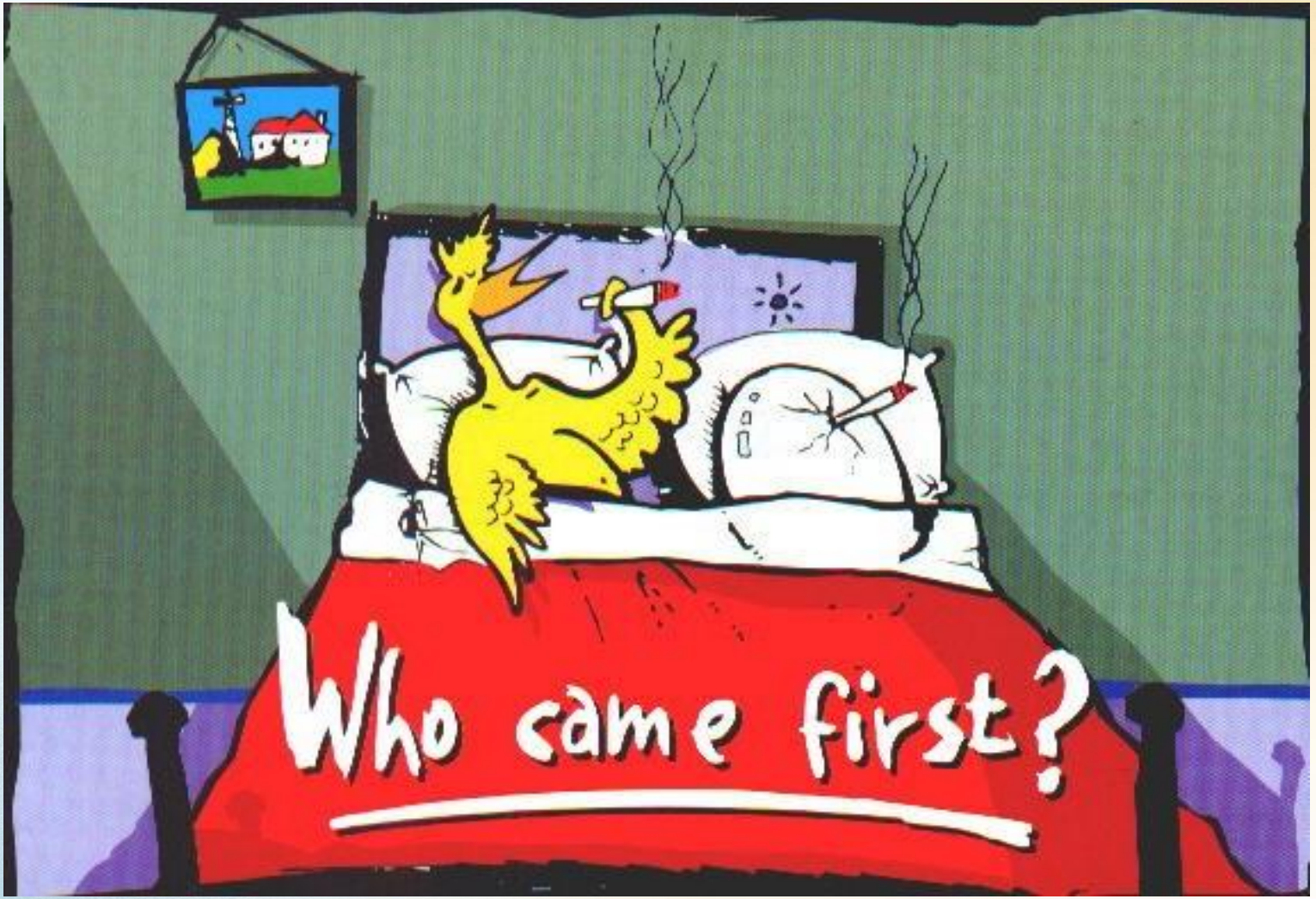
Sensate Focus

- Developed by Masters and Johnson, late 1960's
- Most frequently prescribed behavioral task
- Series of progressive, in vivo desensitization exercises with 3 general goals:
  - Decrease avoidance/anxiety
  - Improve Relaxation
  - Increase Sensuality
- Current use is less formulaic and more individualized

Masters and Johnson, Human Sexual Inadequacy 1970

Psychotherapy/Sex Therapy Common Themes

- Relationship conflict (chicken or egg determines if FSD)
- Major life stressor(s)
- Boredom
- Discrepant desire levels between partners
- Cultural/religious prohibitions/guilt
- Subclinical depression/anxiety/body image
  - If Axis I condition then FSD may not be the diagnosis


Who came first?

HCP Office-Based Sex Therapy: General Sexual Problems

- Monogamy need not mean Monotony
- Redefine “normal” sexual activity
- Alter sexual behaviors that are no longer possible or satisfying
- Alter expectations that response is linear
  - Sexual neutrality/responsive desire
- Expand sexual behavior repertoire
- Improve communication between partners

Heterosexual Dilemma
For Men: Sex => Intimacy
For Women: Intimacy => Sex

Practical Suggestions that Alter Fixed Beliefs and Habits of Your Patients-HSDD Specific (The SS of PLISSIT)

- Plan sexual activity when energy is highest and/or pain is lowest
- Put effort into seduction and foreplay
- Plan a “date night”
  - Do not talk about the kids or mortgage or politics or the stock market
- Experiment with simple but meaningful changes: Music, lightening, location, lingerie

HCPs Must Help Change Patterns: Easy Education Piece

- Alter self-identity as non-sexual
  - Self-Perception Theory
    - People make attributions about their own attitudes by relying on observations of external behaviors (Bem, 1965)
- Teach couple to compromise desire discrepency
  - Wundt's schema of sensory affect
    - Increases of stimulus intensity above threshold are felt as increasingly pleasant up to a peak value beyond which pleasantness falls off through indifference to increasing unpleasantness.

Sex Therapy: HSDD

- Paucity of randomized trials evaluating efficacy of psychotherapy
- Mindfulness-based treatments show promise

The MASTERS of Sex

“There is no such thing as an uninvolved partner in a marriage where sexual dysfunction exists.”

Masters & Johnson, 1970

The Impact of Sexual Dysfunction on a Relationship

When sex is good

It adds 15-20% additional value to a relationship

When sex is bad/non-existent

It plays an inordinately powerful role draining the relationship of all positive value, about 50-70%!

Barry McCarthy 1997 JSMT

Female Orgasmic Disorder Treatment Options

- Cognitive Behavior Therapy (CBT) has been empirically shown to be effective
- Aim: Change attitudes and sexually relevant thoughts, decrease anxiety and increase orgasmic ability
- CBT techniques
  - Directed Masturbation
  - Sensate Focus
  - Systematic Desensitization
  - Sex Ed, communication skills training and Kegels too

Anderson 1983; Morokoff & LoPiccolo, 1986; Heiman 2000, Heiman 2002; Meston & Levin, 2005.

Orgasmic Disorder: Treatment Options for non-therapists

- Permission by physician to:
  - Practice and explore self-stimulation/masturbation in privacy
  - Assert desired stimulation with partner

Maurice WL,1999; Phillips NA, 2000

Dyspareunia or GPPD Non-pharmacologic Treatment

- Chronic pain model

Psychological Pain Interview

- Problems secondary to persistent pain
- Situational fluctuation of pain
- How the patient expresses pain
- How others respond to pt. complaints
- Benefits derived from pain, if any
- Pattern of medication use, substance use
- Assessment of mood

Locus of Control

- Psychological construct, ranging from **internal** to **external.**
- Similar to concept of **self-efficacy**.
- Chronic pain predicts external locus of control, low self-efficacy.
- Integrated treatment fosters more internal locus of control.
- Research supports that greater self-efficacy predicts less disability, improved function relative to pain complaints.

Psychological Strategies

- Mood regulation
- Training in self-regulatory skills (relaxation, biofeedback, stress management)
- Cognitive reconceptualization
- Emphasis on internal locus of control
- Emphasis on active rather than passive self-mgmt.
- Emphasis on function

Vaginismus or GPPD or PFM (pelvic floor hypertonus)

- Success rate-very high particularly now with the addition of pelvic floor PT for a subgroup
- Treatment options vary but typically relaxation training with systematic desensitization using graduated dilators

Weijmar, Schultz and Van de Wiel, 2005

Thank You!

Sheryl.kingsberg@uhhospitals.org