Office Based Sexuality Assessment and Counseling for the Menopause Practitioner

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Objectives

- Identify the symptoms of FSD and its impact on a patient’s quality of life
- Recognize causal factors for FSD and common co-morbid conditions
- Identify the therapeutic modalities available to manage FSD, including their benefits and potential side effects
- Identify the processes for implementing a multidisciplinary treatment paradigm for FSD

Female Sexual Response Cycle

Adapted from Masters WH, Johnson VE. Human Sexual Inadequacy. Little Brown; 1970.
Biopsychosocial Model of Female Sexual Response

- 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, life stressors, finances)

Overlap of Female Sexual Disorders

- Sexual Desire Disorders
- Sexual Arousal Disorder
- Orgasmic Disorder
- Dyspareunia
- PFM spasm

Prevalence of Sexual Problems Associated with Distress

<table>
<thead>
<tr>
<th>Age-stratified Prevalence</th>
<th>Desire 2868/28,447</th>
<th>Arousal 1556/28,461</th>
<th>Orgasm 1315/27,854</th>
<th>Any 3456/28,403</th>
</tr>
</thead>
<tbody>
<tr>
<td>18-44</td>
<td>8.9</td>
<td>3.3</td>
<td>3.4</td>
<td>10.8</td>
</tr>
<tr>
<td>45-64</td>
<td>12.3</td>
<td>7.5</td>
<td>5.7</td>
<td>14.8</td>
</tr>
<tr>
<td>65 or older</td>
<td>7.4</td>
<td>6.0</td>
<td>5.8</td>
<td>8.9</td>
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</tbody>
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Aging and Chronic Diseases Negatively Affect Sexual Function

- Mood Disorders: Major Depression, Bipolar disorder
- Anxiety Disorders: Generalized Anxiety, Specific Phobias
- Psychotic Disorders: Schizophrenia
- Endocrine Disorders: Diabetes, Thyroid disorders, Hypogonadism, Adrenal Insufficiency
- Urologic conditions: Renal Failure, Urinary Tract Infection, Urinary Incontinence
- Cardiovascular Disease: Hypertension, Coronary Artery Disease, Myocardial Infarction
- Gynecologic Disorders: STIs, Chronic Pelvic Pain, Endometriosis, Dysmenorrhea, Vulvar Pain Disorders, Vaginal Tract Infections, Pelvic Organ Prolapse
- Cancer and surgical, chemotherapies: Breast Cancer, Anal Cancer, Colorectal, Gynecological
- Dermatologic Conditions: Eczema, Psoriasis, Paget's, Vulvar Dystrophies

Medications Associated with Sexual Problems

- **Antidepressants/mood stabilizers**
  - Selective serotonin reuptake inhibitors (SSRIs)
  - Serotonin-norepinephrine reuptake inhibitors (SNRIs)
  - Tricyclics
  - Antipsychotics
  - Benzodiazepines
  - Antiepileptics
  - Monoamine oxidase inhibitors (MAOIs)

- **Antihypertensives**
  - β-blockers
  - α-blockers
  - Diuretics

- **Cardiovascular agents**
  - Lipid-lowering agents
  - Digoxin

- **Hormones**
  - DHEA
  - Estrogens
  - Progestins
  - Antiandrogens
  - Gonadotropin-releasing hormone (GnRH) agonists

- **Other**
  - Histamine₂ receptor blockers
  - Narcotics
  - Amphetamines
  - Anticonvulsants

FSD Psychosocial Factors

- Relationship conflict
- Major life stressor(s) (illness; caring for dependents; $)
- Boredom
- Discrepant desire levels between partners
- Cultural/religious prohibitions/guilt
- Depression/anxiety/body image issues

FSD Negatively Impacts Women’s Lives

- Associated with negative effects including:¹,²
  - Poor self-image
  - Mood instability
  - Depression
  - Strained relationships with partners

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%!

Women seek help from PCP/GYN most often...BUT prefer the HCP bring up the topic


Conducting the Interview

Closed ended questions (1/min) are the NORM

HOWEVER: Open-ended questions = most efficient in revealing clinical picture within 90 seconds

- *UBIQUITY STYLE* (with menopause, many women have changes in FSR, tell me about...)
- *NORMALIZING STYLE* (Sexual concerns very common...)
- Use silences to allow the patient to speak
- *Monitor body language. Culture/age appropriate words

“Since you did ask...”

Paula is a naturally postmenopausal 57 year old women (LMP age 54) who is seeing you for routine follow up. She has no major illness, and is on one prescriptive medication for hypertension (well controlled).

She takes a daily multivitamin, exercises 2 x/ week and uses a vaginal lubricant “once in a while”.

She has been “happily married” x 30 years, has three grown children who do not live at home. She complains of progressively worsening vaginal dryness and loss of desire for sex over the past 3 years. She states, “Frankly I could care less...we had 25 good years...its not that great anymore anyway.”

Types of Interventions

- Sex therapy/Office based counseling
- Pharmacologic therapies
- Physical therapy, pelvic floor rehab

Office-Based Counseling: PLISSIT Model

Permission to talk about sexual issues, reparation and empathy

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

Specific Suggestions
  e.g., use of lubricants, altering position

Intensive Therapy
  e.g., referral for psychotherapy

Annon, 1976

Office Based Sex Therapy

- Brief, problem focused therapy to address a sexual problem of an individual or a couple
- Based on principles of cognitive processing as the mechanism of change
- Requires broadening the perspective that “sexual wellness” = MORE than genital function and sexual frequency
- Involves brief in-office discussion and follow up “homework assignments” aimed at: overcoming anxiety, altering negative sexual interactions, confronting resistance, practicing specific techniques and desensitization.

Heron, J Arch sex Behav 2002

Empirically Tested Sex Therapy Techniques

  • Brief (5-20 session) solution-focused treatment
  • Cognitive-behavioral therapy (CBT)
    • 1. Alter dysfunctional behaviors, emotions, cognitions
    • Refocus patient on motivation component of desire
    • “Are you ready to retire from this aspect of your life?”
    • “What are the LONG TERM risks/benefits?”

  2. Restructure perceptions of partner/ lovemaking
     - Realistic time assessment
     - Secondary gains
     - Return on investment
     - Distinguish lovers vs friends

Herman and Meston, 1997; Meston and Levin 2005

Sensate Focus

  • Masters and Johnson - late 1960’s
  • Most well-known technique and most frequently prescribed behavioral sex therapy
  • Series of progressive, homework and desensitization exercises
  • Enhance partners’ awareness of pleasurable experiences, preferences for nongenital and genital sexual touch outside of coitus
  • Reduces anxiety- particularly in cases of sexual pain

Masters and Johnson, Human Sexual Inadequacy 1970
Systematic Desensitization for Pain

PELVIC FLOOR MUSCLE PT
Core stabilization
Internal release
Graduated dilators
Therawand home program

OTHER SEX THERAPY TECHNIQUES

Other Sex Therapy Techniques:
- Sexuality education (particularly RE: aging and FSR)
- Communication skills training (how to communicate with a partner - bringing up difficult, sensitive topics)
- Directed Masturbation (particularly useful for orgasm issues)
- Bibliotherapy (particularly useful for desire issues)

CLINICAL PEARLS........

HERE ARE “TOP 7 MESSAGES” FOR POSTMENOPAUSAL WOMEN

MESSAGE #1: ADD MOISTURE DAILY
- MOISTURIZERS not only to decrease pain but data shows increased sexual pleasure
- Water based; bioadhesive. Apply pv 2-5x / week irrespective of timing of sex.
- Decreases dryness and eases penetration and thrusting. **Look for hyaluronic acid in ingredients****
- Shover, L JSM 2014: MOISTURIZERS INCREASE COMFORT, SATISFACTION WITH SEX AND EASE OF ORGASM
Message #2: NOURISH
- LOVE TO EAT?? THEN EAT TO LOVE……..
- MEDITERRANEAN DIET- high in fresh fruits, vegetables, nuts, fish, olive oil, whole grains and red wine...promotes sexual function during aging
- REGULAR EXERCISE, ie: walking, good for mind (body image) and genitals (increased blood flow)

Message #3: TALK
- GET SEX INTO THE CONVERSATION!!
- Partners SHOULD SPEAK HONESTLY about changes in sexual response and what can be done to optimize pleasure.
- NEVER HIDE SEXUAL PROBLEMS!

MESSAGE #4: PRIORITIZE PLEASURE
- INTIMATE TIME TOGETHER DOESN’T “JUST HAPPEN”
- ADVISE PLANNING 20 MINUTES OF WEEKLY “SACRED TIME” WITH PARTNER.....NO INTERRUPTIONS!!

Initially time is for talking, hugging when ready, progress to kissing, carressing and pleasuring.

Women with regular touch report feeling closer to the partners and maintain ability to have intercourse as they age. “USE IT OR LOSE IT” is TRUE.

Message #6: THINK
- “SEX ON THE BRAIN” helps......
- Women are more motivated for sex if thoughts are regularly stimulated by erotica (reading / movies)
- THEN...
- Use MINDFULNESS to focus on “sexy thoughts” that catalyze arousal
- And focus on bodily sensations during sex......Rather than being distracted by worries, anger, boredom, a “to do list”, and concerns

Eastern Approaches for Enhancing Women’s Sexuality: Mindfulness, Acupuncture, and Yoga (CME)
Lori A. Brotto, PhD; Michael Krychman, MD; and Pamela Jacobson, LAc, Dipl OMT
MESSAGE #6: STIMULATE

- **Vibrators** = not just for preMW
- Menopause = more intense stimulation in order to climax
- Incorporate vibrator stimulation into sexual repertoire — (explain “medical necessity”) 
- Websites LELO, MEDAMOUR, MIDDLESEXMD DRUGSTORE.COM and CVS.COM websites

Message #7... TRY...

- Incorporating these suggestions shows concern and care for the relationship. Taking ACTION speaks volumes to a partner...

Conclusions

- Female sexual disorders are highly prevalent
- Initiate the discussion ...Ask open-ended questions
- Offer simple sex therapy suggestions
- REFER for INTENSIVE THERAPY:
  - AASECT.ORG: ISSWSH.ORG
  - Refer as a collaborative consult, not as a dismissal

- THANK YOU FOR YOUR KIND ATTENTION!
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