ISSWSH HSDD PROCESS OF CARE AND MENTAL HEALTH TREATMENTS

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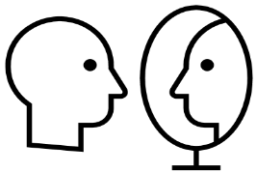
2/25/25 ISSWSH/ISSM 2025 Joint meeting

DISCLOSURES & ACKNOWLEDGEMENTS

Disclosures: past consultant for strategic science and technologies, LLC

Positionality statement:

- Cisgender, heterosexual, married woman with two children. From the Midwestern United States.
- Clinical Psychologist in academic medical position, integrated into an OBGYN department, part of an interdisciplinary women's sex med team.
- Largely Cognitive Behavioral Therapy and Acceptance and Commitment Therapy approach.



- I'd like to thank **Dr. Sheryl Kingsberg** for her tremendous support, mentorship, sponsorship

OBJECTIVES

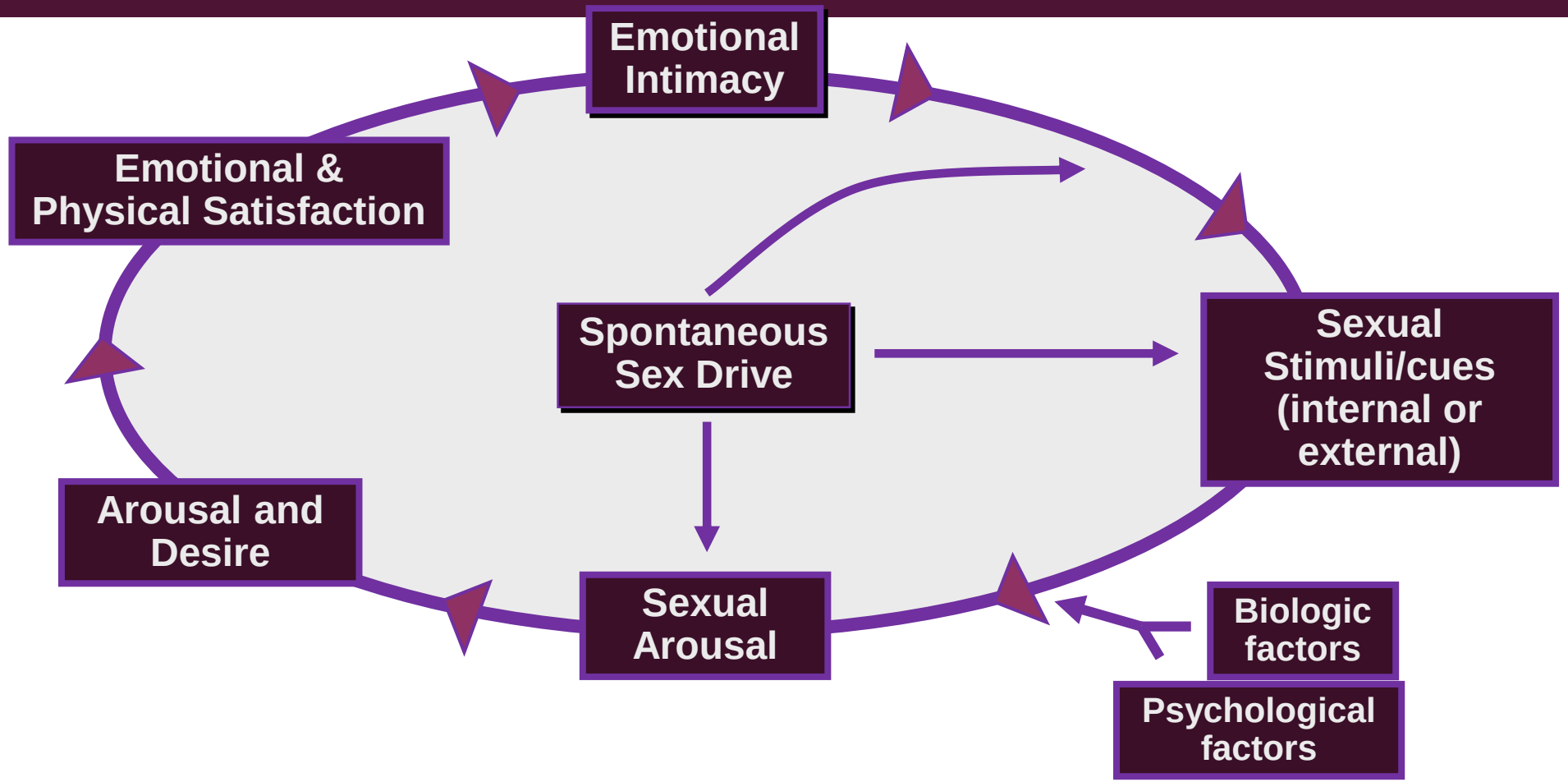
- To describe the ISSWSH Process of Care for hypoactive sexual desire disorder (HSDD)
- To describe strategies for office-based psychoeducation and counseling for women with HSDD
- To summarize psychotherapy treatments for HSDD

UNDERSTANDING DESIRE

HUMAN SEXUAL RESPONSE: CLASSIC MODELS

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

FEMALE SEXUAL RESPONSE CYCLE



Basson, Obstet Gynecol, 2001; 98

HSDD: ISSWSH NOMENCLATURE

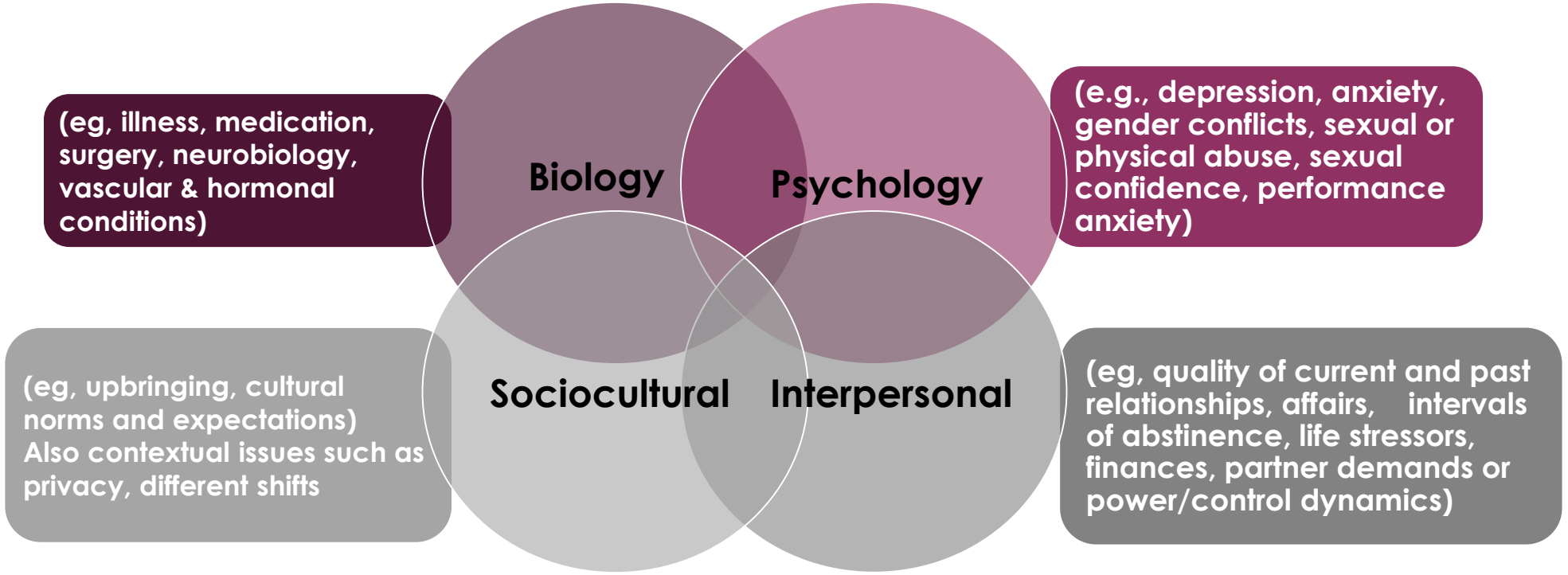
	6+ months of *any* of the following	
	Lack of motivation for sexual activity as manifested by either: o Reduced or absent spontaneous desire (sexual thoughts or fantasies) o Reduced or absent responsive desire to erotic cues and stimulation or inability to maintain desire or interest through sexual activity	
	Loss of desire to initiate or participate in sexual activity, including behavioral responses such as avoidance of situations that could lead to sexual activity, not secondary to sexual pain	
+	*Clinically significant personal distress (e.g., frustration, grief, guilt, incompetence, loss, sadness, sorrow, worry)*	
specifiers	*Lifelong vs. Acquired*	*Situational vs. generalized*

Also consider:

- Desire Discrepancies in relationship;
- Asexuality

Parish SJ, Goldstein AT, Goldstein SW, et al. Toward a more evidence-based nosology and nomenclature for female sexual dysfunctionsdpart II. J Sex Med. 2016;13(12):1888-1906, Parish et al., 2019 Mayo Clin Proceed

BIOPSYCHOSOCIAL MODEL OF SEXUAL RESPONSE



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

ISSWSH processes of care (Parish et al., 2019; Clayton et al., 2018).

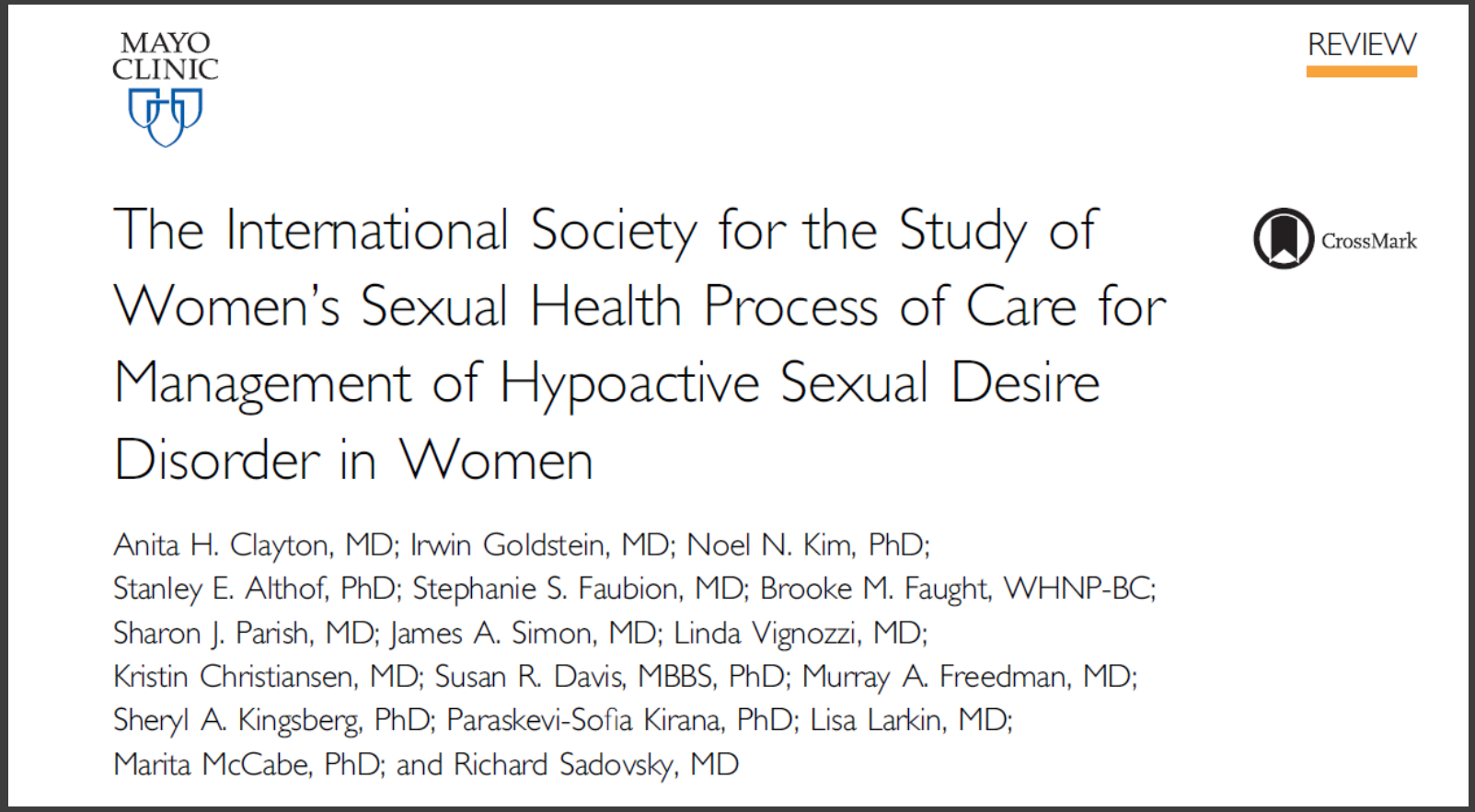
ETIOLOGY OF HSDD

	Excitatory	Inhibitory
Physiological / Organic	• **Neuromodulators of excitatory pathways such as:** • **Dopamine** • **Oxytocin** • **Melanocortin** • **Norepinephrine**	• **Neuromodulators of inhibitory pathways such as:** • **Serotonin** • **Opioids** • **Endocannabinoids**
Psychosocial/ Interpersonal	• **Intimacy (physical/emotional closeness)** • **Positive beliefs about sex** • **Shared values** • **Romance** • **Experience/behavior**	• **Relationship conflict** • **Negative stress** • **Negative beliefs about sex** • **Experience/behavior**

- Bancroft J, et al. *J Sex Res*. 2009;46:121-142.
- Perelman MA. *J Sex Med*. 2009;6:629-32
- Clayton et al., 2018.

ISSWSH POC

- Mayo Clinic Proceedings, 2018. Volume 93, Issue 4, 467 - 487



MAYO CLINIC

REVIEW

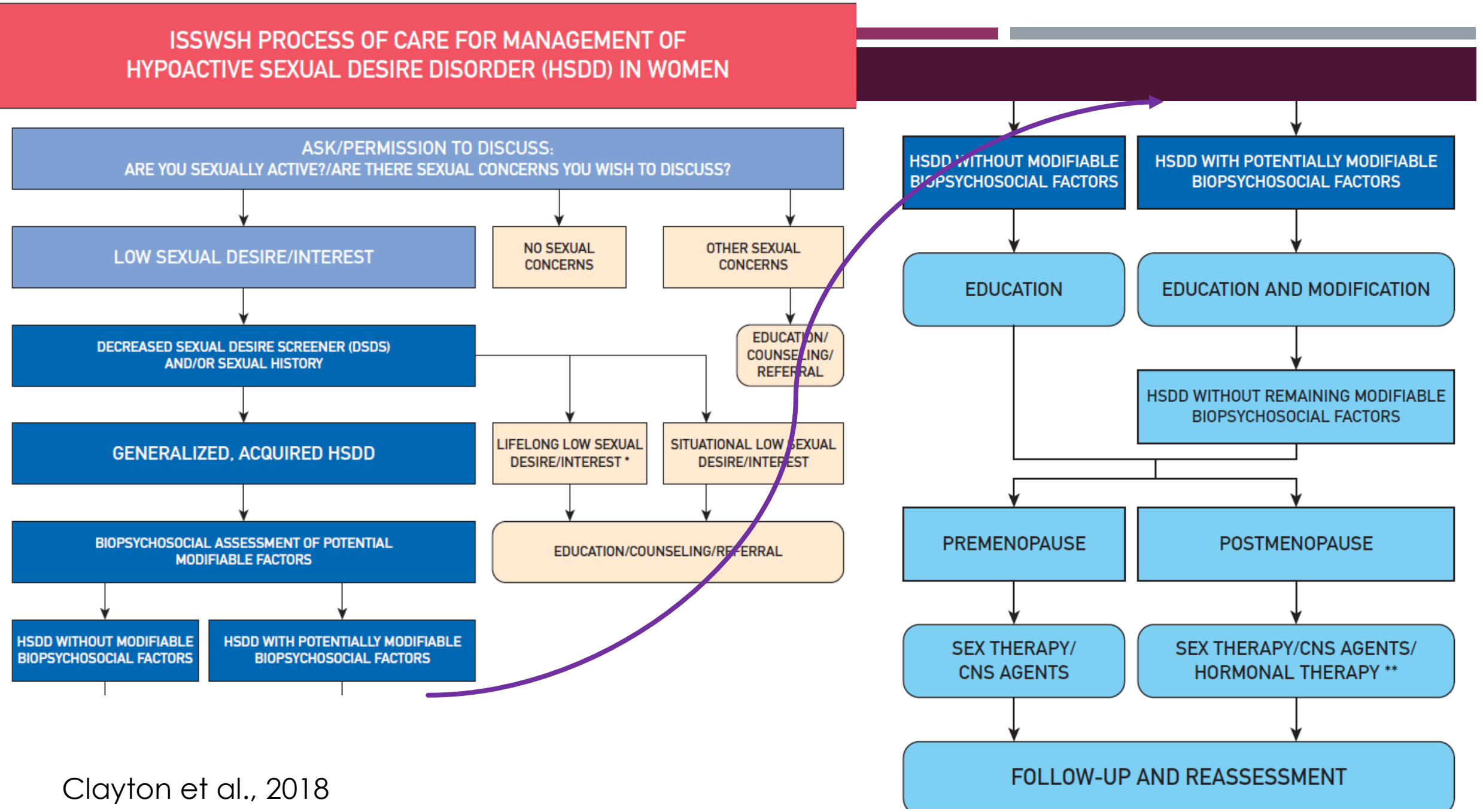
The International Society for the Study of Women's Sexual Health Process of Care for Management of Hypoactive Sexual Desire Disorder in Women

CrossMark

Anita H. Clayton, MD; Irwin Goldstein, MD; Noel N. Kim, PhD; Stanley E. Althof, PhD; Stephanie S. Faubion, MD; Brooke M. Faught, WHNP-BC; Sharon J. Parish, MD; James A. Simon, MD; Linda Vignozzi, MD; Kristin Christiansen, MD; Susan R. Davis, MBBS, PhD; Murray A. Freedman, MD; Sheryl A. Kingsberg, PhD; Paraskevi-Sofia Kirana, PhD; Lisa Larkin, MD; Marita McCabe, PhD; and Richard Sadovsky, MD

METHOD

- International multidisciplinary panel who individually conducted evidence-based literature reviews
- N = 17 panelists (researchers, clinicians, ISSWSH members and nonmembers)
- 2-day convening using modified Delphi method to review and discuss management strategies for HSDD
- Result: consensus development of a clinical guideline for the health care professional



Clayton et al., 2018

SCREENING

SCREENING DURING VISIT

- **When**? Any visit, when feels most natural. Also, re-screen over time (ask for permission: *E.g.,* if patient says "no concerns", ask, "Is it OK if I check back with you about any potential sexual concerns in the future?").
- **How**? using ubiquity statement, normalization, consider appropriate body language and privacy.
- Ask/permission to discuss.

"Are you sexually active?"

yes

no

"Are there sexual concerns you wish to discuss?"

"I ask every patient I see about their sexual wellbeing. Many women experiencing [diabetes, cardiovascular problems, depression] have concerns about sexual functioning. What concerns do you have?"

SCREENING DURING VISIT

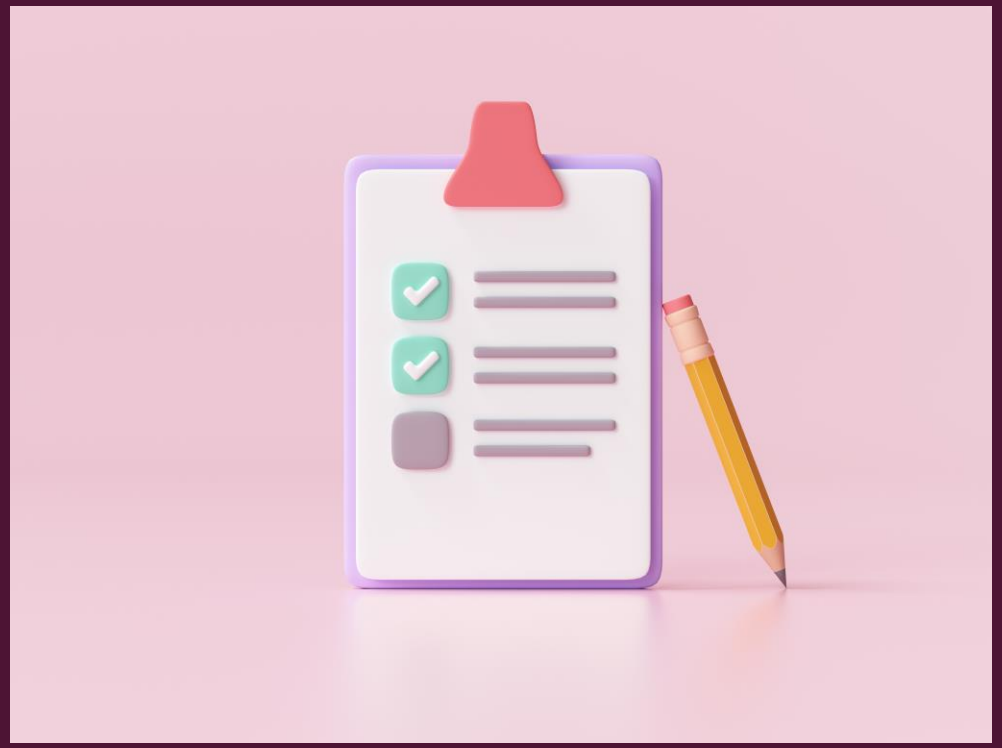
- **When**? Any visit, when feels most natural. Also, re-screen over time (ask for permission: *E.g.,* if patient says "no concerns", ask, "Is it OK with you if I check back with you about any potential sexual concerns in the future?").
- **How**? using ubiquity statement, normalization, consider appropriate body language and privacy.
- Ask/permission to discuss.

If reporting low desire

<u>Elicit her story</u>: "Tell me more about that."

<u>Screen for distress:</u>
"what affect does that have on you [your relationship]?"
"in what ways is that bothersome to you?"

ASSESSMENT



DECREASED SEXUAL DESIRE SCREENER (DSDS, CLAYTON ET AL. 2009)

- 5-item self-report measure for assessment of generalized, acquired HSDD.
  - allows patient to indicate what factors they perceive are affecting decreased sexual desire (e.g, medications; relationship dissatisfaction)

- Clayton AH, Goldfischer ER, Goldstein I, Derogatis L, Lewis-D'Agostino DJ, Pyke R. Validation of the Decreased Sexual Desire Screener (DSDS): a brief diagnostic instrument for generalized acquired female hypoactive sexual desire disorder (HSDD). J Sex Med. 2009;6(3):730-738.

DSDS

In the past, was your level of sexual desire or interest good & satisfying to you?

Has there been a decrease in your level of sexual desire or interest?

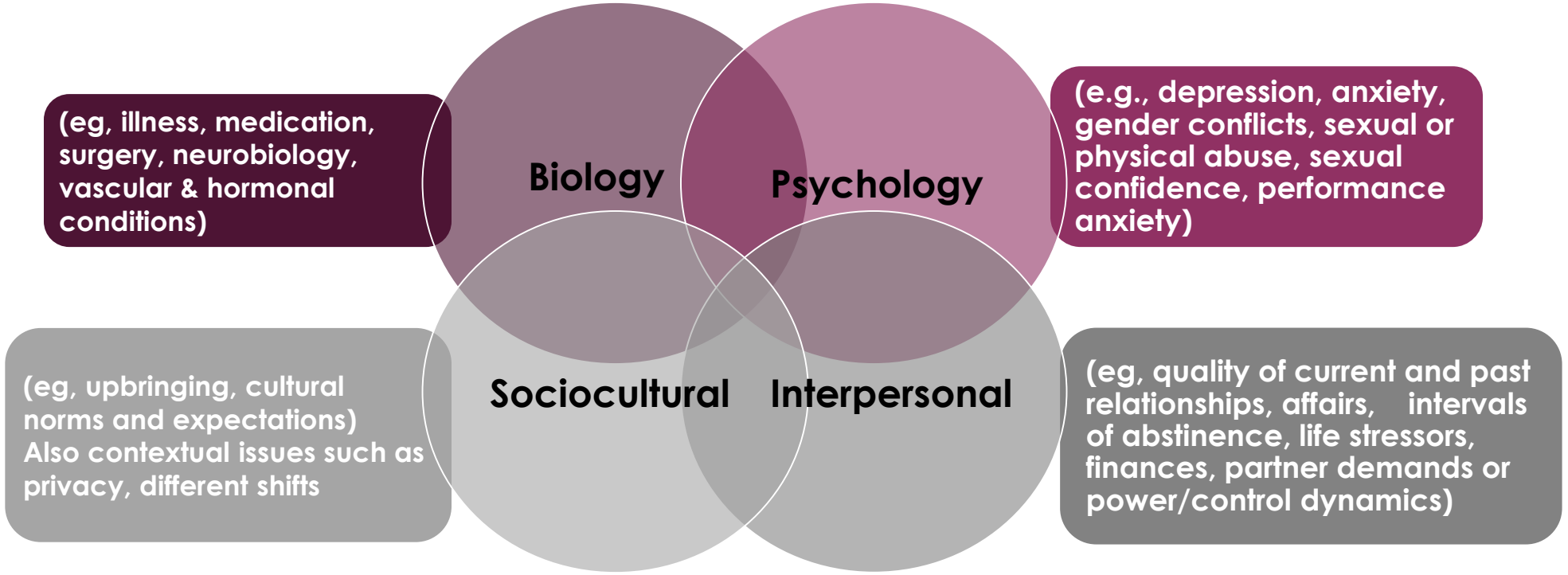
Are you bothered by your decreased level of sexual desire or interest?

Would you like your level of sexual desire or interest to increase?

Please circle all of the factors that you feel may be contributing to your current decrease in sexual desire or interest:

- a. An operation, depression, injuries, or other medical condition
- b. Medications, drugs, or alcohol you are currently taking
- c. Pregnancy, recent childbirth, menopausal symptoms
- d. Other sexual issues you may be having (pain, decreased arousal or orgasm)
- e. Your partner's sexual problems
- f. Dissatisfaction with your relationship or partner
- g. Stress or fatigue

SEXUAL HISTORY TAKING



SEXUAL HISTORY TAKING

- Refer back to diagnostic criteria, biopsychosocial model of contributi
- Determine timeline.
- Determine specifiers.

Factors to consider	
***consider both partnered and unpartnered sexual activity*	
past and present characteristics of the patient's sexual desire/interest	Sexual desire discrepancy (+distress?)
Past and present characteristics of other aspects of sexual function such as arousal, orgasmic function, and/or any pain/discomfort before/during/after sexual activity.	Psychosocial assessment
Past/present relationships	Impact on functioning
Past/present sexual experiences	

PHYSICAL EXAM (IF INDICATED)

Condition (possible contributing factor)	Assessment
Clitoral adhesions/phimosis, or atrophy	Visual exam under magnification
High-tone pelvic floor dysfunction	Manual examination
Labial resoprtion; vulvar, vaginal, or vestibular atrophy	Visual exam under magnification, vaginal smear (wet mount)
Lumber-sacral spinal pathology	Quantitative sensory testing, bulbocavernosus reflex latency testing, MRI of lumbar and sacral spine
Pudental nerve disorder	Assess tenderness of pelvic floor muscles; assess tenderness at ischial spine
Urethral meatal prolapse or telescoping	Visual exam under magnification
Vulvar dermatoses and dystrophies	Visual exam under magnification, biopsy if indicated
Vulvodynia	Cotton swab: assess sensitivity to pressure around

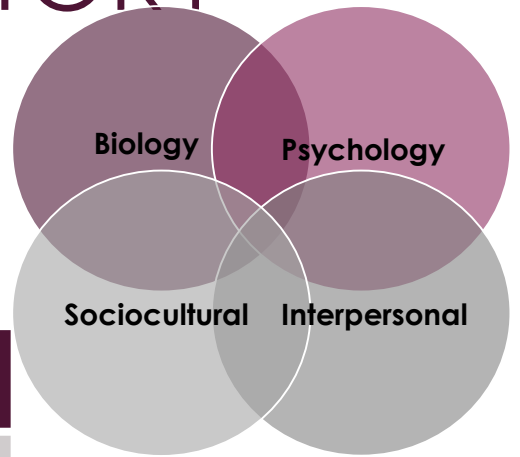
LABORATORY TESTING & IMAGING (IF INDICATED)

- Determined by physical exam results & history taking
- Testing of hormone levels *not indicated* for HSDD diagnosis
- No biomarkers that confirm or exclude HSDD
- Opportunity for referral for other conditions (LoE = 2 to 3)

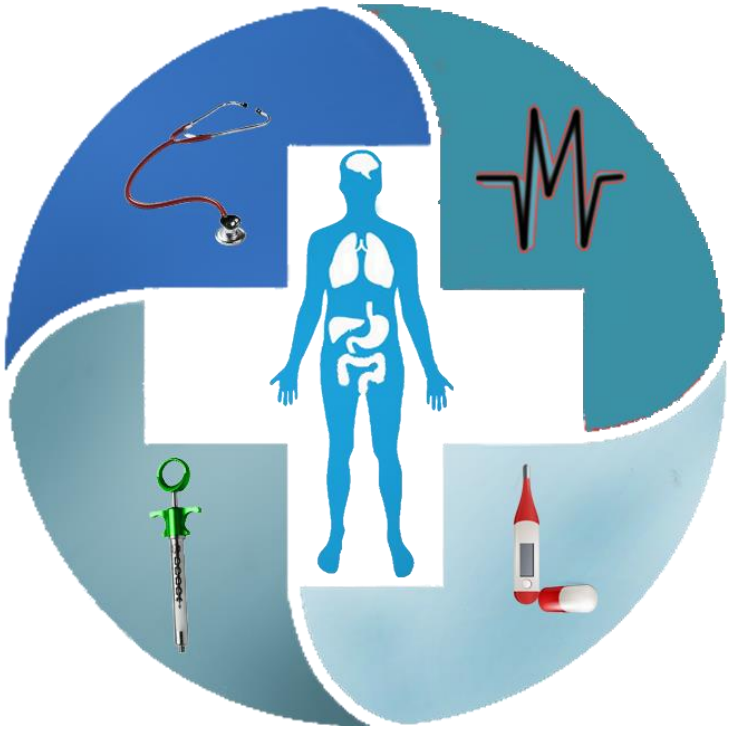
Hormone	Possible condition
Estradiol, progesterone, LH, T, sex hormone-binding globulin	Oligo- or amenorrhea
Prolactin	Hyperlactinemia causing ovarian suppression and low sex steroid production
Thyroid function panel	Hypo- or hyper-thyroidism

OVERALL DOMAINS TO CONSIDER IN HISTORY TAKING

CLAYTON ET AL., 2018, *MAYO CLINIC PROCEEDINGS*



Screening for other sexual problems and relationship factors (consider timeline)
Psychiatric conditions & medications
Medical problems
Menopausal status (& if surgical vs. Natural)
Medications
Substance use
Gynecologic history (e.g., GSM, pelvic floor dysfunction)



Medical conditions	
Hypertension	Diabetes
Metabolic syndrome	Pituitary tumor/hyperprolactinemia
urinary incontinence	Other conditions contributing to lower androgen levels
Spinal cord injury/MS/neuromuscular disorders	Parkinson disease/dementia/head injury
Major depression [routinely screen!]	Malignancy & treatment (anal, bladder, breast, colorectal and gynecologic)
Pelvic operations, trauma, or radiotherapy contributing to pain or altered ovarian function	Medications that lower testosterone production (e.g., CHCs)

MEDICAL CONDITIONS POTENTIALLY AFFECTING DESIRE

*ASSOCIATED WITH DESIRE DISORDER
Anticholinergics
Antihistamines
Amphetamines & related
Cardiovascular, antihypertensive*
Hormonal preparations*
Narcotics*
Psychotropic (e.g., SSRI)*
Other (e.g., chemotherapeutic agents; aromatase inhibitors, histamine 2 receptor blockers & promotility agents, indomethacin, ketoconazole, phenytoin sodium)

MEDICATIONS AFFECTING SEXUAL FUNCTION

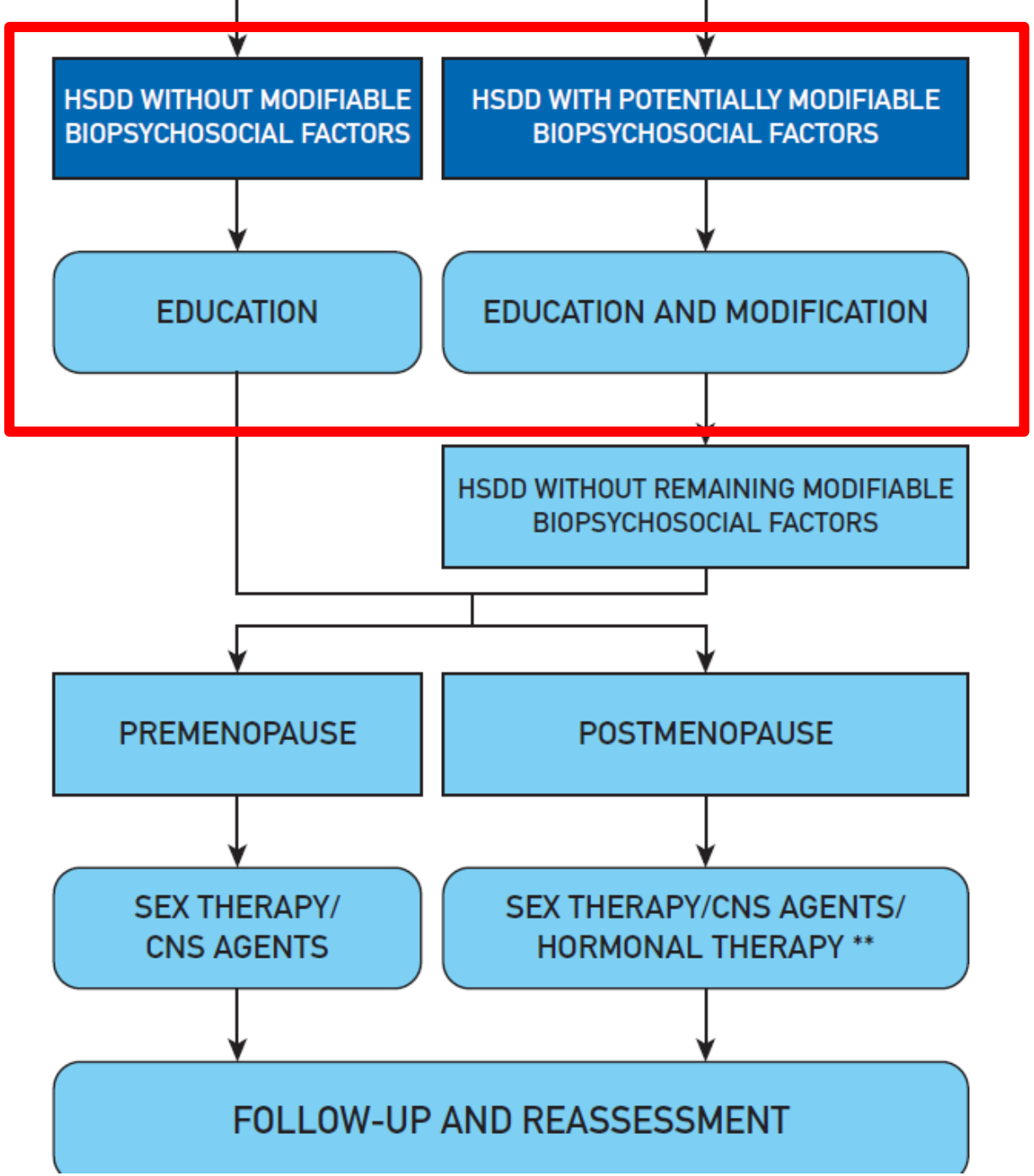
CLAYTON ET AL., 2018, *MAYO CLINIC PROCEEDINGS*

MANAGEMENT


SO NOW WHAT?

FIRST AND SECOND LINE THERAPIES

Clayton et al., 2018, *Mayo Clinic*



EDUCATION

Normal sexual functioning

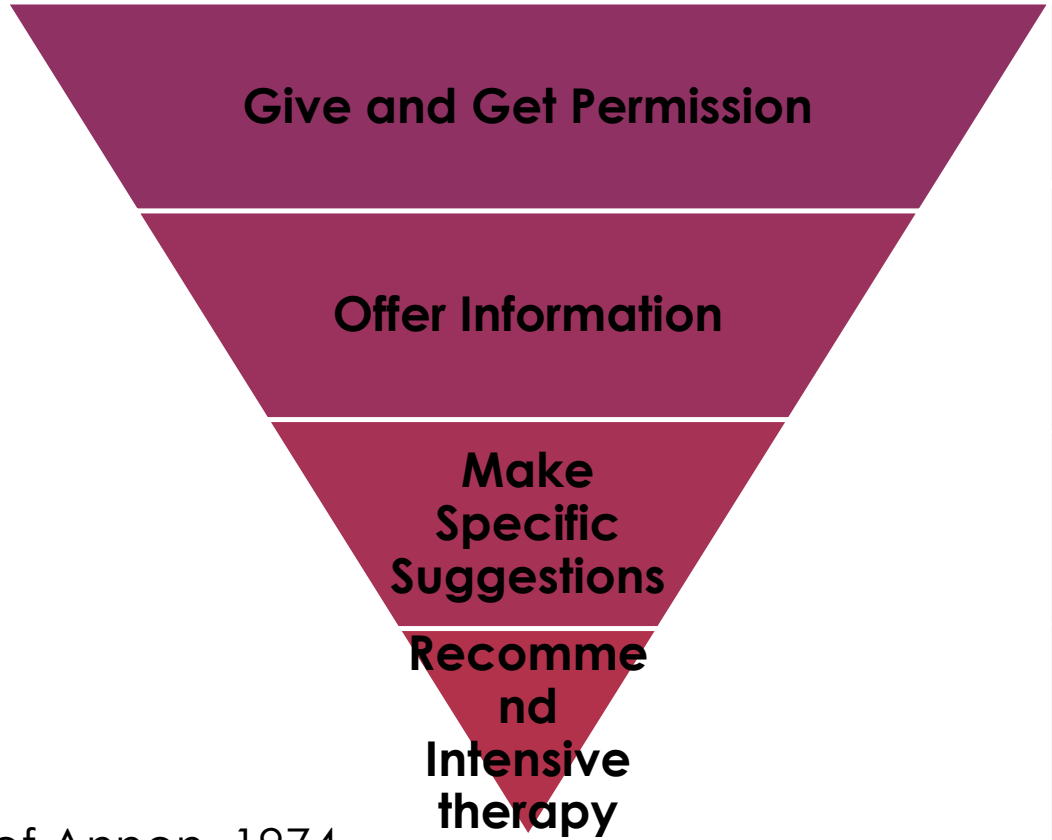
Factors from their own history taking that may disrupt desire

Assess treatment motivation & discuss treatment options

- may involve partner
- Ask what they have tried in the past

Clayton et al., 2018,
Mayo Clinic Proceedings

OFFICE-BASED COUNSELING: THE POSIT MODEL
(KINGSBERG ET AL., 2023)



Giving patients permission to raise sexual issues
Give patients appropriate information (e.g., education about sexual side effects of medications, genital anatomy, educational resources and relevant patient information
Making specific suggestions based on a full evaluation of presenting problems (e.g., change position, use lubricants)
Referral to intensive therapy (i.e., sex therapy, psychological interventions, and/or biomedical approaches)

Adaption of Annon, 1974
PLISSIT model

MODIFICATION

Potential modifiable factors	
Genital arousal symptoms or pain	Addressing sexual changes with cancer/cancer treatment
Diabetes	Sleep difficulties/insomnia
Vasomotor symptoms of menopause	Depression (but consider treatment-emergent sexual dysfunction)
Review patient's medication list for possible (safe) modifications	Substance use
Psychological factors (see next slide)	

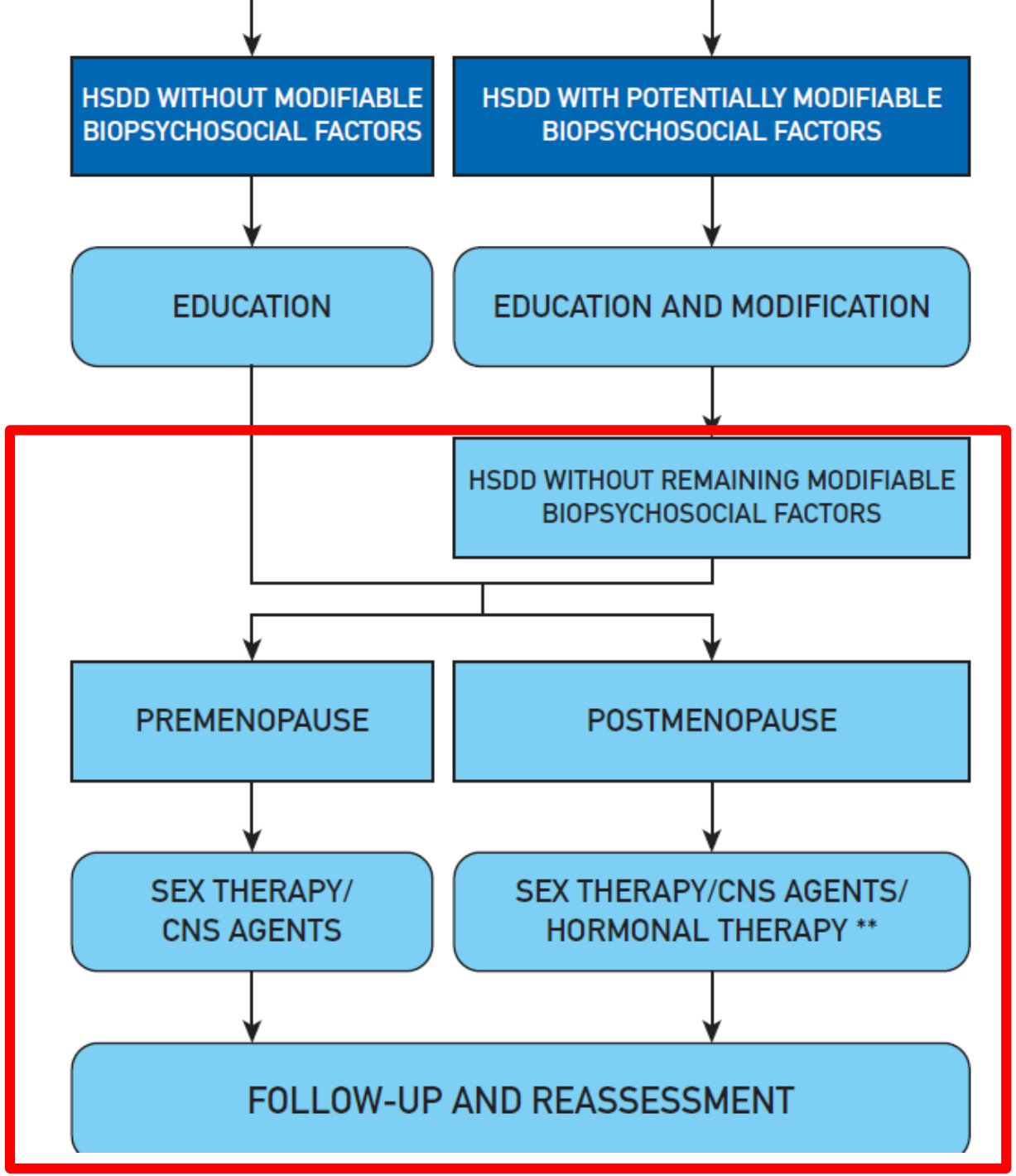
PSYCHOLOGICAL FACTORS

BOLD = POTENTIALLY ADDRESSABLE WITH OFFICE-BASED COUNSELING

MODIFIABLE CONTRIBUTING FACTOR	MANAGEMENT STRATEGIES
Depression/anxiety	History of exposure to interpersonal trauma
Poor self-esteem or body image	stress/distraction
Substance use disorder	**Self-imposed pressure for sex**
Religious, cultural, personal, or family values and beliefs	**Relationship factors**
Lifestyle factors	**Sexual factors**

THIRD LINE TREATMENT

Clayton et al., 2018,
Mayo Clinic



FOLLOW-UP AND REASSESSMENT

- Should be done at **regular intervals** to monitor progress of treatment, medical status of patient, & other opportunities for education and therapy
  - E.g., assess change in medication, treatment preferences, other domains of sexual function

Clayton et al., 2018,
Mayo Clinic Proceedings

PSYCHOTHERAPY MANAGEMENT/ SEX THERAPY

SEX THERAPIES

CLAYTON ET AL., 2018, *MAYO CLINIC PROCEEDINGS*

Therapy	Components	Evidence
Behavior therapy	Education, communication skills, sensate focus	Sensate focus alone unlikely effective for HSDD
CBT	Alter unrealistic thoughts & behaviors contributing to low desire	3 RCTs => effect over WLC
Mindfulness-based CBT	Increase present-moment, nonjudgmental awareness of sensation	2 WLC studies show support

EDUCATION/ SEXUAL COUNSELING

Provide education (e.g., about sexual response, prevalence, contributing factors to low desire)

Evidence that supportive sex education improves desire

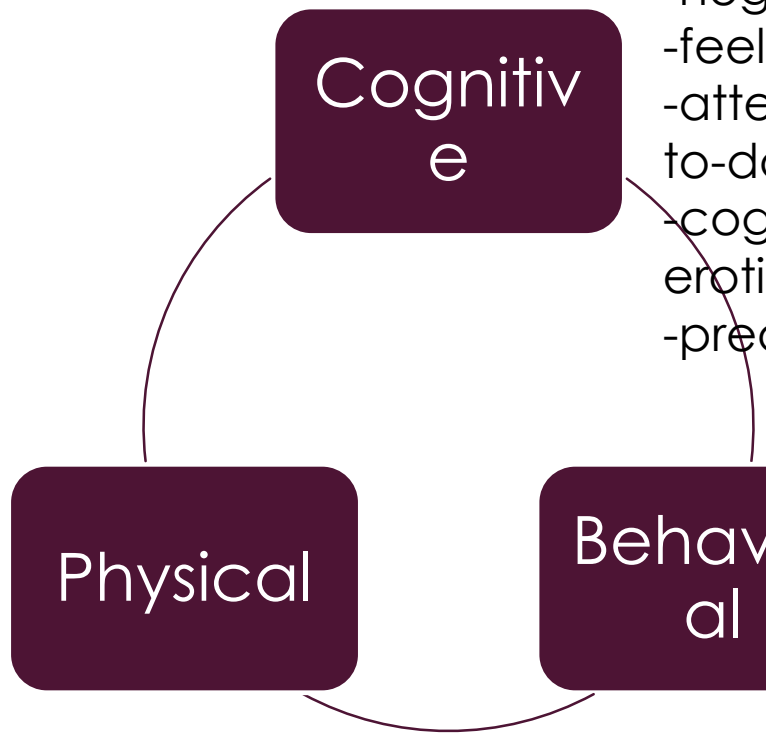
- May be that it provides normalization and validation and increased self-understanding
- May also be due to an increase in self-compassion
- Perhaps also increased recognition of interoceptive awareness– teach patient to notice and attend to sexual arousal (Brotto et al., 2022 JSR)

SEX THERAPY

- Specialized form of psychotherapy that draws on an array of behavioral interventions known to effectively treat sexual dysfunction
  - Sexual function is the focus
  - Offers insight and understanding to the genesis of the sexual problem
  - Affectual awareness that strives for recognition of positive and negative emotions related to sexual interaction and desire
  - **Reframing cognitive factors** and distracting thoughts
  - **Alters maladaptive behaviors**
  - **Communication skills training**
  - Usually 5-20 sessions, includes between-session homew

Althof, 2022; Heiman and Meston, 1997; Sawyer & Durllak 1997

COGNITIVE-BEHAVIORAL MODEL



-negative self-image or –esteem
-negative beliefs about sex
-feeling incompetent -
-attentional avoidance during sex (e.g., thinking of to-do list during sex)
-cognitive distraction draws attention away from erotic cues
-preoccupying ruminative thoughts

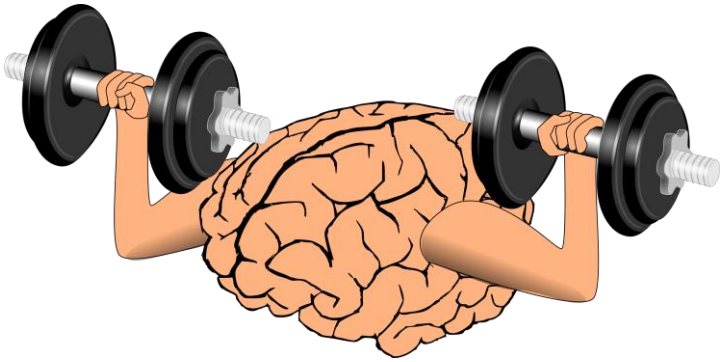
Low desire

-Behavioral avoidance of sexual stimuli, communication, and activity
-leads to fewer positive sexual experiences

COMMON EXAMPLES OF MALADAPTIVE BELIEFS

- “I’m not good enough for my partners”
- “My partner will leave me”
- “This will never be enjoyable”
- “Something is wrong with me”
- “My stomach looks so fat, I am unattractive”
- "I'm not normal"
- "I don't deserve to experience pleasure"
- "My partner thinks I'm not attracted to them"

COGNITIVE-BEHAVIORAL THERAPY



Cognitive

-Restructure maladaptive thoughts about self, sex, or sexual performance
-Redirect focus from performance to pleasure & sensuality
-Attentional re-direction

Behavioral

-Improve communication skills with partner
-Address interpersonal issues
-Reduce barriers to intimacy
-Reduce avoidance (e.g., avoiding looking at own body)

Physical

Improved desire

Support for CBT: e.g., Pyke & Clayron, 2015; Clayton et al 2018

SENSATE FOCUS SEX THERAPY

Masters and Johnson, Human Sexual Inadequacy 1970

Weiner L & Avery-Clark C 2017. Sensate Focus in Sex Therapy:The Illustrated Manual. New York, NY: Routledge

Developed by Masters and Johnson, late 1960's

Sensate focus exercises combine elements of mindfulness and in-vivo desensitization

- a feared situation is gradually mastered by breaking it into discrete steps experienced under safe conditions and staying present with the experience

Series of progressive "sexual" exercises for individuals or couples with 3 general goals:

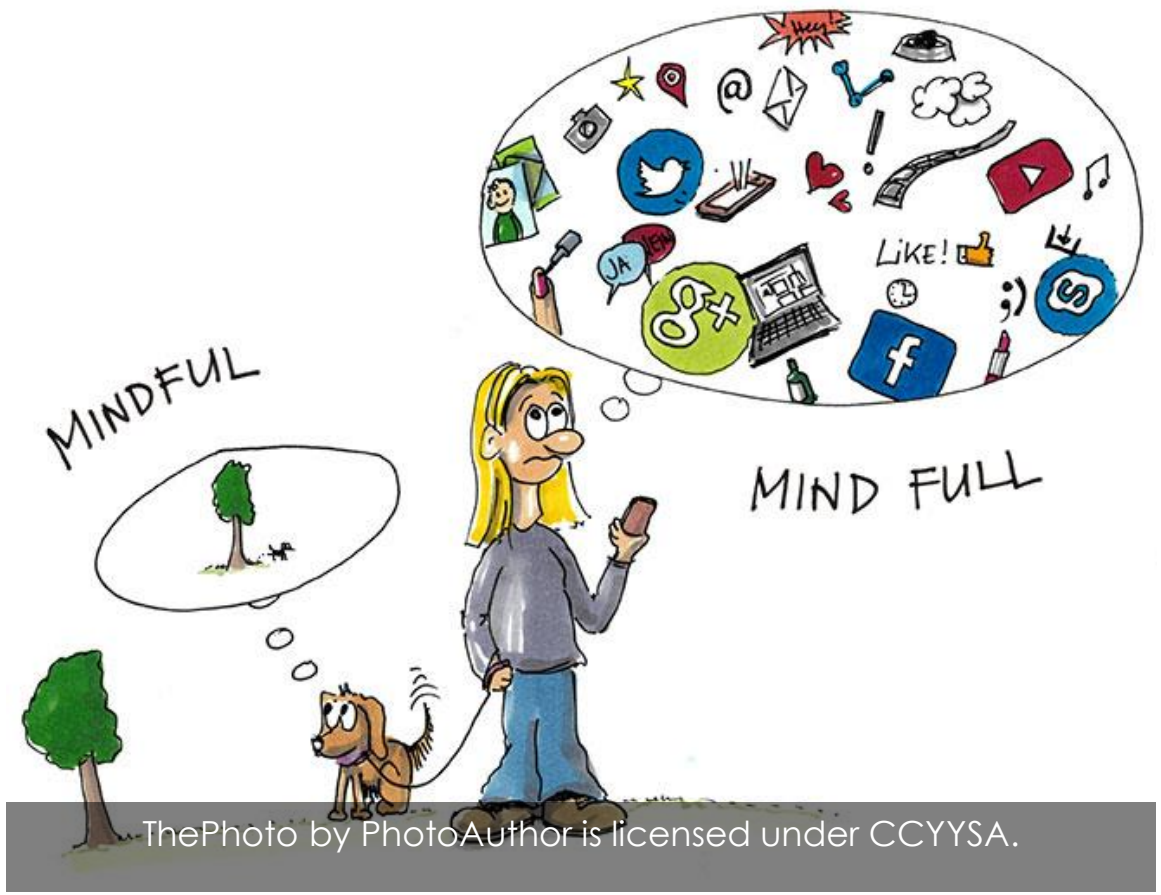
- Decrease avoidance/anxiety
- Increase personal and interpersonal awareness of self and partner's experienc
- Improve sexual function

Current use is less formulaic and more individualized

SENSATE FOCUS SEX THERAPY

Inadequacy. New
- York, NY: Little Brown & Co.
- Sinclair Institute 2002
- http://health.howstuffworks.com/sexual-health/sexuality/sensate-focus-dictionary6.htm

- Appears exclusively behavioral
- But, other psychosocial variables often are brought to light and can be addressed
  - E.g., these progressive partnered exercises may increase awareness of anxiety, communication difficulties, unhelpful or unrealistic beliefs about sex, relationship, or self etc.



MINDFULNESS

- Can focus on targeting the relationship between awareness of sexual stimuli & responsive sexual desire
- Growing research support for efficacy (Banbury et al., 2021; Brotto et al., 2021; Pyke & Clayton 2015)
  - Higher trait mindfulness --> decreased risk for FSD, sexual distress, & better sexual function (Sood et al., 2022)
- Encourages increased attention to sexual cues
- Encourages intentional awareness of bodily sensations
  - **Non-judgment**
  - **Present-focused awareness**
  - **+Compassion (openness to one's own suffering, alleviates suffering through kindness)**

MINDFULNESS-BASED COGNITIVE THERAPY (MBCT)

Usually around 8-12 sessions (group or individual)

Potential mechanisms: reduces depressive symptoms and self-criticism and increases mindfulness, interoceptive awareness, and self-compassion

- neuroplastic changes in the structure and function of the brain regions involved in the regulation of attention, emotion and self awareness

Sessions include:

- Psychoeducation (e.g., sexual response, prevalence, contributing factors to low desire)
- Mindfulness practice (e.g., body awareness, body scan, mindfulness of thoughts and movement, non-masturbatory genital self-stimulation) (continued at home practice)
- Instructions for at-home practice of mindfulness after exposure to body touch or interactions with stimulus (e.g., vibrator, sexual content)

QUESTIONS?

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