Female Sexual Dysfunction: Focus on Low Desire

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Question 1:

You discuss bupropion as a possible treatment for low sexual desire. In a patient complaining of low sexual desire who is currently otherwise successfully responding to an alternative antidepressant for a mood disorder, such as a selective serotonin reuptake inhibitor (SSRI), do you recommend changing to bupropion? How do you conduct the change in medication and what type of follow-up do you recommend?

Response from Drs. Kingsberg and Woodard:

First, it is important to establish that the low desire is likely tied to the SSRI. This would necessitate a discussion with the patient to establish a temporal link with the onset of her low desire with the onset of the use of the SSRI.

If it is likely that the low desire is a side effect of the SSRI, it is fair to consider adding bupropion as a possible treatment for the side effect while continuing with the SSRI. Alternatively you can taper her off her SSRI and add in the bupropion, but closely follow to assess if symptoms of depression are recurring and/or the bupropion is causing a side effect of anxiety. I would have the patient return within 2–4 weeks and/or call if there is any return in symptoms of depression.

Question 2:

You discuss cognitive-behavioral therapy and sex therapy as interventions that may be useful in management of patients with low sexual desire. As a general gynecologist, I often find myself at a loss as to how to refer these patients, and I appreciate the referral resources you listed for sex therapists. Can you recommend referral resources for finding cognitive-behavioral therapists trained and experienced in the management of sexual dysfunction? How do you counsel patients with regard to what they can expect when seeing a sex therapist?
Response from Drs. Kingsberg and Woodard:

The web sites listed as referral resources should list the credentials of each practitioner and the International Society for the Study of Women’s Sexual Health (ISSWSH) Find-a-Provider service lists a self-description of the style of therapy (eg, cognitive-behavioral therapy). Many patients may be concerned about what to expect when seeing a sex therapist. The most succinct explanation is that sex therapy is typically psychotherapy (primarily cognitive-behavioral therapy or mindfulness-based therapy) with a chief complaint of a sexual problem. Cognitive-behavioral therapy alters dysfunctional emotions, behaviors, and cognitions through a goal-oriented, systematic procedure. It is based on the theory that we can change the way we think to feel/act better, even if the situation does not change.

Homework between sessions is an essential component.

Therapy is relatively short-term (5–20 sessions), problem-focused, and may be either individual or couples. Treatment will focus on modifying precipitating or contributing circumstances or behaviors.

Traditional sex therapy is a behavioral treatment to improve the a person’s erotic experiences and reduce anxiety and self-consciousness about sexual performance.

Question 3:

Testosterone as a treatment for hypoactive sexual desire seems to be somewhat controversial. You suggest that androgen levels are not helpful in diagnosis, but later you do note that free testosterone levels may be assessed during therapy to ensure they remain in the physiologic range for premenopausal women. At what point in assisting a patient with low sexual desire would you consider implementing testosterone therapy, and how do you counsel her?

Response from Drs. Kingsberg and Woodard:

Commonly available testosterone assays are inaccurate at lower serum levels seen in women. As a result, there is not an absolute cutoff level that defines testosterone deficiency; thus, androgen levels are generally not helpful in the diagnosis of hypoactive sexual desire in this population. However, they can be useful in ensuring that supraphysiologic levels are not being reached as a result of therapy.

Testosterone therapy can be considered when all other medical and psychological conditions have been ruled out as the etiology for low desire. The patient’s psychosocial and relationship status should also be adequately addressed and optimized. Women who are considering testosterone therapy should be counseled that testosterone use for this purpose is off-label and not approved by the U.S. Food and Drug Administration. They should also be informed of potential safety issues related to therapy, including potential virilizing effects. They should also be made aware that although randomized trials have not shown increased risk for breast cancer or cardiovascular disease, data on the safety of long term testosterone use are still being collected.

Question 4:

Does health insurance typically cover cognitive-behavioral or sex therapy for low sexual desire? Does it cover pharmacologic therapy?
Coverage for mental health services, including cognitive-behavioral therapy and sex therapy, varies widely and is highly dependent on individual insurance plans. Sometimes, pharmacologic therapy, specifically testosterone therapy, is not covered because its use is considered to be off-label. Patients are encouraged to contact their insurance companies to verify coverage.

Response from Drs. Kingsberg and Woodard:

Question 5:
How do you recommend counteracting low sexual desire caused by medically necessary drugs that the patient cannot discontinue, such as anticonvulsants or cardiovascular agents? For example, in a patient with a refractory seizure disorder who is well-controlled on carbamazepine and is advised not to try to change their anti-epileptic medication, how would you tailor your approach to their medication-related low sexual desire? Similarly, how would you recommend treating a patient with chronic heart disease who has been placed on long-term ACE inhibitor and/or digoxin therapy?

Response from Drs. Kingsberg and Woodard:

When medically-necessary drugs are thought to be the cause of low sexual desire, the first step is to see if there are viable alternatives that cause fewer sexual side effects. This requires a partnership with health care providers who are sensitive to sexual issues in patients with chronic diseases. For instance, one could try to use an anti-epileptic drug that does not alter sex hormone binding globulin (SHBG) levels. When there are no suitable alternatives, it is important that the patient be educated on the cause of her low desire and that her concerns are validated. She should be encouraged to consider and explore psychological-based treatments such as cognitive-behavioral and sex therapy.

Question 6:
Many patients are unable to take hormone replacement therapy for menopausal symptoms due to cardiovascular- or cancer-related risks, and their management can be challenging. In a patient who finds relief of her vasomotor symptoms with venlafaxine or paroxetine and who is unwilling to change medications, how do you recommend treating her low sexual desire?

Response from Drs. Kingsberg and Woodard:

Sometimes modest dose reductions in antidepressant medications used to treat vasomotor symptoms can help improve desire. One can also consider adding bupropion, which has been shown to be effective at reversing SSRI-induced sexual dysfunction in a small case series.

Question 7:
In screening a couple with sexual problems, how do you coordinate care of the male partner for problems such as premature ejaculation or erectile dysfunction?

Response from Drs. Kingsberg and Woodard:

Comprehensive sexual health care requires collaboration between multiple health care providers who are skilled at addressing sexual issues seen in their patient population. As a gynecologist, your role in caring for the male patient is generally limited to obtaining a good medical and sexual history, ordering preliminary laboratory testing as warranted, and educating him and his partner on the possible causes and treatments for his condition. Then, he should be referred to a urologist, who conducts a complete evaluation, which includes a physical exam, and makes treatment recommendations.
**Question 8:**

How do you approach low sexual desire in a same-sex relationship? Are there differences in your discussion approach as compared with a heterosexual couple? If both members of a same-sex couple are your patients, how do you handle documentation in the medical records and billing? Do you bill both patients? If there is unresolvable tension in the relationship, how do you determine for whom you should advocate?

**Response from Drs. Kingsberg and Woodard:**

The approach to a discussion of low sexual desire in one partner in a same-sex relationship is similar. The impact on the relationship, the causes, and treatments are typically the same. If both partners are your patients, documentation would be under the patient presenting with low desire and the bill would be generated for the partner with the condition. As a gynecologist, you will refer a couple with relationship conflict, and thus advocate for both, by helping them with a referral to a mental health professional who can then work with the couple.

**Question 9:**

Many women are distressed by low sexual desire in the postpartum period. What are the major differences in management for them compared with women in midlife?

**Response from Drs. Kingsberg and Woodard:**

Low sexual desire in the postpartum period is fairly common, and there are multiple reasons for this. The postpartum period is characterized by many physiologic and psychosocial changes. Hormonal changes such as those associated with breastfeeding may not only diminish desire, but can also contribute to vaginal dryness that may make sexual intercourse painful. The stress and fatigue associated with the care of a newborn can also interfere with desire. Education of the patient and her partner are of utmost importance. They should be reassured that this is a normal experience and that it is usually temporary. They should be encouraged to communicate about their sexual relationship and find alternative ways to achieve intimacy and express affection. If and when sexual intercourse is desired, adequate foreplay and the use of lubricants can make the experience more pleasurable and satisfying for both.