

Sexual Health for ALL Genders

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Objectives:

1. Biopsychosocial approach explained
2. Evaluate
3. Treat

Female Sexual Health

1. Hormones
2. Sexual pain
3. Low sexual desire
4. Hypoactive sexual desire disorder
5. Decreased arousal
6. Orgasmic dysfunction

The Biopsychosocial Approach

Western medicine's way of describing the whole person approach to sexual medicine.

Complex but not too complicated.

The Biopsychosocial Approach

Bio: medication side effects, hormones, physical health, pain

Psycho: mental health, performance anxiety

Social: upbringing, lack of sex education, society, culture, religion, expectations

Interpersonal: relationship, finances, life stressors, cultural norms

These intersect and contribute to “Sexual Health”

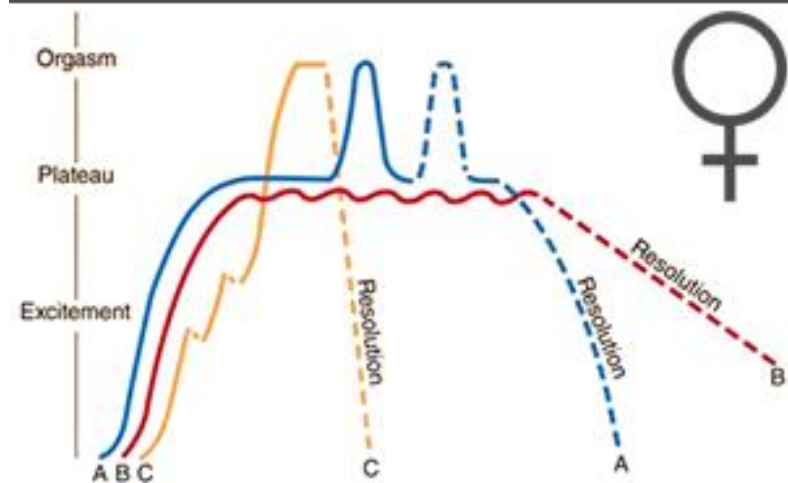
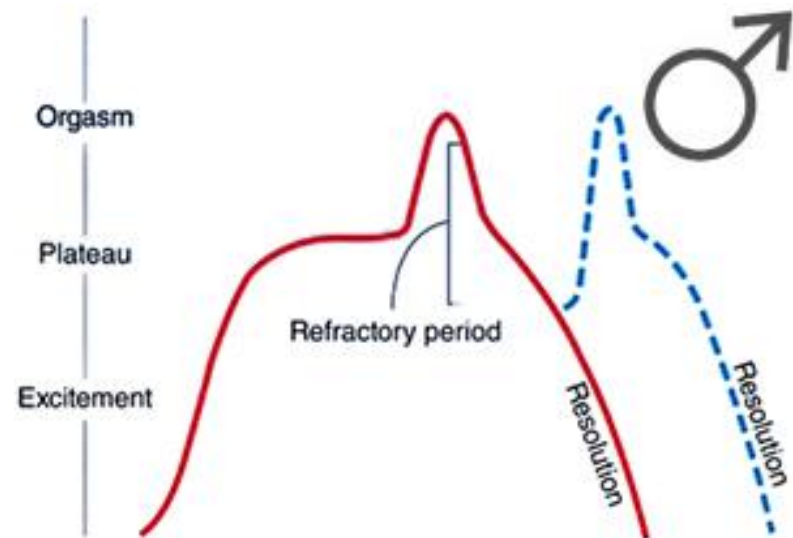
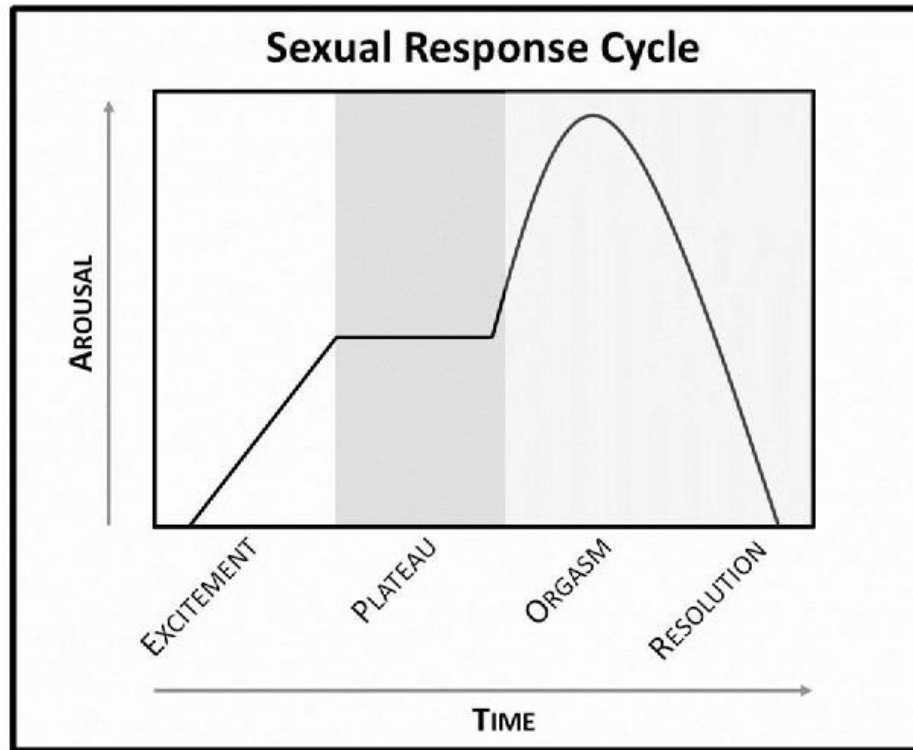
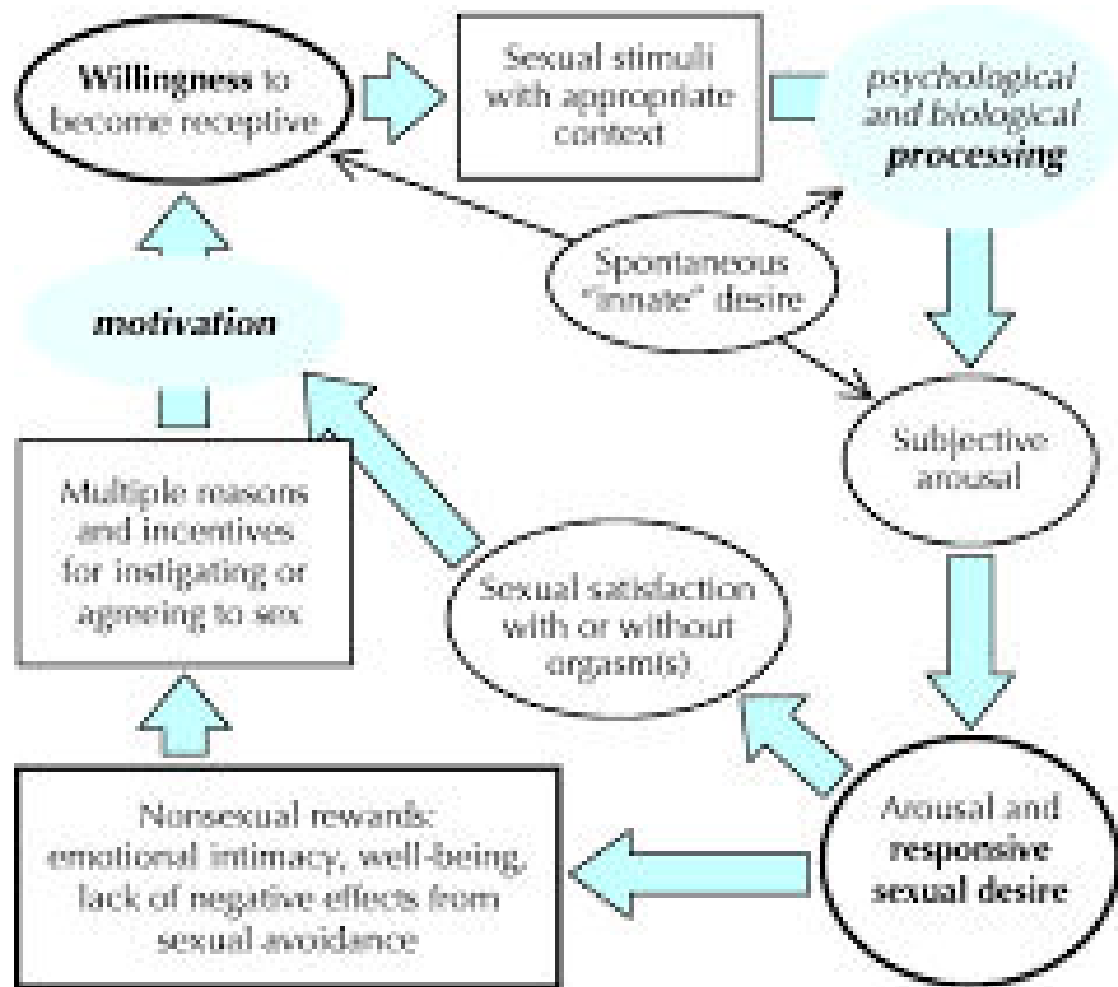


Fig 1. Masters-Johnson Model of sexual response



Mayo Clinic Proceedings

The international Society for the Study of Women's Sexual Health Process
of Care for the Identification of Sexual Concerns and
Problems in Women

Sexual dysfunctions manifest as chronic sexual symptoms related to sexual pain and the 3 phases of the sexual response cycle: desire, arousal, and orgasm. Normal variations in sexual function are distinguished from FSDs by their persistence for a minimum of 3 months, occurrence with at least 75% of sexual experiences, and their association with sexually related personal distress. Female sexual dysfunction may be lifelong or acquired after a period of normal functioning and may be situational (present only in certain situations) or generalized (present in all situations); and related distress is characterized as mild, moderate, or severe. Women may experience problems in multiple aspects of their sexual response, thus FSDs may be concurrent. The etiology of FSD is often multifactorial and includes biological, psychological, interpersonal, and sociocultural risk factors and contributors.

“Dysfunction”

Dysfunction needs to have distress

But some might consider the definition of dysfunction faulty

Duration of more than 3 months?

Lack of education and realistic expectations?

Heteronormative lens?

Is there pleasure/satisfaction?

Is it dysfunction, disorder, difference or difficulty?

Overlap of female sexual disorders

I will focus primarily on biological consideration but will also address issues with following a rigid sexual script, goal oriented intimacy, the dual control model of sexual desire, expanding sexual repertoire and the role of sexual aids.

Sexual Desire Disorder

Dyspareunia

Orgasmic Disorder

Vaginismus

Sexual Arousal Disorder

Female sexual dysfunction

FSD is common and a catch all term for any recurrent or persistent problem with sexual desire, response, orgasm or pain that causes distress.

Sexual pain/dyspareunia: pain before, during or after intercourse.
Vaginismus, vulvodynia, infection, hormonal changes, endometriosis and hypertonic PFD

Low sexual desire: decrease in activity that persists and causes distress

Hypoactive sexual desire disorder HSDD: >6mths

Decreased arousal: decreased or absent response to touch or stimulation, diabetes, nerve injury, med side effects, hormones

Orgasmic dysfunction: absent or diminished

PLISSIT Model

Permission to talk about sexual issues, reassurance and empathy

Limited Information; education about anatomy or educational resources

Specific Suggestions: use of lubricants, altering position

Intensive Therapy: referral for psychotherapy/sex therapy

Differences

Biological differences: Who is the person in front of you?

It's a spectrum; The wide spectrum of baseline desire includes asexual to hypersexual

This can change throughout the lifetime.

It is all a bell curve and the middle is more common but not more "normal".

Gendered Differences

Gendered differences in desire is an overgeneralization but important consideration.

Spontaneous desire: desire that occurs “out of the blue” a visual stimulus, thought, etc. promotes desire. Often the stimulus initiates physical arousal and this results in desire.

Responsive desire: desire that evolves out of a context that is low in stress, high in energy and pleasure. Distractions are reduced, affection and attention are expressed and desire evolves.

Biology

Differences in people

Pain: distracting, decrease blood flow, muscle tension

Medication side effects: birth control, SSRI's, GLP1, Finasteride

Hormones and Medical Conditions: hormones can impact desire, arousal and orgasm. ADHD, cancer, pain, injury, illness

Stressors

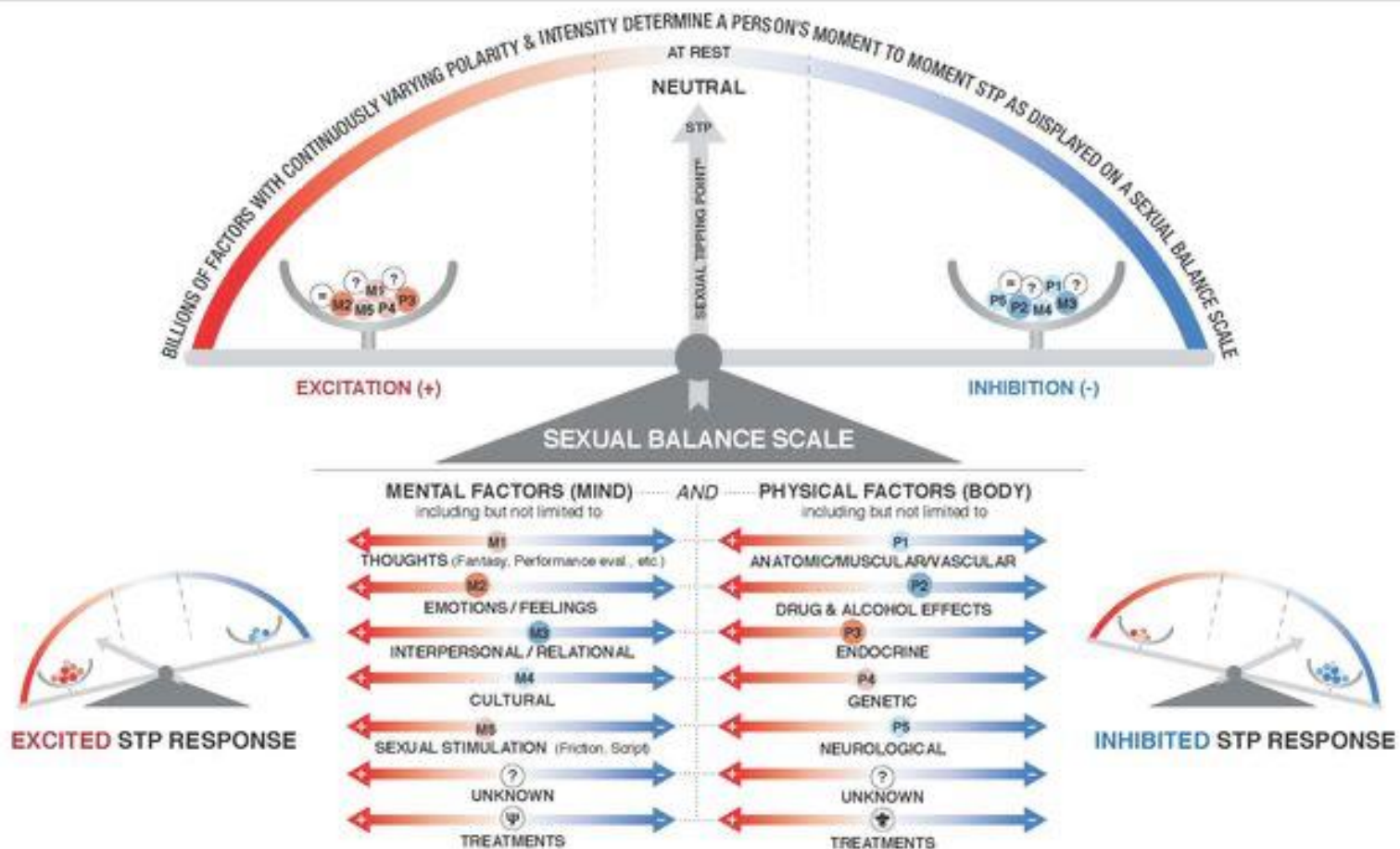
Some are modifiable some are not.

Cancer is non modifiable stressor, the tissue issues associated are modifiable.

Children are non modifiable but planning for intimacy without distraction is.

Disability/injury is non modifiable but expanding sexual repertoire and inviting sexual aides is modifiable.

THE SEXUAL TIPPING POINT® A BIOMEDICAL-PSYCHOSOCIAL & CULTURAL MODEL



Dual-Control Model

Accelerators v. Brakes

Accelerators

Activates Arousal - ON

Things you can see, hear, smell, touch, taste or imagine.

Examples: how your partner smells or tastes, fantasies, loving or erotic touch, visual cues, a clean bedroom, ambiance, vocalizations, etc.



Some people have more sensitive accelerators and others have more sensitive brakes.

Brakes

Stops Arousal - OFF

*often has nothing to do with sex!

External: life management (bills, work, the news cycle, kids, etc.), lack of privacy, lack of safety, risk of STI/pregnancy, fear of social consequences, etc.

Internal: negative body image, memories of previous experiences, internalized patriarchal attitudes, worries about performance, mood, etc.

What activates your accelerators and what hits your brakes?

Arousal = activating the accelerators and deactivating the brakes

What is desire?

Desire is not arousal!

Desire happens in the brain.

Arousal happens in the body.

You can experience one without the other.

Treatment

Education:

1. 85% of women orgasm with purposeful clitoral stimulation
2. Women need an average of 20 minutes to become adequately lubricated and aroused.
3. Many women experience changes throughout their lifetime in their desire or ability to become aroused.

Treatment

Lifestyle: Exercise, dietary changes, mindfulness, erotica, sexual aides, reducing stress, improving sleep and health.

Sexual Aides: Lubricants, erotica, sex toys

Treatment

Medications: Some medications can cause side effects that contribute to FSD. There are few medications that help as FSD has many contributing factors. There are 2 FDA approved medications flibanserin and bremelanotide.

Hormones can be helpful and treating genitourinary syndrome is important.

Treatment

Flibanserin: centrally acting serotonin receptor agonist/antagonist that results in transient decreases in serotonin and increases in dopamine and norepinephrine in certain regions of the brain. Daily use results in small increase of sexually satisfying events SEEs per month from baseline to 2-3 times per month.

Treatment

Bremelanotide: a melanocortin receptor agonist, subcutaneous injection 45 minutes before anticipated sexual activity. Studies show increase in sexual desire and satisfaction with no increase in SEE. Side effects include nausea, vomiting, flushing and headache. Prescribing antiemetic can be helpful.

Treatment

Bupropion: often first choice, treats depression, assists with smoking cessation, use for sexual dysfunction including induced by SSRI. Centrally acting agent similar to that of flibanserin. Dosed in the morning, monitor for anxiety, insomnia, hypertension., Studie show increase in pleasure, arousal, orgasm compared to placebo.

Treatment

1. FSD is common and there are treatments
2. FSD is diagnosed by a medical professional, seek an expert if needed
3. Treatment is individualized and deserves a multidisciplinary approach with medical providers, pelvic floor PT & counselor

Male Sexual Health

1. Andropause
2. Testosterone Decline
3. Erectile Dysfunction
4. Peyronies
5. Partner Considerations

Male Sexual Health

Andropause:

As males age testosterone decrease. The decline is slow and expected but for some can be symptomatic.

Male Sexual Health & Testosterone

Testosterone: There are no medical consequences to the decline in testosterone known with certainty.

Low serum testosterone <317ng/dL

Male Sexual Health & Testosterone

Who should be tested?

Males with symptoms or physical findings suggestive of hypogonadism.

Measure early in the morning, fasting, by LCMS. If $<229\text{ng/dL}$ repeat twice.

Testosterone

Who should be treated?

Males with low levels and symptoms.

Testosterone should not be prescribed to men with low levels and no symptoms.

Monitoring: total testosterone, hematocrit, PSA

Testosterone Options

Topical/transdermal delivery: 1% and 1.62% concentration. Applied once a day 5 to 10g. Levels increase in 4-12 weeks.

Intramuscular injections: testosterone cypionate IM results in gradual release from the oil based vehicle prolonging the presence of testosterone in blood.

Oral preparations: methyltestosterone is NOT recommended. Not fully effective and could have hepatic side effects.

Pellet: two to six 75mg pellets every 3 to 6 months. Not routinely recommended.

Nasal gel: one pump actuation delivers 5.5mg recommended dose is 11mg to 33mg/day.

Male Sexual Dysfunction

Types of male sexual dysfunction:

Erectile dysfunction: consistent or recurrent inability to acquire or sustain an erection, sufficient rigidity and duration for intercourse.

Decreased libido: can be accompanied by ED, sexual or voiding disorders or occur over time.

Ejaculatory disorders: premature, delayed, and retrograde ejaculation and anorgasmia.

ED DRUGS 2025

MAIN TYPES

Sildenafil



Onset:
30–50
minutes

Duration:
4–5 hours

Dosages
2,5–20 mg

Tadalafil



Onset:
30–45
minutes

Duration:
up to 36
hours

Dosages
2,5–20 mg

Vardenafil



Onset:
30–60
minutes

Duration:
4–5 hours

Dosages
5–20 mg

Avanafil



Onset:
15–30
minutes

Duration:
6–12 hours

Dosages
50–200 mg

KEY DIFFERENCES

- Tadalafil: Longer-lasting
- Vardenafil: Food can affect absorption
- Avanafil: Quick onset

ALTERNATIVE TREATMENTS



LIFESTYLE CHANGES



REGENmax
PROTOCOL



Low libido

Medications: SSRI, anti-androgens, 5-alpha reductase inhibitors, opioid analgesics

Alcohol

Depression

Recreational drug use

Other sexual dysfunction

Peyronies

Peyronie's disease is acquired localized fibrotic disorder of the tunica resulting in penile deformity, mass, pain and in some erectile dysfunction.

Some cases resolve spontaneously others progress.

Peyronies Treatment

Active disease: pentoxifylline oral therapy
400mg 3 times daily for 3 months to stabilize
disease.

Intralesional injections of collagenase
clostridium histolyticum followed by penile
traction therapy.

Partner considerations



Resources

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