A CLINICAL MASTER CLASS

Sexual Health for ALL Genders

A biopsychosocial approach to evaluating and treating sexual concerns — across genders and life stages.

Skin, Bones, Hearts & Private Parts 2026 · Jessica Bell, PA-C, MSCP, ISSWSH Fellow · GynJess

Disclosures

Financial disclosures

Jessica Bell, PA-C, MSCP, ISSWSH Fellow has no relevant financial relationships with ineligible companies to disclose.

Off-label use

This presentation discusses off-label use of testosterone in women (no FDA-approved female product), bupropion for female sexual dysfunction, and pentoxifylline for Peyronie's disease.

Off-label uses are identified as such where they appear.

What you'll leave able to do

1. **Think biopsychosocially** Frame every sexual concern across biological, psychological, social, and interpersonal factors.

2. **Evaluate** Take a sexual history without judgment and sort dysfunction from normal variation and difference.

3. **Treat** Match education, lifestyle, hormonal, and pharmacologic options — for women and men — to the person in front of you.

Female sexual health

Female

What we'll cover

- Hormones and their role across the lifespan
- Sexual pain (dyspareunia)
- Low sexual desire and hypoactive sexual desire disorder (HSDD)
- Decreased arousal
- Orgasmic dysfunction

The biopsychosocial approach

Western medicine's way of describing the whole-person approach to sexual health — complex, but not too complicated.



Bio

Medication side effects, hormones, physical health, pain



Psycho

Mental health, performance anxiety, mood



Social

Upbringing, sex education, culture, religion, expectations



Interpersonal

Relationship, finances, life stressors, cultural norms

These intersect to shape Sexual Health

What makes it a “dysfunction”?

The clinical criteria

- **Lasts at least 3 months.**
- **Shows up in at least 3 of every 4 sexual encounters.**
- **Causes personal, sex-related distress.**
- Then describe it:

lifelong vs. acquired · situational vs. generalized

distress rated mild, moderate, or severe

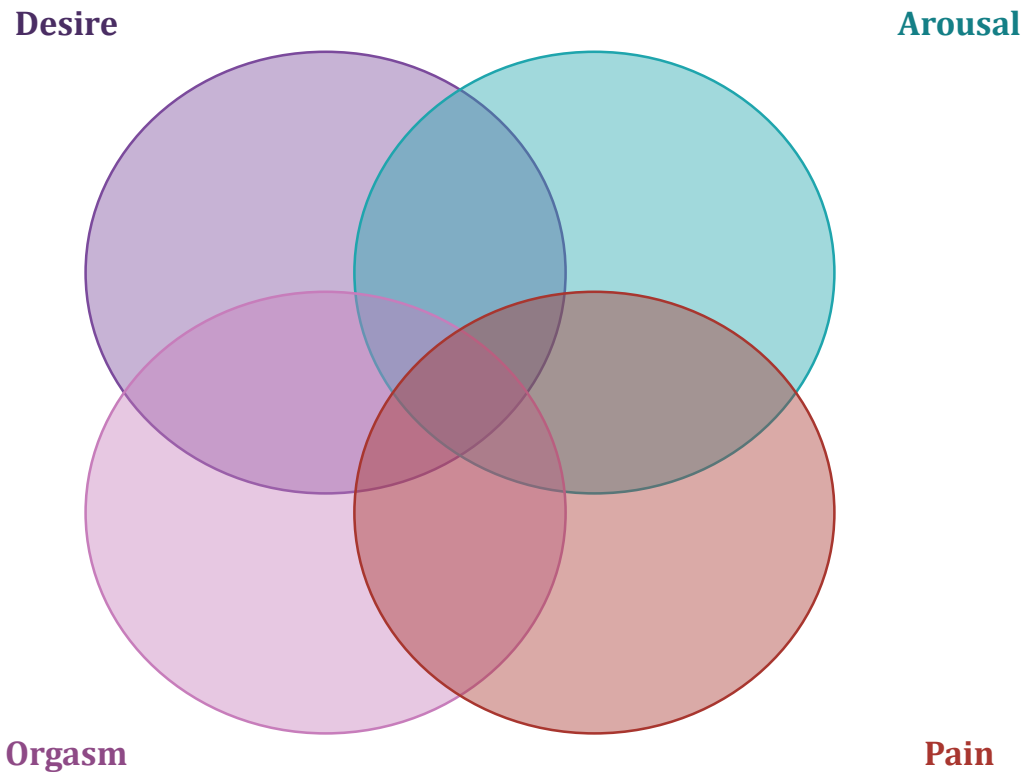
- Often multifactorial and concurrent — bio, psych, interpersonal, sociocultural.

…but is “dysfunction” the right word?

- No distress? Then it may not be a dysfunction at all.
- Is the 3-month cutoff meaningful for this person?
- Is it really a lack of education or unrealistic expectations?
- Are we judging through a heteronormative lens?
- Is there pleasure and satisfaction anyway?
- **Dysfunction, disorder, difference, or difficulty?**

Paraphrased from ISSWSH Process of Care, Parish et al., Mayo Clin Proc

Overlap of female sexual disorders



A catch-all term

- "Female sexual dysfunction" covers any recurrent, distressing problem with desire, arousal, orgasm, or pain.
- **These overlap — problems are frequently concurrent, not tidy silos.**
- We focus on biology, but a rigid sexual script, goal-oriented intimacy, and the dual-control model all contribute.

Types of female sexual dysfunction

Sexual pain / dyspareunia	Pain before, during, or after sex. Vaginismus, vulvodynia, infection, hormonal change, endometriosis, hypertonic pelvic floor.
Low sexual desire	A persistent, distressing decrease in sexual activity or interest.
HSDD	Hypoactive sexual desire disorder — low desire with distress, > 6 months.
Decreased arousal	Reduced or absent response to touch/stimulation. Diabetes, nerve injury, meds, hormones.
Orgasmic dysfunction	Absent or diminished orgasm despite adequate arousal.

The PLISSIT model

A tiered framework for talking about sex — most patients only need the first steps.

P **Permission** Invite the conversation. Reassure and normalize; empathy first.

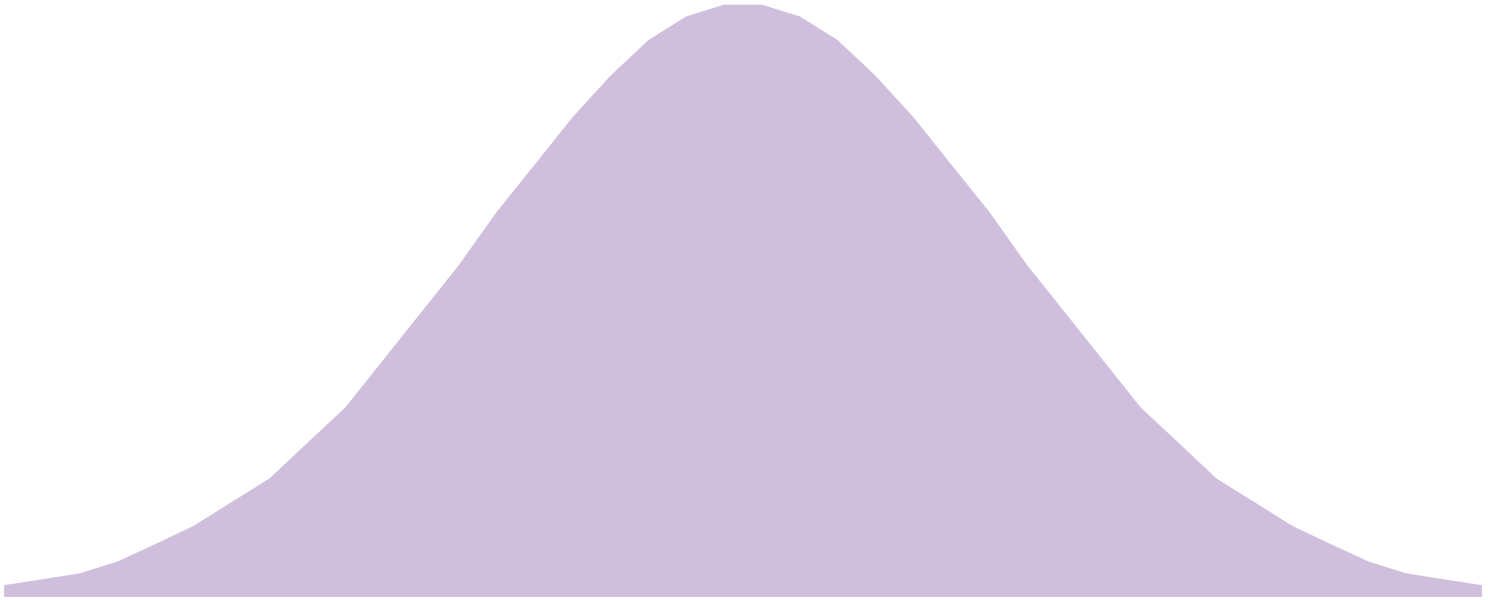
LI **Limited Information** Targeted education — anatomy, physiology, resources.

SS **Specific Suggestions** Concrete steps — lubricants, positioning, pacing, aids.

IT **Intensive Therapy** Refer — pelvic-floor PT, sex therapy, psychotherapy.

Annon, 1976

Desire is a spectrum, not a set point



- **Baseline desire runs from asexual to hypersexual.**
- It's a bell curve — the middle is more common, not more "normal."
- **And it changes across a lifetime.**

Spontaneous vs. responsive desire

Gendered generalization — but a useful lens. Neither is more valid.

Spontaneous desire

Desire that arrives “out of the blue.” A thought, memory, or visual cue sparks it — the stimulus often initiates physical arousal first, and desire follows.

Responsive desire

Desire that evolves out of context — low stress, energy, and pleasure. When distraction drops and affection and attention are present, arousal builds, and desire follows it.

Basson, 2000

The biology of desire, arousal & orgasm

Pain

- Distracting — pulls attention away
- Decreases blood flow
- Increases muscle tension

Medication effects

- Hormonal birth control
- SSRIs
- GLP-1 agonists
- Finasteride

Hormones & conditions

- Hormones shape desire, arousal, orgasm
- ADHD, cancer, chronic pain
- Injury, illness, disability

Modifiable vs. non-modifiable stressors

Some stressors can't be changed — but their sexual impact usually can.

- Cancer is non-modifiable — but the tissue changes it causes are treatable.
- Children are non-modifiable — but planning distraction-free intimacy is not.
- Disability or injury is non-modifiable — but expanding the sexual repertoire and inviting sexual aids is.

Separate the stressor from its sexual consequence — the consequence is where you intervene.

Desire is not arousal

DESIRE

happens in the brain

AROUSAL

happens in the body

You can experience one without the other — and that's normal.

Treatment starts with education

- **Most women reach orgasm with purposeful clitoral stimulation — intercourse alone often isn't enough.**
- Arousal and lubrication take real time — often far longer than people expect.
- **Desire and arousal naturally change across a lifetime — that shift is expected, not broken.**

Two commonly-cited figures — "~85% orgasm with clitoral stimulation" and "~20 minutes to full arousal" — are widely quoted but softly sourced; confirm against your preferred references before quoting exact numbers.

Lifestyle & sexual aids

Lifestyle

- Exercise and dietary change
- Mindfulness; reducing stress
- Better sleep and overall health
- Erotica and fantasy

Sexual aids

- **Lubricants**
- Erotica
- **Sex toys / vibrators**
- Position and pacing changes

Medications: the landscape

- **Some medications cause FSD — review the med list first; deprescribing or switching may be the whole fix.**
- Few medications treat FSD, because desire is multifactorial. Treat genitourinary syndrome (GSM) — it's common and fixable.

Flibanserin

FDA-approved, daily

Bremelanotide

FDA-approved, on-demand

Bupropion

Off-label

Hormones incl. testosterone

Off-label for HSDD

Flibanserin & bremelanotide

Flibanserin (Addyi)

- **5-HT1A agonist / 5-HT2A antagonist — 100 mg PO nightly at bedtime.**
- Modest effect (~0.5–1 more satisfying event/month vs placebo). Stop at 8 weeks if no benefit.
- **BOXED WARNING: hypotension & syncope. Contraindicated with strong CYP3A4 inhibitors and in any hepatic impairment.**
- **No alcohol within 2 hours before the dose.**
- Premenopausal HSDD (2015); expanded to postmenopausal < 65 (Dec 2025).

Bremelanotide (Vyleesi)

- **Melanocortin agonist (MC1R/MC4R) — 1.75 mg SC, ~45 min before activity, PRN.**
- Improves desire, lowers distress; no consistent rise in event count.
- **Max 1 dose / 24 h and ≤ 8 doses / month.**
- **Nausea common (pre-treat); transient BP rise / HR drop; focal hyperpigmentation (~1%).**
- Premenopausal HSDD (2019). Reassess at 8 weeks.

FDA labels; Addyi postmenopausal expansion Dec 2025

Bupropion — the off-label workhorse

- **Often a first choice — it also treats depression and aids smoking cessation.**
- Useful for sexual dysfunction, including SSRI-induced dysfunction.
- Centrally acting (dopamine/norepinephrine) — mechanistically similar in spirit to flibanserin.
- **Dose in the morning; monitor for anxiety, insomnia, and hypertension.**
- Trials suggest improved pleasure, arousal, and orgasm vs. placebo — but it's off-label for FSD.

Testosterone for women

Female

What the evidence supports

- **One established indication: HSDD in postmenopausal women.**
- Benefits beyond libido (mood, energy, cognition) are emerging, not established.
- No FDA-approved female product → use an approved male 1% gel off-label at ~1/10 the male dose, transdermal.
- **Rx: testosterone 1% gel, 0.5 mL (~5 mg)/day. Avoid pellets, compounded, injected, oral.**

The measurement trap

- **No blood level diagnoses low desire — and none is a treatment target.**
- Total T doesn't correlate with symptoms; assays are unreliable at female ranges (use LC-MS/MS).
- Baseline total T + SHBG, lipids, LFTs; recheck at 3–6 wk, then q4–6 mo; stop at 6 mo if no benefit.
- **There is no target number to treat to.**

Global Consensus (Davis 2019); Parish et al. 2021; Kling 2025

Female sexual health: the takeaways

- FSD is common — and treatable.
- It's diagnosed by a professional; refer to an expert when needed.
- Distress is what makes it a disorder — not a number or a duration.
- Treatment is individualized and multidisciplinary.

Male sexual health

Male

What we'll cover

- Andropause and testosterone decline
- Erectile dysfunction
- Peyronie's disease
- Low libido
- Partner considerations

Andropause & testosterone decline

The physiology

- Testosterone declines slowly and predictably with age.
- **The decline is expected — but for some men it becomes symptomatic.**
- **No medical consequences of the age-related decline are known with certainty.**

Diagnostic thresholds

- **Endocrine Society lower limit: ~264 ng/dL.**
- **AUA threshold to consider treatment: 300 ng/dL.**
- Diagnosis requires low T + symptoms, confirmed on a repeat morning fasting draw.
- **Measure early AM, fasting, by LC-MS/MS.**

Testosterone: who to test, who to treat

Who to test

- **Men with symptoms or physical findings suggestive of hypogonadism.**
- Early morning, fasting, LC-MS/MS.
- **Confirm a low result with repeat testing on a separate morning before diagnosing.**

Who to treat & monitor

- **Treat men with low levels AND symptoms.**
- **Do NOT treat low levels without symptoms.**
- **Monitor: total testosterone, hematocrit, PSA.**

Testosterone formulations (male)

Topical / transdermal	1% and 1.62% gels, once daily (5–10 g). Levels rise over 4–12 weeks.	Preferred
IM injection	Testosterone cypionate — oil-based depot gives gradual, prolonged release.	
Nasal gel	One actuation = 5.5 mg; typical dose 11–33 mg/day (divided).	
Pellets	Two to six 75 mg pellets every 3–6 months. Not routinely recommended.	Caution
Oral (methyltestosterone)	NOT recommended — incompletely effective, hepatic toxicity risk.	Avoid

Bhasin et al., Endocrine Society 2018

Male sexual dysfunction: the types

Erectile dysfunction

Consistent or recurrent inability to acquire or sustain an erection of sufficient rigidity and duration for intercourse.

Decreased libido

Low sexual interest — can accompany ED, sexual or voiding disorders, or develop gradually over time.

Ejaculatory disorders

Premature, delayed, and retrograde ejaculation — and anorgasmia.

Low libido: what's behind it

Medications

- SSRIs
- Anti-androgens
- 5-alpha-reductase inhibitors (e.g., finasteride)
- Opioid analgesics

Other contributors

- Alcohol
- Depression
- Recreational drug use
- Another underlying sexual dysfunction

Peyronie's disease

- An acquired, localized fibrotic disorder of the tunica albuginea — producing penile deformity, a palpable mass, pain, and in some men erectile dysfunction.
- **Course is variable — some cases resolve spontaneously; others progress.**

Two phases to recognize

- **Active / inflammatory: changing deformity, pain — the window to stabilize.**
- Stable / chronic: fixed deformity, pain usually resolved — mechanical/surgical options.

Hauck & Weidner, Lancet 2001

Peyronie's: treatment

Active phase — limited options

- **No oral agent is guideline-endorsed; AUA recommends against vitamin E, tamoxifen, procarbazine, and omega-3.**
- Pentoxifylline 400 mg TID is used off-label by some clinicians — evidence is limited and the EAU recommends against it.
- Shockwave therapy may ease active-phase pain (not curvature).

Stable phase — correct the deformity

- **Intralesional collagenase (CCH / Xiaflex) + modeling.**
- **Criteria: stable disease, curvature > 30° and < 90°, intact erectile function.**
- Penile traction therapy; surgery for refractory deformity.

Partner considerations

- **Sexual concerns live in a relationship — assess and, where possible, involve the partner.**
- One person's dysfunction reshapes the couple's dynamic — ED, low desire, or pain rarely stay one-sided.
- Mismatched desire is common and normal — name it without pathologizing either partner.
- Partner health matters too — a partner's medications, menopause, or illness can drive the presenting complaint.
- **Shared decisions and open communication are themselves treatment.**

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