

S08. Treatment of sexual dysfunction across the sexual cycle

Chairs: R. Balon (CH), Z. Zemishlany (IL)

S08.1

Pharmacotherapy of female hypoactive sexual desire disorder

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Epidemiological studies in the United States have found that approximately 30% of the female population aged 18 to 59 complain of problems with low sexual desire. Scandinavian studies using different methodology find a lower incidence of female low sexual desire. There are no generally accepted treatments for female low sexual desire. Attempts to treat low sexual desire with peripheral vasodilators such as phosphodiesterase inhibitors have been unsuccessful. A number of studies have suggested the presence of an androgen deficiency syndrome in women with low sexual desire. Exogenous testosterone at supraphysiological levels have been shown to increase reports of both subjective sexual desire and sexual activity. The health consequences of long term therapy with supraphysiological doses, of testosterone are unclear. Lower doses of exogenous testosterone have not been found to be effective. Studies of the efficacy of dehydroepiandrosterone have been inconsistent. Pilot data suggests that bupropion, a drug with both norepinephrine and dopamine reuptake inhibition, may have efficacy in the treatment of low sexual desire.

S08.2

Pharmacotherapy of sexual arousal disorders

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The essential feature of sexual arousal disorders is a persistent or recurrent inability to attain, or to maintain until completion of the sexual activity, an adequate a) lubrication-swelling response of sexual excitement in case of female sexual arousal disorder (FSAD), b) erection in case of male erectile disorder (ED). Since the introductions of sildenafil, the treatment of ED has received much attention. Besides various mechanical and surgical treatments, pharmacotherapy has become a mainstay in the treatment of ED. Topical vasodilators (nitroglycerin, glyceryl trinitrate, minoxidil), intraurethral suppositories (alprostadil) intracavernous penile injections (e.g., alprostadil, papaverine, phentolamine, vasoactive intestinal polypeptide) have all been used. However, oral preparations, such as yohimbine, trazodone and especially sildenafil are the most frequently used pharmacotherapies for ED. There are limited data available regarding treatment of FSAD. Various lubricants, ointments (glyceryl trinitrate) and creams (with estrogen) and hormones (e.g. transdermal testosterone estrogen replacement in postmenopausal women) have been found useful. Several reports also suggest possible usefulness of sildenafil in FSAD. Combination of various treatment modalities, including psychotherapy, should be used in the treatment of these disorders.

S08.3

Pharmacotherapy – orgasm disorders

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The most mysterious part of orgasm is the well-known intense feeling. Neuroscientists have had much trouble in the investigation of orgasm. An animal model of orgasm is lacking, since it is unknown whether animals experience orgasm in a similar way as humans. But male orgasm is usually associated with ejaculation that can be investigated in animals. Both orgasm and ejaculation have probably overlapping neuronal circuitries in the brain. In recent years, much of the ejaculatory circuitry has been unravelled.

Animal studies in male rats have clearly shown that activation of 5-HT_{2c} receptors delay ejaculation, whereas activation of 5-HT_{1a} receptors shortens ejaculation. The role of 5-HT_{2a} and 5-HT₃ receptors in the ejaculation process has been postulated but has never been demonstrated in animals or humans.

The medial preoptic are (MPOA) in the rostral hypothalamus and the nucleus paragigantocellularis (nPGi) in the ventral medulla are suggested important players in the ejaculation process. Electrical stimulation of the MPOA promotes ejaculation. In the nPGi serotonergic receptors have been demonstrated. It has been postulated that ejaculation-delay induced by SSRIs is related to an action of serotonergic drugs on the nPGi.

S08.4

Female hypoactive sexual desire disorder psychological treatment

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Effective diagnosis and treatment of sexual disorders is often a challenging albeit a rewarding aspect of one's clinical practice. Sexual concerns are intrinsically related to quality of life issues. For many individuals, sexual functioning has major influence on how a person experiences their sense of self and personal adequacy. Within a relationship, sexual behavior may be a major vehicle for expressions of intimacy and contribute significantly to the stability of the relationship. Thus, the identification of contributing & maintaining factors of sexual problems as well as designing effective interventions is a primary concern of clinical psychiatry.

Lack or loss of sexual desire is one the most frequent sexual concerns among female patients. There is little consensus concerning the psychological etiology of this disorder. Sometimes there are factors that may explain the loss of desire; however, many times no identifiable factors can be found. Given the possibility of multiple etiological factors, formulating treatment interventions is often a challenge. There is a paucity of evidence-based psychological interventions in the literature.

I will limit my presentation to addressing psychological treatments. Drawing from my clinical experience I will attempt to demonstrate the importance of the sexual interview. I will attempt to show how a therapist might use etiological factors identified in the diagnostic interview to help to design individual treatment strategies.

S08.5

Pharmacotherapy of sexual dysfunction in special populations

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Sexual dysfunction is associated with many psychiatric disorders including schizophrenia, depression and anxiety disorders, as well