

SEXUAL DESIRE IN WOMEN: PARADOXICAL AND NON-LINEAR ASSOCIATIONS WITH DEPRESSION AND ANXIETY

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Introduction: Previous studies aimed at defining the relationship between high levels of negative mood and sexual desire have shown that, in addition to people describing an expected decrease in sexual desire, some people report an unexpected increase in sexual desire when depressed or anxious (referred to as a “paradoxical effect”, Bancroft et al., 2003). However, these past findings are based on self-inferred causal attributions and retrospective, one-time measurements. Moreover, tests of these associations at the low extreme of negative mood have not been previously conducted.

Objective: The aim of the present study was to replicate and expand previous findings regarding paradoxical effects of negative mood on sexual desire (Bancroft et al., 2003; Lykins, Janssen & Graham, 2006), by analyzing the associations between negative mood and sexual desire across the entire range of depression and anxiety symptoms. Moreover, to address previous limitations, we sought to test for replication using methods that are unaffected by recall bias, and that don't require participants to infer causal associations between their mood and sexual desire.

Methods: A sample of $n=213$ university-aged women completed daily questionnaires for two full menstrual cycles ($M = 58$ daily reports per participant). Measurement included changes in sexual desire, as well as psychological changes (anxiety and depression) and other symptoms associated with the menstrual cycle. Multilevel modeling with random intercepts and slopes, were used to test for individual differences in linear and non-linear associations between mood symptoms and changes in sexual desire. Cluster analyses were used to identify different patterns of change in sexual desire associated with different levels of mood.

Results: Previous findings were successfully replicated. Specifically, high levels of depression were associated with increased sexual desire in 12% of the sample (paradoxical association), and high levels of anxiety were associated with increased sexual desire in 20% of the sample (paradoxical association). Thus, in addition to women who showed either no significant changes or a decrease in sexual desire when depressed or anxious, results confirmed the presence of paradoxical associations between high levels of negative mood and sexual desire (see shaded area on Fig.1). Interestingly, these between-group paradoxical effects were also present at low levels of negative mood. That is, at low levels of negative mood some women reported increased sexual desire while others reported decreased sexual desire. Moreover, for both depression and anxiety, analyses revealed three clusters of women presenting different patterns of change in sexual desire across different levels of mood symptoms. Specifically, results demonstrated the presence of within-person paradoxical associations, whereby, there are some women for whom both low and high levels of negative mood are associated with the same change (an increase or a decrease) in sexual desire. These groups are labeled “Positive Paradoxical” and “Negative Paradoxical” in Fig.1.

Conclusions: Results from the present study underline the importance of considering individual variability when studying sexual desire. Multiple mechanisms, based on personality traits, learning, autonomic activity, or situational factors, might moderate the relationship between mood and sexual desire. A new integrative theoretical framework is proposed to interpret these results (see Figure 2).

Disclosure: No

Images:

Figure 1

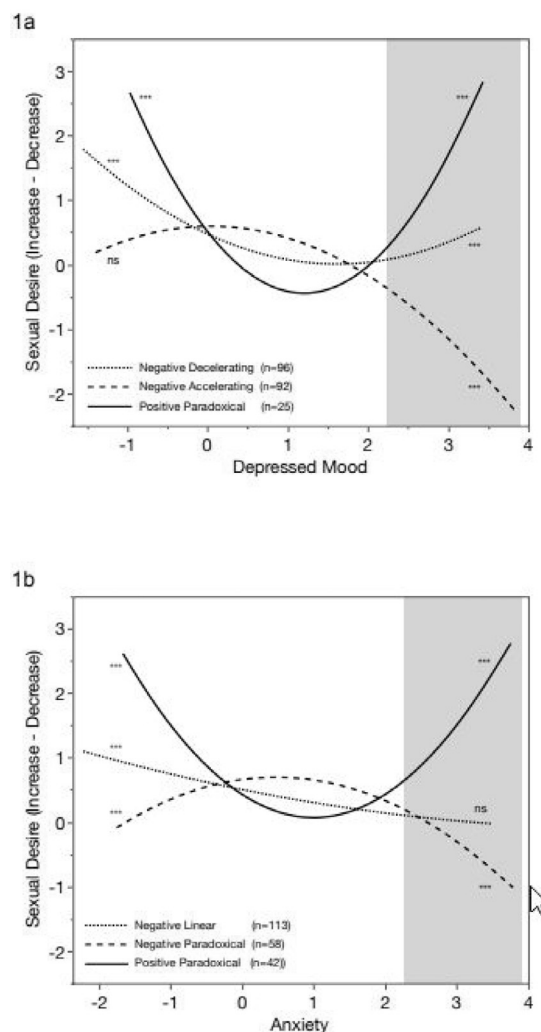
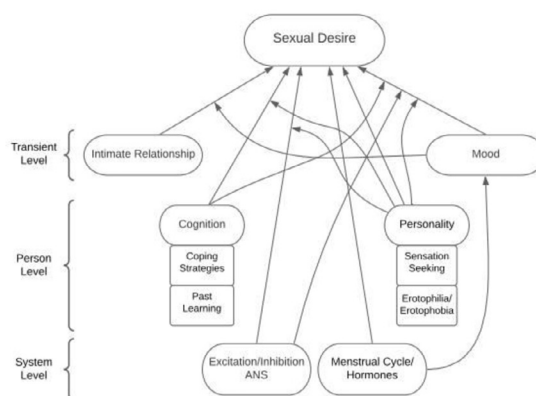


Figure 2



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EATING DISORDER SYMPTOMS AS A RISK FACTOR FOR HYPOACTIVE SEXUAL DESIRE DISORDER IN WOMEN: A PILOT-STUDY

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Introduction: Eating and sexual behavior are driven by neurological mechanisms that are extremely intertwined; emerging evidence indicates that their deep relationship can be mediated by the presence of specific psychopathologies.

Objective: To investigate the relationship between female sexual dysfunction (FSD) and eating disorders (EDs).

Methods: 123 retrospectively recruited women consulting for FSD underwent physical examination and completed the following validated questionnaires: Female Sexual Function Index (FSFI), Female Sexual Distress Scale-Revised (FSDS-R), Eating Disorder Examination Questionnaire (EDE-Q), Binge Eating Scale (BES), Emotional Eating Scale (EES), Barrat Impulsiveness Scale-11 (BIS-11), Beck Depression Inventory (BDI), State-Trait Anxiety Inventory Y (STAI Y), Symptom Checklist 90-Revised (SCL-90-R), Body Uneasiness Test (BUT), Dyadic Adjustment Scale (DAS) and Sexual Inhibition/Sexual Excitation Scales (SIS/SES). Moreover, demographic, medical and psycho-sexuological data were obtained through a structured interview.

Results: In relation to menopausal status, we did not observe any significant difference in all the investigated questionnaires in pre- vs. post-menopausal women. When stratifying patients for BMI (<25, 25-30, >30 kg/m²) we found that all the scores related to EDE-Q subscales were significantly different among the three subgroups (all $p < 0.001$). Furthermore, patients with a history of Unwanted Sexual Experience (USE) had significantly higher BES ($p = 0.034$) and EES ($p = 0.027$) total scores compared with those without. Moreover, when we stratified our patients according to the clinical diagnosis of Hypoactive Sexual Desire Disorder (HSDD), we found that those with HSDD showed a worst psychological profile than those without, in particular a higher score at EDE-Q and BDI (all $p < 0.05$). In contrast, when stratifying patients for the other two main FSD diagnosis, Female Genital Arousal Disorder (FGAD) and Female Orgasm Disorder (FOD), no significant differences among all the investigated questionnaires were observed. To further verify the impact of the different psychopathological aspects on the risk of having HSDD, we found that the only questionnaires scores that contributed to this dysfunction were EDE-Q (OR 1.678, IC [1.164-2.421]; $p = 0.006$), total BDI (OR 1.055, IC [1.006-1.107]; $p = 0.027$) and SIS1 (OR 1.101, IC [1.109-1.190]; $p = 0.015$), after adjustment for age. After simultaneous analysis in a multivariate model of the three questionnaires, we found that both a higher EDE-Q score and a higher SIS1 score were significant risk factors for HSDD ($p = 0.007$ and $p = 0.034$, respectively). Finally, we subdivided our patients into three groups: no Binge Eating (BE), sporadic BE and frequent BE, observing a significant positive association between frequency of BE and sexual distress, as assessed by FSDS-R total score.

Conclusions: In a population of women affected by FSD, ED traits could negatively affect sexual desire, representing a relevant risk factor for the clinical diagnosis of HSDD. Among all the investigated psychopathological aspects, the psychological alterations related to EDs seem to play a more pronounced effect on HSDD than other commonly accepted risk factors for sexual desire disorders, such as depression and increased inhibitory trait. In a clinical perspective, it would worth to investigate the relative change in FSD and ED after treatment for ED and vice versa.

Disclosure: No

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A MULTIDISCIPLINARY APPROACH TO THE TREATMENT OF SEXUAL DYSFUNCTION IN COUPLES

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Introduction: Sexual dysfunction (SD) affects at least a third of adult women worldwide which makes it a public health concern. Given the complexity of both psychological and biological pathology associated with these conditions, a multidisciplinary approach has been advocated. However, there is a limited amount of literature examining a multidisciplinary treatment approach to a couple's sexual and psychological functioning. This program, emphasizes treatment of the couple. This program includes a multidisciplinary team consisting of psychologists, gynecologists, urologists, dieticians, physical therapists, yoga instructors, and nurses. Our group collaborates in the care of each couple; working together to participate in the diagnosis and treatment of their sexual dysfunction. The treatment approach is a biopsychosocial model. Our couples attended weekly lectures on the follow topics: communication, female sexual functioning, male sexual functioning, stress management, chemistry of love, pelvic floor physical therapy, healthy diet, sexual aids, and gaining momentum. They also received counseling from a dyad therapist team. additionally, the couple was responsible for completing weekly homework consisting of sensate focus exercises and other gestures to help them engage with one another. In therapy sessions, communication and visualization exercises were also utilized.

Objective: This study prospectively followed couples pre- and post-attendance of a six-week sexual wellness treatment program (SWP) at a single academic medical center. The following outcomes were used: (1) sexual functioning (2) relationship satisfaction (3) mood stability.

Methods: The study was approved by the IRB. Couples attending the six-week multidisciplinary SWP, were consented and then completed surveys both pre-treatment and at the end of treatment. Surveys administered included the Dyadic Adjustment Scale (DAS), Sexual Functioning Profile (PROMIS), and International Index of Erectile Dysfunction (IIEF) for men only. Linear mixed-effects models were used to estimate the mean change from baseline to first follow-up. A covariance matrix was used to account for dependency. The program included weekly didactic sessions following an initial evaluation. Didactics included cognitive behavioral sex therapy with an attending (psychologist, psychiatrist or gynecologist) paired with a trainee (psychiatry, psychology or gynecology resident or a medical student), and home assignments.

Results: There were 85 respondents – 42 men, 43 women. Mean age was 49.82 years (Range 25-77). Most frequently reported SD were hypoactive sexual desire (32.2%), erectile dysfunction (21.4%), dyspareunia (14.3%), and female orgasmic disorder (10.7%). controlling for patients' sex and baseline PHQ severity, all DAS measurements increased from baseline. The largest improvement was on the total DAS score which increased by approximately 5.18 (95% CI: 2.55 – 7.81) points. Similarly, the PROMIS global satisfaction with sex life score, erectile function score, and interest in sexual activity score significantly increased from baseline while the vaginal discomfort score significantly declined from baseline. Overall, the global satisfaction with sex life score increased from baseline by approximately 5.57 (95% CI: 3.03 – 8.10) points. Among male participants, the IIEF erectile, sexual, and satisfaction scores increased from baseline. On average, men reported a 4.33 (95% CI: 0.04 – 8.62) point increase in their IIEF erectile score from baseline.

Conclusions: The results indicate that a multidisciplinary treatment approach focused on the couple positively impacts multiple aspects of a couple's relationship, including global satisfaction with sex life, relationship satisfaction, interest in sexual activity, and erectile function. These findings