

Female Hypoactive Sexual Desire Disorder

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Abstract

Hypoactive sexual desire disorder is the most prevalent sexual disorder in women, and one of the most challenging to overcome. This paper discusses the current definition for HSDD, the prevalence of HSDD in women, definitions of sexual health and sexual desire, sexual myths and HSDD, and criticisms around creating sexual norms and ideals related to HSDD. This paper will also discuss physical vs. psychological arousal in women, physical, psychological, and relational aspects of HSDD, male HSDD, an Adlerian perspective of HSDD, theories of desire, and proposed definitions of female HSDD including a proposed DSM-V revision of HSDD. Treatment options discussed include hormonal, antidepressant, herbal, CBT, and mindfulness.

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“Remember always that you not only have the right to be an individual, you have an obligation to be one.” –Eleanor Roosevelt

Table of Contents

Abstract	2
Acknowledgements	3
Table of Contents	4
Introduction	6
HSDD DSM-IV-TR Definition	6
Prevalence of HSDD	7
Definition of Sexual Health	9
Definition of Sexual Desire	12
Sexual Myths and HSDD	12
HSDD and Controversy around Diagnosis	14
History of Female Psychosexual Disorders	16
Physiological vs. Psychological Arousal	17
Physical Aspects of HSDD	18
Psychological Aspects of HSDD	24
Relationship Aspects of HSDD	28
Male HSDD	30
HSDD from an Adlerian Perspective	31
Theories of Desire	31
Proposed Definitions of FHSDD	31
Female HSDD Treatment	38
Herbal Therapy	41
Hormone Therapy	41

Antidepressant Therapy	42
Cognitive-Behavioral Therapy	42
Mindfulness	43
Conclusion	44
References	46

Hypoactive Sexual Desire Disorder in Females

Lack of sexual desire or interest in sexual activity affects up to 43% of the adult American female population. Hypoactive sexual desire disorder (HSDD) is considered the most prevalent sexual disorder in women, and one of the most challenging to overcome. This paper will discuss the current definition for HSDD, the prevalence of HSDD in women, definitions of sexual health and sexual desire, sexual myths and HSDD, whether HSDD should be considered a disorder and if it should be treated, a brief history of sexual disorders in women. This paper will also discuss physical vs. psychological arousal in women, physical, psychological, and relational aspects of HSDD, male HSDD, an Adlerian perspective of HSDD, linear and responsive desire, and proposed definitions of female HSDD including a proposed DSM-V revision of HSDD. Treatment options discussed include hormonal, antidepressant, herbal, CBT, and mindfulness.

HSDD DSM-IV-TR Definition

The Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition Text Revision (DSM-IV-TR) defines Hypoactive Sexual Desire Disorder (302.71) as follows:

Diagnostic criteria for 302.71 Hypoactive Sexual Desire Disorder

A. Persistently or recurrently deficient (or absent) sexual fantasies and desire for sexual activity. The judgment of deficiency or absence is made by the clinician, taking into account factors that affect sexual functioning, such as age and the context of the person's life.

B. The disturbance causes marked distress or interpersonal difficulty.

C. The sexual dysfunction is not better accounted for by another Axis I disorder (except another Sexual Dysfunction) and is not due exclusively to the direct physiological effects of a substance (e.g., a drug of abuse, a medication) or a general medical condition.

Specify type: Lifelong Type, Acquired Type

Specify type: Generalized Type, Situational Type

Specify type: Due to Psychological Factors, Due to Combined Factors.

In a concise fashion, HSDD can be defined as lack of desire for sexual activity, and this lack of desire causes distress for the individual client or couple. How does the client or couple know whether the client's lack of desire for sexual activity is a cause for distress? How much of the distress is a result of mismatched libido in a relationship, or expectations picked up from cultural and media messages? The lack of sexual interest is not considered enough to qualify as a disorder in itself; it must be accompanied by distress to qualify as HSDD.

Prevalence of HSDD

The lack of interest in sex for women in long-term relationships is relatively common worldwide. In the US, 32% of women age 18-29; 32% in age 30 to 39, 30% for women 40 to 49 years of age, and for women 50 to 59 years of age, 27%. The lack of interest or desire for sex is higher for women who never married, have less education, or are non-Caucasian. (Warnock, 2001, p.747)

Since a lack of desire or interest in sex is more likely to occur for women who are non-white, unmarried, and have lower levels of education, does the apparent interest in sex that occurs in white, married, and educated women point to cultural expectations? In the United States, eighty percent of women feel that sex is a necessary component of a fulfilling life. (Parish, 2009, p.S20) In communities where sexual needs and pleasure for women are acknowledged, self-reported sexual difficulties are more common. In a Scandinavian community study, only 22% of women reported spontaneous sexual desire more than

occasionally. Women in the same community who experienced desire only rarely or never was 14%. (Basson, 2005, p. 294) According to the current definition of HSDD, the middle 64% would be in the questionable range for diagnosis with a sexual disorder.

One also needs to remember that the lack of desire for sex is not HSDD unless this is distressing to the client or the couple. Depending on age, there are women who are satisfied with their sexuality even when not sexually active. A British study of 290 women age 18-75 found that although 24% had not been sexually active in the previous three months, 79% were very happy with their sex life. Lack of sexual activity does not by default mean that a woman is dissatisfied with their sex life, and “relative infrequency may be the preference for some women. This was also suggested in a study showing that midlife women's sexual satisfaction was higher when their partner's relative physical impairment precluded frequent sex.” (Brotto, 2010, p. 225)

There are some problems with the research surrounding the prevalence of HSDD. Parish points out that many of the studies of female sexual dysfunction have inclusion criteria which limit participants to women who are in stable relationships, or in sexual relationships, and this excludes significant numbers of women. In addition, sexual problems may not be significant enough to a woman to cause distress. (Parish, 2009)

For women who had HSDD in the WISHeS study, their dissatisfaction and distress included not only their sex life but also their marriage or partner, and reported feelings of frustration, hopelessness, anger, loss of femininity, and problems with self-esteem. (Parish, 2009, p.S21) Women age 25-44 have a lower prevalence of sexual desire but are more distressed when it does occur, especially in women who are surgically menopausal. (Rosen, 2009, p. 1556)

Desire may have become as “medicalized” for women as it has for men. In the PRESIDE study, 40% of the women who were distressed by their low sexual desire first contacted their

primary care physician. The study also found that of primary care physicians in a university teaching hospital, most did not screen their female patients for HSDD and did not feel comfortable diagnosing HSDD. (Rosen, 2009, p.1558)

Definition of Sexual Health

If one can diagnose a problem with sexual desire or arousal, it implies that we can also determine whether a client is sexually healthy when our assessments come back negative. Researchers have created a few assessments to determine if research participants have HSDD. One screening tool for hypoactive sexual desire disorder in postmenopausal women is the Brief Profile of Female Sexual Function (B-PFSF). This tool, which consists of seven items, is as follows:

(1) I felt like having sex, (2) I was unhappy about my lack of interest in sex, (3) Getting aroused took forever, (4) I felt sexually numb, (5) I felt disappointed by my lack of interest in sex, (6) I lacked sexual desire, (7) I reached orgasm easily. (Rust, 2007, p. 639)

This assessment was created from the larger Profile of Female Sexual Function, and could be used as a tool to begin a conversation around sexual functioning. One can also wonder what myths regarding sexuality can be triggered by the choice of statements above, and whether a woman would assume that she should get aroused more quickly, or reach orgasm easily.

Sexual health for women and men can look very different. A challenge in defining and assessing sexual disorder is defining what constitutes sexual health. This can lead to psychoeducational work with couples because each partner may define acceptable sexual behavior differently. In Brotto's 2010 article entitled "The DSM diagnostic criteria for

hypoactive sexual desire disorder in women”, reasons for sexual activity for males and females are stated as follows:

Engaging in sexual activity ‘because the opportunity presented itself,’ ‘because I was horny,’ or ‘because the person was there’ were unlikely reasons women provided for engaging in sexual activity. (The most common reasons women provided for engaging in sex were: I was attracted to the person, I wanted to experience physical pleasure, It feels good, I wanted to show my affection for the person, and I wanted to express my love for the person.) (Brotto, 2010, p. 226)

In popular magazine articles and self-help books, the concept of “great sex” and tips for creating it are advertised and promoted as the ideal. What exactly is “great sex”? In the 2009 article “The components of optimal sexuality: A portrait of ‘great sex’”, the authors state, “At present, there is a lack of clinical knowledge, empirical data and in-depth public discourse concerning the nature of healthy sexuality, let alone very special, wonderful sexual experiences.” (Kleinplatz, 2009)

The authors of this article interviewed 44 individuals who reported having experienced “great sex”, and also interviewed 20 sex therapists. The people interviewed were asked “How would you distinguish between 'very good' versus 'great' sex?” Participants’ average age was 66 for heterosexuals, and 48 for sexual minorities. Eight components were identified as major factors in great sex, and two components were also common in a minority of respondents. The major components of great sex were:

1. Being present, focused and embodied – some described this as being totally absorbed in the experience, getting lost in the moment. This component was “reminiscent of...Csikszentmihaly's (1990) characterizations of the state of ‘flow’.”

2. Connection, alignment, merger, being in synch – a strong connection with one's partner during sexual activity, a “loss of personal boundaries, distinct loss of...self-awareness in the sense of separateness from the other.”

3. Deep sexual and erotic intimacy – a deep mutual sense of caring, trust, and acceptance between partners.

4. Extraordinary communication, heightened intimacy – complete and total sharing of themselves, verbal and non-verbal communication, listening and using touch as a form of communication.

5. Authenticity, being genuine, uninhibited, transparency – being emotionally naked with another, “Sex where you can say anything and be anything,” being unselfconscious.

6. Transcendence, bliss, peace, transformation, healing – a sense of the infinite, timelessness, a heightened altered “peak” experience.

7. Exploration, interpersonal risk-taking, fun – a “discovery process”, pushing and expanding boundaries, laughter and fun.

8. Vulnerability and surrender - “A leap of faith”, “being able to put your entire being in somebody else's hands”, willing to surrender.

The minor components listed were intense physical sensation and orgasm, lust, desire, chemistry, and attraction. The minor components were not considered to be sufficient to create a great sexual experience by any of those interviewed. (Kleinplatz, 2009)

What about asexuality as a healthy option? In England,

Bogaert (2004) ...reported that one percent of the population claimed to have no sexual attraction to members of either sex. He identified a number of associated and predictive

features of asexuality, including gender (mainly women), religiosity, short stature, low education, low socioeconomic status, and poor health. (Jutel, 2010, p. 1086)

For some, sexual health may mean a lack of sexuality, and therapists should recognize this as a valid personal preference and not create a problem where none exists.

Definition of Sexual Desire

What is sexual desire? Regan and Berscheid define it as a “psychological state subjectively experienced by the individual as an awareness that people want or wish to attain a (presumably pleasurable) sexual goal that is currently unattainable.” (Goldmeier, 2001) Sexual arousal is the awareness of physiological and psychological sexual excitement, and may coexist with sexual desire. (Goldmeier, 2001) It is difficult to separate sexual desire and sexual arousal for women, as will be discussed later in this paper.

Sexual Myths and HSDD

Differences in sexual response were incorporated into many cultures’ mythologies. The Greek myth of Tiresias illustrates their view of a question which still occurs today:

Tiresias was called upon by the gods Jupiter and Juno to settle their argument about whether the sexual pleasure of man or woman was greatest. He was appointed to ‘arbitrate this jocular dispute’ because he had ‘known both Venuses’, having lived 7 years as a woman, after having been born a man. He agreed with Jupiter: women have more pleasure, he maintained. Tiresias' decision was not without consequence: Juno blinded him for his taking Jupiter's side. To palliate his loss of sight, Jupiter gave him the ability to know the future. (Jutel, 2010, p. 1085)

Culture helps us understand our life and environment by wrapping stories around our experiences. It holds our communal assumptions which hide our mythical thinking from

ourselves, and it seems like this is most easily done in a scientific and logical society, because some of us attribute our beliefs to science and insist that we don't believe in myths.

Few of us received adequate education around sexuality and relationships, and much of what we believe may have been passed to us through peers long ago, or glossy magazine covers.

The most frequently reported sexual myths among women with HSD(D) are the following: men always have sexual desire and are always ready to have sex; making love should not be something planned, but rather an act which occurs naturally and spontaneously; there cannot be any sex if a man does not have an erection; couples should always maintain a regular frequency of sex; and a good sexual experience should always end with an orgasm. (Trudel, 2001, p. 151)

All of the most frequently reported myths are beliefs that may not be discussed in sex education programs, and one wonders how many of these myths may be promoted by views of romantic early love in novels or movies. One can also wonder how much is due to the assumption that early relationship sexual patterns will and should continue throughout the lifespan of the relationship.

HSD(D) does not merely involve some objective deficiency of desire measured against a universal standard of desire. It also involves the perceived failure to meet levels of desire set by perceived societal norms and expectations... The woman's subjective experience of sexual desire should also be viewed in the context of sexual desire discrepancies within couples... The literature shows correlations between HSD(D) and elevated depression, low sexual assertiveness, and feelings of inferiority. (Hurlbert, 2005, p. 17)

HSDD and Controversy around Diagnosis

Whether HSDD should even be diagnosed has been questioned. In Nappi's 2010 article "Hypoactive Sexual Desire Disorder: can we treat it with drugs?" when one tries to evaluate the number of determinants of desire, changes in those determinants throughout different stages of a woman's life, determining the gap between potential and actual desire in a specific relationship and whether this can be achieved, and how these may be affected by cultural norms and personal experiences, one can get "... the idea that HSDD is a made-up condition which serves only marketing purposes for lifestyle drugs." (Nappi, 2010, p. 265)

Some are concerned about whether a lack of desire, which occurs in many long-term relationships, is a valid reason for distress and medical treatment. Many factors influence sexual desire, including "life experiences, stresses and anxiety; body image; communication issues; economic situation; sexual education; belief system; sexual technique and habits; cultural expectations...the list is endless. Do we need to take a pill for each one of these?" (Markovic, 2010, p. 260)

Markovic's 2010 article "Hypoactive sexual desire disorder: can it be treated by drugs?" discusses whether prescribing medication is damaging because the medicalization of HSDD may lead to:

'Monstrification' ... HSDD labels and pathologises the person and takes the whole issue out of the context of the couple relationship. A common assumption is that this person's desire needs to be raised... (when encountering) couples with desire/frequency differences... often the partner with the lower sexual desire becomes scapegoated. It is concerning to think that by giving drugs to that partner, professionals join in this monstrification process.

‘Masking’...relying on drugs can mask underlying issues and make the person inert, taking away the potential to mobilise and strengthen their internal resources and to understand them and learn from them.

‘Scoring’...What is really the point of such treatment? Is the point to have more sex or less sex and to get the right score in the end? Or is the point to help couples negotiate a consensual arrangement for their sex life...

‘Pathologising’...Why sex and why desire? When I ask my clients this question, it often unfolds that responses to external pressures had formed huge anxieties and misconceptions, such as ‘If we don't have sex at certain level, it means the relationship is wrong’; or ‘It is unhealthy’; or ‘We are abnormal.’...if we give them pills, would we not be running the risk of reinforcing their restricting belief system? ...would we not be limiting the possibility for those who present with such misconceptions to claim a sense of their own personal and relational preferences? (Markovic, 2010, p. 261)

By medicalizing sex, people are under more performance pressure so that they will not perceive themselves as abnormal. This perception causes shame, embarrassment and anxiety, and “by promoting drug treatment outside an integrated approach, could it be we are reinforcing the very problem we are trying to solve!?” (Markovic, 2010, p. 262)

The impacts of marketing and pharmaceutical profit are also explored by Jutel, who states ...the disease category of ‘Female Hypoactive Sexual Desire Disorder’ (FSDD), its genesis and detection fingers the presence of powerful stakeholders and androcentric, heterosexual definitions of normal sexuality... The prevalent use of the hypersexualised female in all forms of media present a fantasy of constant desire and sexual fulfillment, and underlines the inadequacy of the consumer. A consumer solution is promoted by the

pharmaceutical industry, in the exercise of disease-branding: marketing the diagnosis in order to create demand for its cure. (Jutel, 2010, p. 1084)

History of Female Psychosexual Disorders

According to Studd's article "A comparison of 19th century and current attitudes to female sexuality (Studd, 2007) "In medieval times people feared three things: the devil, Jews, and women." Female sexual disorders in the latter 1800's consisted of nymphomania, neurasthenia, hysteria, moral insanity, menstrual madness, and masturbation. In the case of female masturbation, doctors believed at the time that it would "progress through insomnia, exhaustion, neurasthenia, epilepsy, moral insanity, insanity, convulsions, melancholia, paralysis, to eventual coma and death" and the fashionable cure at the time was clitoridectomy. Most novels and music of the time followed the theme that fallen women must die as a punishment for their promiscuity. A number of artists – Titian, Manet, and Courbet – challenged this view in their paintings, such as Venus of Urbino, L'Origine du Monde, and The Sleepers. In the first half of the 1900's, most sexuality manuals, which were marketed toward married couples, were banned from publication in the United States. In 1953 Kinsey's *Sexual Behaviour in the Human Female* presented researched data on female sexuality, including premarital sex, infidelity in marriage, orgasm, and masturbation.

Physiological vs. Psychological Arousal

Prior to 2001, measurements of sexual dysfunction in women were determined by genital vasocongestion, only one aspect of female sexual arousal and one that does not match psychological and subjective experiences. Many women are not even aware of their own physiological arousal, so measurement of genital response does not correspond to their

psychological experience. In order to define female sexual dysfunction, a description of satisfactory sexuality for women needs to be determined. (Basson, 2001)

Much of the research evidence on genital response in women is based on vaginal pulse amplitude, but this is not a measure of sexual arousal or desire because women also have a vaginal response to sexual stimulus that is threatening or disliked. Vaginal response is most likely an automatic response, and it allows for vaginal penetration with minimal damage to the woman. For a comparable measure of female arousal and desire, and the closest measurable comparison to male arousal and desire, the clitoral response must be measured as well.

(Bancroft, 2010, p. 167) Since the DSM-IV-TR has separate conditions for desire disorder and arousal disorder, and since desire is seen as preceding arousal in the current definitions, why should we be concerned with arousal?

The reason why we need to include arousal in the assessment is that women who have sexual dysfunctions usually have a mismatch between their mental and physical arousal, compared to women who do not have dysfunctions. Also, women who have high concordance between mental and genital arousal have high rates of orgasm. Research has shown that the closer the match between subjective and genital/clitoral arousal, the fewer sexual problems a woman experiences. Fortunately, the relationship between mental and physical arousal can be altered over time. In one study, the longer women watched erotic videos, the more concordance between body and mind occurred. “Also, the more the videos varied the levels of eroticism – heated up and then cooled off – the more concordance women reported. All that waxing and waning of genital responses just may force women to notice them more.” (Elton, 2010, p.77)

Physical Aspects of HSDD

Female sexual desire can be affected by many typical reproductive experiences, such as menstrual cycles, hormonal contraceptives, postpartum and lactation, oophorectomy, hysterectomy, perimenopause, and postmenopause. (Warnock, 2002) Hormones impact desire, and specifically estrogen is important because it makes pelvic tissue resilient enough for intercourse, primes the sensory organs, increases clitoral sensitivity, and regulates serotonin, noradrenaline (norepinephrine) and dopamine in women. Dopamine affects sexual behavior by activating drive and motivation, often in pursuit of pleasure. Androgens are vital to libido in women, and without androgen women lose: pubic hair, muscle mass, libido, desire for sex, sensitivity in nipples and clitoris, and energy. (Warnock, 2001)

Some physiological and psychological reasons for low sexual desire in women are pathologically low testosterone level, hyperprolactinaemia, hypothyroidism, alcohol and drug abuse, prescription medications, and clinical depression. (Goldmeier, 2001) Factors associated with general sexual complaints are poor health, thyroid conditions, urinary incontinence, depression, anxiety, and low education levels. (Parish, 2009)

A woman's menstrual cycle can affect libido. The common, yet unproven, theory is that women should feel an increase in desire for sexual activity shortly prior to ovulation in order to increase chances of reproduction. Some studies have shown a decrease in interest in sex post-ovulation. (Warnock, 2001) Also, women who experience premenstrual syndrome or premenstrual dysphoric disorder may have lower motivation for sexual activity prior to menstruation because of breast tenderness, bloating, and other physical and mood symptoms. (Warnock, 2001)

Hormone contraceptives can impact desire in some women, and 25% of sexually active women in the US use hormonal contraceptives. One theory for lower desire in women using hormonal contraceptives is a reduction in the level of free testosterone. (Warnock, 2001) Testosterone's effect on desire will be discussed later in this paper.

Postpartum states can also affect desire because of the abrupt decline in estrogen after delivery. This could also contribute to postpartum depression. Breastfeeding increases the production of prolactin, which can result in vaginal dryness and dyspareunia (painful intercourse). Prolactin also decreases libido by inhibiting ovarian function, resulting in lower estrogen and androgen levels. In addition, sleep deprivation, childcare, and other marital or financial stressors can reduce libido. (Warnock, 2001)

Hysterectomy can affect the physiological sexual experience for some women because of the loss of uterine contractions and less vasocongestion, in addition to potential nerve damage from surgery. (Warnock, 2001)

Two case studies presented by Riley, Gibbin and Riley discussed sexual desire disorders caused by distress over physiological conditions. The first female reported a loss of sexual desire after having her third child, three years earlier, and when asked if she had any urinary symptoms she broke down into tears, stating that she was embarrassed by wetting the bed. She inhibited her own orgasms, hoping that would prevent leakage, but the leakage then occurred during penile thrusting. The woman confessed that she felt guilty about not doing enough exercises after the birth of her second child. The woman was treated using Femina Cones:

...a set of cones of different weights which can be inserted and retained in the vagina.

The treatment involves starting with the lightest cone and retaining it in the vagina whilst walking around for 15 minutes. If the cone slips out, it is re-inserted. When the cone can

be retained for 15 minutes, the procedure is repeated with progressively heavier cones.

The cones are used twice a day. (Riley, 2005, p. 217)

The woman found great improvement in her incontinency in three months. (Riley, 2005)

The second woman in the case study, age 26, was afraid of “peeing herself” but did not leak urine at any other time, and was not orgasmic. She reported that when using a vibrator in her teens, “a lot of white stuff shot right across the ... floor” and this caused her a great deal of anxiety. She stopped masturbating and held back or avoided sex until treatment. Treatment focused on sex education and therapy, and the woman started to reframe herself as “super female” rather than as leaky and inadequate, once she learned about the G-spot and female ejaculation. (Riley, 2005)

Urinary incontinence for women age 30-49 years is 10.9%. The peak rate for urinary incontinence in women is 60% in women age 45-54 years. In another study of nonhospitalized women in the age group of 40 to 59, the rate was also 60%. Sexual dysfunction is found in 46% of women with urinary symptoms, and approximately the same percentage of women complaining of orgasmic difficulties and low sexual desire also have incontinence. Penetration, orgasm, and clitoral stimulation can all result in leakage, and in a study of incontinent women, 56% had incontinence during sexual activity. In addition,

...incontinence and weak orgasm could both result from pelvic floor dysfunction. The pelvic floor comprises various muscles, including the levator ani and pubococcygeus, ligaments and fascia that provide support for the pelvic organs and is involved in the maintenance of urinary and faecal continency. It is also involved in sexual function, including orgasmic sensation...It is estimated that around 50% of parous women will lose pelvic support resulting in some degree of prolapse, although not all these women will be

symptomatic nor seek treatment. The aetiology of pelvic floor dysfunction is multifactorial involving mechanical disruption, muscle degeneration and neurological abnormalities. Childbearing is a predisposing factor. (Riley, 2005, p. 219)

Regarding female ejaculation and the Grafenberg spot, the appendix of the Riley article stated that the following books were loaned to the client: *The G Spot, The Good Vibrations Guide* by Cathy Winks (1998), *The Clitoral Truth, The Secret World at Your Finger Tips* by Rebecca Chalker (2000), and the following books were recommended: *Sex for One*, by Betty Dodson (1987) and *Woman's Pleasure*, by Rachel Swift (1993).

There are many hormones involved in sexual arousal and desire:

Steroid hormones activate mechanisms of sexual excitation by directing the synthesis of enzymes and receptors for several interactive neurochemical systems. Those include dopamine (DA), norepinephrine (NE), melanocortin (MC), and oxytocin (OT) systems acting in hypothalamic and limbic regions of the brain to stimulate sexual arousal, attention, and behaviors directed at both conditioned and unconditioned sexual incentives. (Pfaus, 2009, p. 1510)

Are there differences in dopamine and norepinephrine levels in sexually functional and dysfunctional women, when exposed to erotic stimuli? Bupropion (Wellbutrin) is a dopamine reuptake inhibitor which has been found to help women with HSDD. Norepinephrine has been found to increase sexual arousal responses in post-menopausal woman with female sexual arousal disorder. Norepinephrine is also the dominant transmitter of the sympathetic nervous system, and drugs that increase the sympathetic nervous system outflow enhance physiological sexual arousal. (Meston, 2005)

Norepinephrine levels significantly increase for sexually functional women when they are shown an erotic film, and also increase following sexual activity. Yet, when sexually dysfunctional women viewed erotic films, their norepinephrine levels were significantly higher than functional women. The authors of this study speculate that the higher levels in dysfunctional women were due to an anxiety response about both viewing erotic films and having their arousal measured. (Meston, 2005) So, increasing norepinephrine levels may seem like a logical way to increase sexual arousal but in dysfunctional and possibly sexually anxious women the increase in arousal translates to an increase in anxiety.

“A well-documented side-effect of the treatment of Parkinson's disease with 3,4-dihydroxy-L-phenylalanine (L-DOPA) is enhanced libido. Subsequent work showed that L-DOPA stimulated both appetitive and consummatory sexual behaviors in sexually sluggish or castrated male rats.” (Pfaus, 2009, 1512) Whether the increase in sexual behavior in sluggish or castrated male rats would translate to an increased libido in women with HSDD is not documented.

The effect of most antidepressants is well known to lower sexual desire and arousal in humans.

Brain opioid, endocannabinoid, and serotonin systems blunt the action of excitatory mechanisms. This occurs normally at the end of the sexual response cycle during a period of “sexual satiety” or refractoriness (e.g. after one or many orgasms). However, it can also occur if the endogenous inhibitory mechanism(s) is (are) tonically activated by situational variables such as stress or by drugs that augment their actions (e.g. SSRIs). (Pfaus, 2009, p.1516) Serotonin neurons arise in the Raphe nuclei of the midbrain, and send extensive axonal projections to brainstem, midbrain, and forebrain sites, including

the hypothalamus, limbic system, hippocampus, and cortex, and down the spinal cord to lower lumbar and sacral regions that control genital reflexes. The idea that brain serotonin induces satiety comes from the feeding literature, in which serotonin transmission in certain hypothalamic regions decreases appetite. (Pfaus, 2009, p. 1520) Interestingly, SSRIs are used to help manage paraphilias and to treat premature ejaculation, both of which may result from a hyperactive excitatory or arousal systems. (Pfaus, 2009, p .1522)

Are there any contraindications to increasing dopamine activity in the brain?

Amplification of brain DA transmission carries a risk of drug dependence, addiction, obsessive-compulsive or hypomanic episodes, anxiety, and a sensitization of psychosis, as has been reported for drugs like cocaine. Inhibition of brain opioid, endocannabinoid, or serotonin systems carries a risk of anxiety, dysphoria, or depression. (Pfaus, 2009, p. 1522)

Changing the levels of brain hormones in order to affect sexuality is a balancing act between excitation and inhibition. There may be a decrease in excitation and/or an increase in inhibition at the neurochemical level for persons with HSDD, and the result of this below or above normal functioning leads to a decrease in thoughts and behaviors associated with desire. Appropriate levels of inhibition are protective, because they help to keep an individual from getting into trouble, and understanding sexual inhibition may provide clues as to why alcohol and other drugs, or events, lead to a lack of sexual inhibition and risky sexual behavior. (Pfaus, 2009) Inhibition's power over the nervous system is generally stronger than excitation, and “disinhibition” is a neurochemical process which allows for sexual behavior. At the end of sexual behavior, the inhibition mechanism is turned back on. When an individual cannot turn off

the inhibition mechanism, it may be a result of internal neurochemical imbalances or a result of external influences such as a lack of a 'reward' for sexual behavior or psychiatric medications that increase serotonin, cannabinoid, or opioid transmission. The result of this inhibition switch remaining on is an increase in disorders of arousal, desire, and orgasm. (Pfaus, 2009)

Psychological Aspects of HSDD

'In the early stages of relationships, the infatuation stage, people can't get enough sex,' says University of Texas sexologist Cindy Meston. 'They can't stop thinking about that person'...people in the early stages of falling in love have brain serotonin levels as low as those seen in people with obsessive-compulsive disorder. (Elton, 2010, p. 73)

This leads one to assume that after the initial stages of falling in love, the brain serotonin levels return to normal and give people a feeling of satisfaction or satiety, as mentioned in the paragraphs above.

Is worrying a factor in low sexual desire? In the article "The relationship between worry sexual aversion, and low sexual desire" (Katz and Jardine, 1999) self-report questionnaires were given to 138 random college undergraduates, and "the tendency to worry was no more related to sexual aversion than it was to a disinterest in sex or low levels of libido... Worry, therefore, does not appear to be associated with sexual desire problems." (Katz and Jardine, 1999 p. 295)

What about self-esteem, assertiveness, and other factors? In Hurlbert's 2005 study of the effects of depression, sexual assertiveness, and self-esteem in women with HSDD,

Older age of the women with HSD(D) was related significantly with a more positive disposition toward sexual fantasy, and marginally, with the less they perceived their sexual desire problem as negatively impacting their marital relationship. Longer duration of HSD(D) was linked to less sexual desire and a more negative disposition toward

sexual fantasy. Lower socioeconomic status was marginally associated with lower self-esteem and significantly correlated with less sexual assertiveness. A larger family size was linked marginally to a more negative disposition to sexual fantasy. Women with acquired type HSD(D) reported marginally more pronounced feelings of depression than women with lifelong HSD(D). (Hurlbert, 2005, p. 20)

Also, women with low sexual desire often have low self-image and mood instability. (Basson, 2005)

How do people with higher and lower levels of sexual desire respond to sexual stimuli? According to Barlow's model of sexual functioning, higher sexual-desire individuals pay more attention to sexual cues, and they also have a greater positive emotional response to sexual cues than individuals with lower sexual desire. (Prause, 2008) In Prause's study, eyeblink startles is used as a measure of potential approach or avoid responses to stimuli. A mixture of brief aversive, pleasant and neutral images are presented to the participant, and the greater the approach-or-avoid response, the greater the startle and eyeblink response. Pleasant images tend to create less of a startle response than aversive. One prior study suggested that participants with higher sexual desire had a higher startle response to sexual stimuli than lower desire levels. (Prause, 2005)

Another part of Prause's study was measuring attention through a dot detection task. This is done by showing the participant two images – one neutral and the other aversive or pleasant – and after the images are displayed, a dot appears where one or the other image was displayed. The amount of time the participant takes to detect the location of the dot is measured. If the participant has, for example, a spider phobia, and they detect dots where the spider was faster than average, then they are considered to have an attentional bias toward spiders. In depressed

individuals, dot detection is of equal speed whether it is located in positive or negative stimuli, and non-depressed participants find the dot more quickly in positive stimuli. In another study, dot detection took longer when it appeared in the area of a photo of their preferred sex, and they remembered the preferred sexual images accurately. This suggests that when pleasant things are viewed, participants gave *less* attention to them, and the more interested the participant is in the pleasurable object, the less visual attention is focused on the image. (Prause, 2008)

In the dot detection portion of the Prause study, the individuals who had lower sexual desire were able to locate the dot more quickly in a sexual image, compared to a neutral image. Participants with higher sexual desire attended to the sexual stimuli less, and took longer to locate the dot. The authors of the Prause study state that the lower sexual desire participants may have their attention captured more by the sexual image because it is unfamiliar and novel to them, or feel a stronger emotional reaction. Negative emotions in this type of dot detection test lead to slower response times. In comparison, the higher sexual desire individuals may have had more exposure to sexual images, but may also have longer delays because of positive attentional engagement. (Prause, 2008) Two possible reasons for the longer time in high sexual desire participants may be from delayed disengagement, or inhibition of return. Disengagement is how we regulate emotional upset, and as an example, individuals with high anxiety levels have difficulty disengaging fearful stimuli. Disengagement in the high sexual desire group may be due to their greater absorption in the sexual stimuli.

Individuals who are more absorbed by sexual stimuli tend to have more appetitive and stronger sexual arousal responses to them... (and) stronger emotional stimuli are known to reduce response time. Also, it has been argued that individuals who seek out more sexual experiences than others may have a more complex semantic network for sexual

stimuli, which could contribute to their absorption by sexual stimuli through additional cognitive elaboration. (Prause, 2008, p. 945)

Inhibition of return is the second concept which may explain the longer response times with the high sexual desire group. Inhibition of return is when an individual is slow to return visual attention to an area of visual space that was previously viewed, perhaps because of inhibition. This could have been the case if the high desire group scanned the sexual stimuli area quickly before the dot appeared on the screen, and then searched the neutral stimuli when the dot finally appeared in the first area. (Prause, 2008)

The Prause study found that assessing the emotional responses of individuals by startle eyeblink demonstrated that lower sexual desire individuals do not necessarily evaluate sexual stimuli negatively, as had been assumed prior to this study. Therefore, treatments which were designed to reduce negative feelings about sex may not be as effective as traditional assumptions would predict. (Prause, 2008)

Relationship Aspects of HSDD

Women who have aspects of HSDD in the United States and Europe between age 18 and 65 have more negative interaction patterns with their partner than women who do not have challenges related to HSDD. (Nappi, 2010) What are the positive aspects associated with a healthy level of sexual desire in women?

Hurlbert's study found that when women were inclined to see sexual fantasy as a positive aspect of their sexuality, they were more likely to experience high relationship satisfaction and also a high degree of intimacy in their relationship. Also, couples who had a high level of sexual compatibility were associated with women who were self-motivated to remedy their sexual desire challenges. Other areas with marginal correlations in this study included,

(1) high sexual assertiveness and high marital satisfaction, sexual compatibility, and closeness; (2) high intimacy and high sexual desire; (3) husband perceiving less relationship impact of HSD(D) and high closeness; and (4) less depression and greater marital satisfaction, sexual compatibility, and closeness. (Hurlbert, 2005, p. 21)

The male partners in the Hurlbert study considered the quality of the marital relationship to hinge on the positive or negative emotions experienced during sex. As a result, the negative impact of HSDD on the sexual relationship translated into a negative couple relationship evaluation for the men. (Hurlbert, 2005)

Another aspect of sexuality which may affect the woman's sexual experience may be initiation and rate of copulation. Female rats determine when the male rat may mount and how frequently, and this 'pacing' is, for female rats, the critical factor for sexual rewards. (Pfaus 2009) The term 'sexual rewards' describes whether the sexual event was satisfying for the female rats, in this study. Weighing this against the frequency of human females to engage in sexual behavior for reasons other than desire or arousal, one could wonder if pacing in humans should be taken into consideration in HSDD.

When comparing male sexuality and desire to women's, men spend more time thinking, fantasizing, and working to get sex, initiate sex more frequently, have a stronger appetite for sex, place more importance on sexuality in their life, and masturbate more frequently than women. A man's level of desire is on average higher than a woman's when comparing their behavior and cognition.

For women, the one thing that has been found to alter a woman's level of desire is obtaining a new partner. Conversely, the more familiar a partner becomes in a woman's life, the more likely she is to consider them a family member. Once this has occurred, sex with their

partner may be distasteful, because “...sex with family members is taboo.” (Elton, 2010, p.75)

Women in long-term relationships have an increased desire for tenderness and lower sexual desire, which does not occur for men in long-term relationships. (Brotto, 2010)

So, what do women really want? While women fantasize about being found irresistible or ravished, women want to be:

... *uniquely* desired – to be chosen as The One. Perhaps that's why they are turned on by relationships at the onset. Women want a commitment because it signals they are uniquely desired. But after a commitment has been made, it's meaning changes. ‘Once people get married, your guy is stuck,’ says Meana. ‘He can't sleep with anyone else. His advances to you no longer signal your unique desirability the way they did before you were married.’ (Elton, 2010, p. 76)

Male HSDD

While much of the focus of HSDD has been on female desire dysfunction, Meuleman and Van Lankveld wrote in a brief article titled “Hypoactive sexual desire disorder: an underestimated condition in men” that “male hypoactive sexual desire disorder (HSDD) is erroneously presented and treated as erectile dysfunction (ED),” and in their conclusion stated, “HSDD is more common in men than in women.” (Meuleman, 2005)

Male HSDD is equally complex:

Contrary to the public perception of male sexuality as being natural and simple, male sexuality is multi-causal, multi-dimensional, and complex, with large individual, couple, cultural, and value differences... In couple sex, the adolescent/young adult male experiences easy, predictable, and most important, autonomous sexual function. In other words, he can experience desire, arousal, and orgasm and need nothing from his partner...

Male sexual socialization and these early learning experiences unfortunately set the man up for sexual dysfunction and inhibited desire with his aging and the aging of the relationship... The core issue is usually a sexual secret. By order of frequency, this includes; 1) a variant arousal pattern (deviant arousal is much less common); 2) a preference for masturbatory sex rather than intimate couple sex; 3) a history of poorly processed sexual trauma; or 4) a conflict about sexual orientation. The issue is not the lack of sexual desire, but a secret/shameful desire/arousal pattern. Many of these men enter new relationships with the hope that this time the desire problem will not reoccur. Often the newness and romantic love/passionate sex allow sexual desire and function, but this usually fades after weeks or months, seldom lasting more than 2 years. (McCarthy, 2009, p. 59)

Primary HSDD affects as many as 10% of men. Secondary HSDD in men is usually a reaction to other dysfunction, such as erectile dysfunction. "When couples stop being sexual, whether at 40, 60, or 80 it is the man's decision in over 90% of cases." (McCarthy, 2009) The Good Enough Sex model has been used to treat men with secondary HSDD. (McCarthy, 2009)

HSDD from an Adlerian Perspective

The Adlerian life task regarding sexuality and love is typically presented as a problem to be overcome earlier in life, and the primary way to overcome this life task is through social interest. In female HSDD within long-term relationships, social interest may not be sufficient. Instead of focusing even more outside of the self, a woman with HSDD may already be too externally focused and unwilling or unable to take the time to focus within. Perhaps there is a lack of balance between the life tasks, or the fourth and fifth life tasks of coming to terms with the self and finding meaning in life arise as the relationship progresses. Since many clients with

HSDD are in long-term relationships, consideration of the relationship as a whole and looking at the five life tasks to see if the relationship is meeting challenges in these areas may also be useful for the client.

Organ inferiority and organ jargon can also play a role. Using “The Question”, and finding out how the client’s HSDD is helping them to pursue a goal which may not be known to them is important. When communication with their partner is challenging for the client, physical desire and arousal problems may be an easier method for pursuing their goals until the client gains more courage.

Collecting stories of the clients first sexual experiences as well as the first experiences of the current relationship could be used as a sort of early recollection. Dreams and metaphorical expressions may also help to express the purpose of the clients HSDD.

Theories of Desire

In 1979, Helen Singer Kaplan proposed a model of sexual response which involved three phases. The first phase was desire, followed by sexual excitement, and ending with orgasm. As diverse sexual disorders were defined after that time, practitioners engaged in treatment found there was a disconnect between theory and reality, and some felt that the initial three phase model was based on male sexuality and a different model was needed for female sexuality.

Women in long-term relationships initiate or agree to sex for reasons such as emotional closeness, to feel more attractive, to conceive, and to increase their sense of well-being, and only rarely initiate sex as a result of their own sexual desire. (Basson, 2005) But even when women do not experience sexual desire at the outset of an encounter, many women become aroused which lead to feelings of sexual desire for the woman. (Basson, 2005)

Research from the Netherlands has found that motivation for sexual activity may not

spontaneously arise from within an individual, but may emerge as a response to sexual stimuli. This supports the 'responsive' theory of sexual desire, which posits that the exposure to sexual stimuli initiates a process that prepares a woman (or man) for sexual activity. (Brotto, 2010) During the late 1990's and early 2000's, the term 'responsive' began to appear in articles describing female sexuality, particularly in Brotto and Bresson's journal articles.

Should 'responsive' sexual desire be treated, or considered to be within the normal range of human sexuality? According to Goldmeier (2001),

Over 75% of women referred to my sexual function clinic because of low sexual desire seem to be complaining of 'responsive sexual desire'. In terms of therapy, what, if anything, should be done for these women? Certainly, explaining the perceived 'normality' of responsive sexual desire usually comes as a great relief to the woman and her partner, and seems to make therapy for such cases shorter and simpler. However, questions remain. Why does the woman in a long-term relationship no longer have 'spontaneous' desire? (Goldmeier 2001, p. 384)

While in 2001 Goldmeier may have questioned why spontaneous desire does not take place in long-term relationships, in 2010 Brotto stated "...there is both clinical and empirical support suggesting that sexual desire is commonly a triggered (i.e., responsive) experience and, therefore, a lack of spontaneous sexual desire should not be pathologized." (Brotto, 2010, p. 227)

Proposed Definitions of FHSDD

The DSM-III first defined "Inhibited Sexual Desire" as persistent and pervasive inhibition of sexual desire. The DSM-III also stated that this was a rare disorder that was primarily determined by whether the individual or the partner experienced distress due to inhibited desire. (Brotto, 2010, p. 222)

In the DSM-IV-TR, the first two criteria for HSDD are:

A. Persistently or recurrently deficient (or absent) sexual fantasies and desire for sexual activity. The judgment of deficiency or absence is made by the clinician, taking into account factors that affect sexual functioning, such as age and the context of the person's life. (And) B. The disturbance causes marked distress or interpersonal difficulty.

In 2001, Basson proposed a revised definition which stated,

HSDD is the persistent or recurrent deficiency (or absence) of sexual fantasies, thoughts, desire for sexual activity (alone or with the partner) and inability to respond to sexual cues that would be expected to trigger responsive sexual desire. These symptoms need to be causing personal distress. (Basson, 2001, p. 106)

In 2000, the Working Group for a New View of Women's Sexual Problems proposed a different way to categorize sexual dysfunction for women. Their approach was created using a feminine perspective and an anti-medicalization viewpoint, and dismissed much of the language of HSDD as 'pathologizing language'. Their method was to create a classification based around four categories of sexual problems. In the New View approach, women's sexual problems stem from social, political or economic factors; partner or relationship factors; psychological factors; or medical factors. In identifying the cause of the disorder, it has an advantage in guiding the focus of treatment while remaining aware of the many influences on sexual experience. (Brotto, 2010)

In 2005, The American Foundation of Urological Disease proposed revisions to the DSM-IV-TR definitions as follows:

Definition of women's sexual desire/interest disorder is

‘Absent or diminished feelings of sexual interest or desire, absent sexual thoughts or fantasies and a lack of responsive desire. Motivations (here defined as reasons/incentives) for attempting to become sexually aroused are scarce or absent. The lack of interest is considered to be beyond a normative lessening with life cycle and relationship duration.’

Definition of combined genital and subjective sexual arousal disorder is

‘Absence of or markedly diminished feelings of sexual arousal (sexual excitement and sexual pleasure) from any type of sexual stimulation as well as complaints of absent or impaired genital sexual arousal (vulval swelling, lubrication).’

Definition of subjective sexual arousal disorder is

‘Absence of or markedly diminished feelings of sexual arousal (sexual excitement and sexual pleasure) from any type of sexual stimulation. Vaginal lubrication or other signs of physical response still occur.’

Definition of genital arousal disorder is

‘Absent or impaired genital sexual arousal. Self-report may include minimal vulval swelling or vaginal lubrication from any type of sexual stimulation and reduced sexual stimulations from caressing genitalia. Subjective sexual excitement still occurs from nongenital sexual stimuli.’ (Basson, 2005, p. 293)

In 2010, Brotto stated items for consideration regarding changes to the definition of HSDD and women's sexual dysfunction. Whether sexual fantasies are a useful criteria in determining a disorder and if 'responsive desire' should be an aspect of the criteria were suggested, as well as what measures to use regarding relational dynamics and sexual disorders, overlap between desire and arousal, and if subjective distress experienced should be a criteria of disorder. (Brotto, 2010)

The “interpersonal difficulty” criterion for HSDD has been criticized, because the relationship problems may have caused the sexual problems rather than vice versa, as the criteria assumes. Also, a couple can experience sexual problems without relationship problems, and clients may also experience distress about their sexuality without an actual sexual or relationship problem. Research has found that poor partner communication, emotional strain, and a partner’s sexual dysfunction are all closely linked to female HSDD. For women going through the menopausal transition, the highest predictors of sexual response were how they felt about their partner and whether they experienced good communication with them, and less significant were estrogen levels. For women of all ages, having a partner who desires more sex than the woman is associated with low desire. It may simply be a matter of comparison, for women who had partners with a lower level of desire were not being assessed for HSDD. Also,

Other significant compatibility factors for predicting low desire were: partner not stimulating the right way, a belief that the partner believes the woman is not ‘doing things the right way’ during sex, the partner having sexual needs that the woman believes she cannot satisfy, the woman having sexual needs that the partner cannot satisfy, and not finding the partner attractive. (Brotto, 2010, p. 231)

The “unable to be accounted for by another disorder except another sexual dysfunction” criterion is also problematic. Women may experience multiple sexual dysfunctions, but the overlap between them has not been clarified. For example, Female Sexual Arousal Disorder is concerned with physical, vaginal response to sexual excitement, and does not contain mental arousal criteria. It is still unclear where to draw the line between mental arousal and desire, which has led to proposals for a combined sexual disorder definition. (Brotto, 2010)

A recommendation has been suggested, which defines 6 months or more as the criteria

for duration of any of the sexual dysfunctions, and that low desire is present in $\frac{3}{4}$ of all encounters. This may not be relevant for women who have a sexual disorder, but are not in a current relationship. (Brotto, 2010) Criticism of the diagnostic criteria for ISD and HSDD has included the imprecise measures, and the degree to which dysfunction has been left to the judgment of the practitioner and client as to appropriate desire levels considering the length of the relationship and the age of the partners. Whether the practitioner or client has an accurate understanding of sexual myths and cultural beliefs versus research is not aided by clear criteria as it is in other DSM diagnoses.

Other criticisms of the DSM-IV-TR definition are that it promotes the incorrect idea that sexual desire should occur at the outset of all sexual experiences, and sexual desire should also occur between sexual experiences. Infrequent sexual desire and thoughts about sex have been shown to be typical in sexually healthy women, and rather than fantasies demonstrating sexual desire, women often use fantasies to stay focused during sexual experiences. (Basson, 2005) Because there have been no specific criteria for frequency and duration of any of the sexual disorders, there is a higher risk of labeling normal variations of sexual desire as disease. Women from Asian cultures are often found to have lower levels of sexual desire, and the longer they reside in North America and become more acculturated, the higher levels of sexual desire they experience. In the DSM-IV-TR, there is nothing to help the clinician address cultural differences in sexuality. (Brotto, 2010)

The inclusion of the term “hypoactive” in naming this disorder is also questioned in 2010 by Brotto:

Although the term ‘hypoactive’ was introduced in the third edition of the DSM in 1980, there are problems with the label hypoactive. It connotes a deficiency of activity and,

therefore, unnecessarily emphasizes sexual activity as the central focus of the loss of desire. Some interpret the ‘hypo’ in HSDD to infer a biological deficiency of testosterone. However, to date, the majority of studies (including two large studies) have failed to find a correlation between low sexual desire and serum testosterone levels. Moreover, in many cases of presentation of low sexual desire in a woman, it is apparent that the distress over her frequency of feeling desire is due to a discrepancy in desired sexual activity between the woman and her partner, as opposed to being attributable to a deficient level of her own sexual desire. I am proposing, therefore, that ‘hypo’ be removed from the diagnostic name of this condition. (Brotto, 2010, p. 234)

Lori Brotto is a member of the Sexual and Gender Identity Disorders Work Group for the DSM-V. Brotto's revision of HSDD proposed for the DSM-V is as follows:

Proposed criteria for Sexual Interest/Arousal Disorder (or Sexual Arousability Disorder)

A. Lack of sexual interest/arousal of at least 6 months duration as manifested by at least four of the following indicators:

- (1) Absent/reduced interest in sexual activity
- (2) Absent/reduced sexual/erotic thoughts or fantasies
- (3) No initiation of sexual activity and is not receptive to a partner's attempts to initiate
- (4) Absent/reduced sexual excitement/pleasure during sexual activity (on at least 75% or more of sexual encounters)
- (5) Desire is not triggered by any sexual/erotic stimulus (e.g., written, verbal, visual, etc)

- (6) Absent/reduced genital and/or nongenital physical changes during sexual activity (on at least 75% or more of sexual encounters)

B. The disturbance causes clinically significant distress or impairment

Specifiers

- (1) Lifelong or acquired
- (2) Generalized or situational
- (3) Partner factors (partner's sexual problems, partner's health status)
- (4) Relationship factors (e.g., poor communication, relationship discord, discrepancies in desire for sexual activity)
- (5) Individual vulnerability factors (e.g., depression or anxiety, poor body image, history of abuse experience)
- (6) Cultural/religious factors (e.g., inhibitions related to prohibitions against sexual activity)
- (7) Medical factors (e.g., illness/medications)

(Brotto, 2010, p. 235)

Female HSDD Treatment

Researchers have found various non-medical methods of increasing sexual desire for women. Romantic gestures and events have been found to increase sexual desire and simply increasing the amount of time devoted to the relationship through vacations or dates are beneficial. Also, resolution of childhood conflicts and family-of-origin issues helps as well. Using erotic literature and films enhances sexual response, and CBT has been shown to resolve sexual desire problems in a third of women. (Goldmeier, 2001)

The B-PFSF is designed for women to self-administer, to see if their concerns were

significant enough to discuss with their primary physician. The study to verify the effectiveness of the brief profile found that, “Most women, irrespective of considering themselves as having HSDD or not, indicated that they thought a questionnaire like this would make it easier to start a conversation with their physician.” (Rust, 2007, p. 642)

Therapy Goals

Understanding the concept of distance or space and how this relates to levels of desire is important for the clinician. Women experience strong spontaneous desire for their partner in the early stage of their relationship, and this can decrease over time until the woman experiences no desire for her partner. The woman still experiences sexual desire for other men, and her lack of desire is specific to her partner as a result of the closeness over time. (Durr, 2009) Desire in long-term relationships decreases for all women, and the happiness or unhappiness of the relationship has no affect on whether desire decreases over time. For women to maintain sexual desire, a balance between closeness and distance needs to be created. This is a complex balance to maintain, and although we assume that the more emotional intimacy the higher the level of sexual desire for women, it turns out that the inverse is true:

In fact, the results of this study support the contention of Morin (1995) and Perel (2007), which is that too much intimacy *deadens* desire and that individuation and separateness is a prerequisite for sexual connection. A positive influence on women's experience of sexual desire is the wish to establish emotional intimacy with a man, but it seems that once this has been achieved, this particular influence is no longer there. Since the majority of other influences – such as merging, familiarity, domesticity, stress, age, and conflict – dampen sexual desire, the absence of a positive influence, even if others remain, is likely to be significant. The role of emotional intimacy in sexual desire was

found to be highly ambiguous and while the emphasis thereupon in scripts in the social context in which the relationship exists often leads to the erroneous belief that safe, intimate relationships nurture sexual desire, the opposite is true. (Durr, 2009, p. 296)

What are the goals, then, for a clinician? Some clients state that their reason for seeking treatment is that if they could increase their own level of desire, it would be easier to deal with their partner's sexual demands. In marital therapy practice, the most effective means to address sexual desire was to increase the emotional distance. "The key for successful therapy evidently lies in *identifying the "motivations (reasons/incentives)" for being willing to attempt to become sexually aroused* by their partners in order to experience responsive sexual desire and then enhancing those motivations (Basson, 2005)" (Durr, 2009, p. 299). In addition, increasing individuation can create positive individual growth, and also may increase desire.

Intervention should foster individuation and promote differentiation in order to avoid unhealthy intimacy and emotional smothering...a person's desire is seldom aroused unless something in the partner and situation is viewed as resistant to it...eroticism does not develop towards a fully accessible partner. In other words, to be desired, the object of desire should be somewhat 'remote'...Eroticism requires romance, obstacles, ambivalence, anticipation, teasing, conquering, the element of 'forbidden fruit' and 'guilty pleasures', naughtiness and the like as stimuli of sexual desire. (Durr, 2009, p. 302)

Increasing the intimacy and isolation of the couple does not tend to increase the level of desire for each partner. "(avoid) emotional fusion, dependency, possessiveness or control being confused for 'intimacy... The practitioner should therefore promote intimacy as the ability to hold on to the emotional connection/togetherness by the process of differentiation *without*

emotional merging.” (Durr, 2009, p. 303)

Herbal Therapy

Four herbal therapies were noted in the Journal of Family Practice for increasing levels of sexual desire. Ginkgo biloba increases blood flow by inhibiting platelet-activating factor; L-arginine is required to produce nitric oxide, which increases blood flow; Damiana leaf stimulates sexual desire and may have progestin-like action; and Ginseng has phytoestrogenic activity and increases blood flow. (Simon, 2009) Since the above herbs work to alter blood flow and physical arousal signs, they may increase levels of responsive desire if the client is aware of their physiological response.

Hormone Therapy

Testosterone at above-normal levels in women can increase libido and eliminate fatigue, but the side effects of hirsutism (excessive hair growth on the body) and acne discourage many women from testosterone therapy, unless they have unusually low testosterone and hormones are administered to bring levels back to normal. (Goldmeier, 2001) Women produce androgens in the ovaries and adrenal glands, which each contribute 25% of testosterone production. At the time of ovulation, the ovaries increase testosterone production by 10-15%. Women produce 0.2 to 0.3 mg of testosterone per day. Of this amount, most is bound to sex hormone-binding globulin and albumin, and only 1% is free and physiologically active in the female body. (Abdallah, 2007)

Testosterone therapy can improve sexual function in postmenopausal women by increasing “arousability, sexual desire and fantasy, frequency of sexual activity and orgasm, and satisfaction and pleasure from the sexual act.” (Abdallah, 2007) In one study where transdermal testosterone was used with premenopausal women, 46% of the participants reported a 50% or

more increase in their total sexual self-rating score. Frequency of sexual activity increased from 0.98 episodes per four weeks, to 2.1 episodes per four weeks. In addition, study participants had no significant increase in androgen side effects such as acne, hirsutism, or balding. In postmenopausal women, testosterone helps to increase bone mineral density when treated with estradiol. Hot flashes do not seem to be affected by testosterone therapy. (Abdallah, 2007)

There is hope that transdermal testosterone may help with HSDD because of the lower side effects and safety. When testosterone is administered transdermally, it is not metabolized by the liver and supplies a constant dose of testosterone. For these reasons transdermal testosterone is considered safer than other methods of delivery. (Feldhaus-Dahir, 2009) Still, the effects of testosterone therapy for women with HSDD are uncertain, because women who had relationship problems and depression were excluded from the study above, and the study sample was 34 women without medical diagnoses.

Antidepressant Therapy

Bupropion (Wellbutrin) has been shown to help 29% of women with low sexual desire after three months. Bupropion enhances noradrenergic and dopamine neurotransmission in the brain, and whether this affects low sexual desire directly or whether relief from a specific neurochemical type of depression leads to more sexual desire is unknown at this time. (Goldmeier, 2001) In a 2005 study, women who took bupropion “improved in sexual arousability and response but not in “desire” as in sexual thinking, fantasizing, and initial desire/interest for sex.” (Basson, 2005, p.298) Another potential antidepressant therapy for HSDD was flibanserin (Nappi, 2010), but in October 2010 development of the drug was discontinued.

Cognitive-Behavioral Therapy

Cognitive-behavioral therapy and sensate focus techniques (nonsexual to sexual touching, similar to systemic desensitization) are useful therapies for HSDD. (Basson, 2005) Cognitive-behavioral therapy has been used to successfully treat HSDD. One study used a group format cognitive-behavioral couple sex therapy program for treatment of female HSDD. In the group, couples had been together an average of 13 years, and the women in the study averaged six years of HSDD. Techniques focused on analysis of causal factors leading to HSDD, sexual information, intimacy exercises, sensate focus, communication skills, emotional communication skills, mutual reinforcement, cognitive restructuring, and sexual fantasy. (Trudel, 2001)

The treatment outcome for the cognitive-behavioral group format sex therapy in Trudel's article state that "74% of women were considered improved or cured at the end of treatment, and this proportion stabilized at 64% at three months and one year follow-up." This study found that:

Many dysfunctional, negative cognitions associated with sexual and marital functioning changed after treatment. For example, partners showed less sexual perfectionism, less rigidity in sexual roles, a more positive attitude toward sexuality, and a more positive and flexible conception of sexuality with fewer doubts about oneself and one's partner.

Subjects also showed fewer 'musts and shoulds' in their thinking style...They also demonstrated better information on sexuality and reported more frequent sexual fantasies. (Trudel, 2001, p. 159-160)

The techniques judged most useful by participants were sensate focus exercises and communication training. (Trudel, 2001)

Mindfulness

The mindfulness program created by Lori Brotto uses Buddhist principles to forge a

connection between the mind and the body. This program has been used successfully by women with various sexual disorders, including HSDD.

The first stage of the mindfulness program is to train women in the basics of mindfulness meditation, and returning thoughts to the present when distracting thoughts arise. After women have successfully practiced mindfulness meditation for some time, women are instructed on how to observe and examine their own body in nonsexual ways, and to reduce distracting thoughts during this examination that are judgments of their physical appearance, especially negative thoughts about their appearance during sex.

Women are then instructed in the next stage to repeat the previous body-focused step, but with a sexual focus. Finally, women are taught to connect emotional pleasure with physical arousal by using fantasy, vibrators, or erotica for about five minutes, then engaging in a mindfulness exercise to increase their ability to detect their own physical sensations. (Elton, 2010)

Why does this mindfulness method work well for women? Perhaps it is because:

...women find it arousing to think of themselves in lingerie or nude. Thinking of themselves as sexy boosts desire. 'Women have this sexual relationship with themselves that's integral to their sexual relationships, period,' Meana argues. Feeling good about themselves emotionally and physically appears to be a bigger mediator of women's desire than men's. (Elton, 2010, p. 76)

Conclusion

Female Hypoactive Desire Disorder is a multifaceted disorder that brings into play various cultural, physical, relationship and individual factors. Understanding how this condition arises and the goals and methods of treatment reach into the core of the paradox of long-term

relationships for women and how intimacy can be the enemy of desire. The disconnect between the body and mind of women is something we can remedy, and increasing those connections may benefit a women's sex life and other areas of her life as well.

As the poet Khalil Gibran wrote in *The Prophet*:

Let there be spaces in your togetherness, And let the winds of the heavens dance between you. Love one another but make not a bond of love: Let it rather be a moving sea between the shores of your souls. Fill each other's cup but drink not from one cup. Give one another of your bread but eat not from the same loaf. Sing and dance together and be joyous, but let each one of you be alone, Even as the strings of a lute are alone though they quiver with the same music. Give your hearts, but not into each other's keeping. For only the hand of Life can contain your hearts. And stand together, yet not too near together: For the pillars of the temple stand apart, And the oak tree and the cypress grow not in each other's shadow. (Gibran, 1923)

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