
Management of Hypoactive Sexual Desire Disorder

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Abstract

Epidemiological studies have found that problems with sexual desire are one of the most common sexual complaints in females. Such complaints are far less common in males. In women, problems with sexual desire have been found to be associated with age, relationship duration, relationship distress, and complaints of anxiety and depression. Evidence-based interventions include cognitive behavioral therapy and androgen therapy. Endocrinopathies are common causes of male problems with libido. There is minimal evidence available concerning the treatment of psychological etiologies of low sexual desire in men.

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Disorders of sexual desire are frequently encountered in psychiatric practice. These disorders may be part of the presentation of common psychiatric disorders such as depression and anxiety disorders, a drug side effect, secondary to relationship discord or idiopathic. Understanding the etiology of problems of low sexual desire is also complicated because of the interplay of biological, psychological and interpersonal influences. Because these disorders can have a multitude of etiologies, diagnosis is often complicated and most often imprecise. Because sexuality is such an important part of one's self-identity and plays a significant role in intimate relationships, low sexual desire can have a multitude of unfortunate consequences and obviously should be a focus of psychiatric interventions [1].

The goal of this chapter is to review current evidence concerning the diagnosis, epidemiology, etiology and treatment of hypoactive sexual desire disorders. Masters and Johnson [2] and the DSM-IV-TR [3] regard male and female sexual disorders as symmetrical. However, there appear to be sex differences in the strength of sexual desire, its covariates, its sequencing in the sexual response cycle, and its response to relationship

discord [4]. In this chapter, female disorders of desire will be considered separately from male disorders of desire as they may represent different diagnostic entities.

Female Hypoactive Sexual Desire Disorder

Diagnosis

Modern nomenclature for the sexual disorders can be traced to Masters and Johnson [2] who delineated premature ejaculation, ejaculatory incompetence, impotence, orgasmic dysfunction, vaginismus and dyspareunia. Except for vaginismus and dyspareunia, the sexual dysfunctions were linked to the phases of the sexual response cycle (excitement, plateau, orgasm). The sexual response cycle and those disorders of sexual response were considered to be analogous in both sexes. This diagnostic scheme was initially adopted by most mental health clinicians. As more clinicians gained experience in the treatment of sexual disorders, it became increasingly obvious that the major problem of many patients was the absence of desire for sexual activity, a concept not included in the Masters and Johnson diagnostic schema. Harold Lief and Helen Singer Kaplan, both psychoanalysts, introduced this concept of the diagnosis of inhibited sexual desire [5]. The first official nomenclature for the sexual disorders was published in the DSM in 1980. In this system, inhibited sexual desire was defined as persistent and pervasive inhibition of sexual desire. The text also indicated that the diagnosis would rarely be made unless the lack of desire was a source of distress to either the individual or partner. In DSM-III-R the term inhibited was deleted as this was felt to imply a psychodynamic etiology and the somewhat awkward term, hypoactive sexual desire was substituted for inhibited sexual desire. The definition was also slightly modified. The new definition was persistently, or recurrently deficient or absent sexual fantasies and desire for sexual activity. In this edition, the following subtype modifiers were introduced: psychogenic only or psychogenic and biogenic, lifelong or acquired, generalized or situational. In DSM-IV, the definition of hypoactive sexual desire remained unchanged except for a new provision that the diagnosis could not be made unless the disturbance caused marked distress or interpersonal difficulty. This definition remained unchanged in DSM-IV-TR.

Numerous individuals and groups have criticized the DSM-IV-TR criteria for sexual disorders. Major suggestions for revision have been made by an international consensus group funded by the American Urological Association. This group met on four occasions and has published a number of manuscripts detailing recommended changes [6]. This group specifically suggested that the criteria sets for hypoactive sexual desire disorder be modified. Data indicating that many sexually responsive women do not report sexual fantasies was cited as well as evidence that some sexually responsive women do not experience desire for sexual activity but respond to sexual stimuli once involved in a sexual situation. It was recommended that lack of responsive desire be substituted for absence of desire for sexual activity. This group also

noted evidence that interest in sexual activity appears to lessen both with age and relationship duration for many women. Basson [7] specifically states that the linear sequencing of desire, arousal, orgasm as outlined in DSM-IV-TR is a model better suited to male than female sexuality. She posits that many women are unaware of desire for sexual activity at the onset of sexual activity and that emotional intimacy may be the most important factor influencing a woman's initial sexual responsiveness. In this model, responsive desire and sexual arousal clearly overlap.

It should be noted that the DSM-IV-TR criteria and suggested revisions lack precise criteria sets designating severity or duration criteria. Also, the separation of sexual dysfunctions from relationship discord and adjustment disorders is imprecise. Many clinicians would not diagnose a sexual problem as a sexual dysfunction if it is clearly secondary to relationship discord. However, this is not clearly specified in the DSM-IV-TR text. Similarly, the distinction between an adjustment disorder influencing sexual function and a sexual dysfunction is not clearly specified. Precise operational criteria are necessary to define homogenous clinical groups for research and advancement of knowledge in the field.

Epidemiology

There have been numerous well-conducted epidemiological studies of the prevalence of sexual problems in the United States, Europe, and globally [8]. These studies have used differing criteria for identifying sexual problems, yet have produced somewhat similar results. Most studies have found that complaints of low desire are the most common female sexual complaint. Studies have also found that complaints of low sexual desire increase with age, relationship duration, number of small children, relationship discord and symptoms of anxiety and depression [9–11]. These studies have been criticized as not distinguishing between sexual problems (transient issues not requiring medical intervention) and sexual dysfunction (persistent, pervasive problems in adaptation requiring medical intervention).

The limitations of epidemiological data in providing estimates of the frequency of sexual dysfunction in the general population can be appreciated by a careful analysis of the most comprehensive studies to date, the Global Study of Sexual Attitudes and Behavior [8]. This study collected data from 27,500 men and women in 29 countries. Sampling techniques had to be modified for some countries such that comparisons of rates across countries is somewhat problematic. The question pertaining to low sexual desire was 'During the last 12 months have you ever experienced for a period of two months or more when you lacked interest in having sex?' If the answer was affirmative, the subject was then asked to rate its frequency as occasionally, sometimes or frequently. This study has been quoted as finding that approximately 33% of women in Canada and the United States complained of low sexual desire. However, this number represents an aggregate of all women reporting occasional, periodic and frequent problems with low libido. The number of women reporting frequent problems with libido was only 7.9%. A stratified population sample survey in the UK [12] found that