PROGRAM CE14 • RELEASE DATE: APRIL 20, 2011 • EXPIRATION DATE: APRIL 20, 2012
ESTIMATED TIME TO COMPLETE: 1.0 HOUR

# Hypoactive Sexual Desire Disorder in Women: An Evolving Understanding

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**STATEMENT OF NEED**

Many clinicians have little knowledge regarding female sexuality and its impact on a woman's overall health. Low sexual desire in women is a complex condition involving a variety of issues. Social and religious influences have often defined women, and genital mutilation continues to exist in some cultures. Low desire may be particularly high among women with certain medical diagnoses, and women often do not report low sexual desire because of shame, embarrassment, or a discomfort discussing sexual issues. Untreated desire disorders may have profound implications for a woman and her partner. Hypoactive sexual desire disorder (HSDD), defined as "the deficiency or absence of sexual fantasies and desire for sexual activity," causes "marked distress or interpersonal distress." HSDD is the most common sexual disorder in women, affecting up to 1 in 10 women in the United States. Concern about low sexual desire may be present in 30% to 40% of women. Clinicians involved in women's health and infertility should be familiar with the issues related to HSDD and its potential impact on a woman's well-being, as well as the treatment modalities available to address this disorder.

**TARGET AUDIENCE**

Nurses whose primary interest is women's health and infertility.

**LEARNING OBJECTIVES**

*After completing this activity, the reader should be able to:*

- Describe the growing understanding of female sexuality and the implications of low sexual desire in women on their overall health and well-being and interpersonal relationships
- Discuss the prevalence of low sexual disorder in women and its causes, including body shame, domesticity, and cultural, social, and religious influences
- Review the approaches to a comprehensive assessment of women with low sexual desire and the treatment modalities available today

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The high incidence of low sexual desire in women has caught the attention of mental health professionals who are seeking clarity about the etiology of this phenomenon. Low desire may be particularly high among women with a medical diagnosis, such as infertility, polycystic ovarian syndrome, or dyspareunia (pain during intercourse). Women may not report low sexual desire and avoidance of sex because of shame, embarrassment, or a discomfort discussing sexual issues.[1] Untreated desire disorders may have profound implications for a woman and her husband or partner.[2] Clinicians helping women may need to consider this issue, which can have implications on a woman's overall health and well-being, and when appropriate, consider the option of sex therapy or other avenues to explore sexual desire issues. This article reviews the current literature on low sexual desire in women, as well as the current psychotherapeutic interventions available to women with low desire.

There is an increasing awareness of the need for accurate assessment and treatment of low sexual desire in women. This article addresses the limitations of the current classification of hypoactive sexual desire disorder (HSDD) in the *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision* (*DSM-IV-TR*),[2] and proposes a different model for the assessment of women's low sexual desire. It also reviews the current literature on treating low sexual desire in women.

Throughout history, the experience of women has been misunderstood. Social, political, economic, and religious influences have often defined women and dictated what they want and should be experiencing. It is little wonder that women's sexuality has been the subject of speculation, exploitation, and pathologizing. For example, Freud promoted a valuative judgment about "mature" female orgasm, which has influenced concepts of normalcy, femininity, and pathology.[3] Genital mutilation continues to exist in some cultures, and the cosmetic and pharmaceutical industries are robust with business from women who have been acculturated to believe that they need to fix themselves.[4]

Clinicians dealing with women's health must question the cultural assumptions from which these premises are based. What is normal? How is a woman's sexual experience different from or similar to a man's experience? How do we learn about this disparity? And how do these issues affect women's well-being? All these issues serve to make the study of women's sexuality complex, difficult, and interesting.

### The Early Models of Female Sexuality

In the United States, research on human sexuality has historically focused on the experience of men.[5,6] In 1966, Masters and Johnson were the first investigators to systematically study the physiology of the human sexual response in men and women in the United States.[7] They described a 4-stage linear model of sexual behavior—excitement, arousal, plateau, and resolution (orgasm). This model presumed that an internal biological drive would propel the individual toward self or partner sexual stimulation, which would lead to orgasm. Moreover, Masters and Johnson looked for similarities in the sexual response between genders. In 1979, Kaplan added the integral concept of "desire" to the physiologic model of Masters and Johnson.[8] Kaplan recognized that the mind and body were intertwined with physiologic sexual responses.[8]

In both linear models, however, experts assumed the male and female sexual response cycle as identical.

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Future theorists have considered the more complex nature of women's subjective sexual experience; moreover, questions about the role of motivation in determining women's sexual behavior have emerged, and these broadened the understanding of the female sexual experience.[9,10]

Basson recognized the differences between genders in the sexual response and identified the need for intimacy as a motivator of sexual behavior in women.[9] This is a significant departure from the aforementioned linear models. Thus, female sexual desire is viewed as a process that is responsive rather than biologically driven. Often, the motivation for sexual intimacy in a partnered relationship is related to the desire for emotional closeness rather than a biological hunger for sex. The emphasis in Basson's conceptualization is on the woman's "willingness" to become aroused.[1] Multiple factors may facilitate arousability, she says, "including feeling desired rather than feeling used, feeling accepted by the partner, the partner's behavior, and the woman's body image and mood."[1]

### Hypoactive Sexual Desire Disorder

The *DSM-IV-TR* classifies HSDD as "the deficiency or absence of sexual fantasies and desire for sexual activity," which causes "marked distress or interpersonal distress."[2] This disorder may be lifelong or acquired, generalized or situational.

HSDD is the most common sexual disorder in women,[11] affecting up to 1 in 10 women in the United States.[12] Moreover, concern about low sexual desire may be present in 30% to 40% of women, according to Basson.[1] The important issue that arises from this emerging body of research is the reality that the range of sexual desire is extremely inconsistent for women; thus, some women with low desire may actually fall within a wide range of normal variability.

A 1998 International Consensus Committee meeting expanded upon the *DSM-IV-TR*'s definition of HSDD to propose the concept of receptivity in its provisional definition.[13] It defines HSDD as the "persistent or recurrent deficiency (or absence) of sexual fantasies, thoughts and/or desire for or receptivity to, sexual activity, which causes personal distress."[9] This revision appears to more accurately describe the range of "normalcy" with respect to sexual desire in women.

The disparity between women's physiologic arousal and the subjective experience of their arousal has been an area of recent investigation.[9,14-16] In 2003, changes to the *DSM-IV-TR* were recommended that would include a woman's subjective experience of being arousable as the marker for identifying a disorder, rather than a physiologic response alone. Thus, if a woman is not distressed about her lack of arousability, she would not be classified as having a disorder.[17] In addition, orgasm would not be essential to a woman's subjective experience of sexual satisfaction.[9]

In 2000, a group of feminist scholars, therapists, and researchers convened, resulting in the "new view" campaign of women's sexuality.[18] They proposed new classifications for women's sexual problems, suggesting that female sexual problems are influenced by, or are associated with, several factors, including:

- Sociocultural, political, or economic components
- Partner and relationship factors
- Psychological aspects
- Medical conditions.

This model contextualizes women's sexuality in a much broader perspective than what was initially proposed by earlier theorists, and provides more accurate and specific information to guide in the assessment and treatment of women's sexual disorders.

### Low Sexual Desire in Women

Toates examined the role of inhibition in attenuating the sexual behavior of women.[19] Inhibition can prevent sexual desire or sexual behavior, and can be caused by myriad factors, including aversion, conflict, relational factors, and medical or psychological issues. Hertlein and colleagues proposed an "intersystemic model" to reflect their understanding and assessment of HSDD, which combines individual, interactional, and intergenerational factors.[20,21] This comprehensive paradigm recognizes the historical, psychological, and relational influences that contribute to a woman's sexual identity and ability for sexual responsiveness.

The roles of "body shame" and self-consciousness diminish a woman's ability to enjoy partner-related sexual activity[22]; in a small yet provocative recent study, women were able to identify multiple factors that significantly contributed to their diminishing desire.[10] The issue of domesticity was thematic in reducing the wish for sexual intimacy. It appeared difficult to be "turned on" by a person with whom one pays the bills, cares for children, and is overly familiar.[10] Messages internalized from one's culture are very influential in determining the acceptability of certain sexual behaviors in women.[23]

### Assessment of Low Sexual Desire

In addition to the diagnostic criteria for HSDD,[2] a comprehensive assessment of HSDD would have to include a woman's sexual experience within the context of her life.[24] Assessment of HSDD should therefore include[24]:

1. Family and early developmental histories, including information about gender influences, exposure to sexual themes, and sexual experiences and trauma
2. A complete psychological history to identify other axis I and II disorders (ie, coexisting mood or personality disorders), as well as a medical history to identify biological or medication influences on desire, arousal, and orgasm
3. History of the presenting problem, and information about ways in which it may have changed over time, or with different partners
4. Beliefs and cognitions about sex, intimacy, identity, and power/lack of power within her relationships
5. Sexual history, including sexual experiences and preferences
6. A review of her current relationship, if applicable, including conscious and unconscious emotional patterns, negotiations, beliefs, and agreements; look for a history of affairs or emotional disloyalty.

In addition, the issues of balance of power, emotional safety, openness, and acceptance should be explored as part of a comprehensive assessment. Basson suggests assessing the quality of the sexual interaction, as well as the thoughts that occur during the sexual interaction.[1] Cognitive distractions or preoccupations with antisexual thoughts could impair a woman's sexual experience.

### Approaches to Treatment

Discussion of low sexual desire in women must presuppose that there is much that we do not yet understand, and any therapeutic model should only serve as a starting point from which to launch a treatment plan for the individual or the partners. During the assessment, the clinician collates information about life experiences that serve as pearls of insight for constructing a treatment strategy.

#### *Sex Therapy*

In the context of sex therapy, the therapist incorporates the individual experiences of each partner and notes their interactions (if partnered). Sorting out the jigsaw puzzle that comprises any relationship is always the task of therapy. Each partner brings her/his story to the relationship, and the relationship, of course, has its own story as well.

A woman's sexual self is, in many ways, consistent with her identity; therefore, an intimate exploration of her history vis-à-vis identity formation is a useful guide in treatment. Because self-objectification may have obscured her ability to know herself accurately, cultivating healthy boundaries is one way to gain clarity and perspective about her experience as a sexual being.[21]

The therapist or the clinician must challenge the woman's limiting assumptions about the self and her relational possibilities. Resolving past issues of abuse, trauma, parentification, or exploitation can provide release from an identity of "victim" or sense of powerlessness. The clinician can help the patient to become responsible for her own sensual experience and to give up self-imposed limitations.

In a survey assessing what was considered the greatest sexual "turn on" for women, Ogden found that 4 of 5 women said it was "love."[25] In this same survey, many male respondents similarly described themselves as wanting connection, feelings, and meaning in their sexual relating.[25]

Ultimately, a major goal for successful treatment of HSDD is to help the woman understand and develop her authentic sexual identity and to choose partners with whom she would be fully permitted to experience it. The "intersystems model" mentioned earlier views HSDD as a relational issue.[20] There is no "identified patient," and the treatment addresses the complex individual, intergenerational, and interpersonal issues that collectively have an impact on the relating of the system that is the couple.[21]

#### *The Partner Component*

This treatment approach will help partners to recognize feelings and thoughts as they relate to one another, as well as increase their capacity for effective communication. In addition, ongoing discussions with a professional sex therapist will dispel myths and misinformation about sexuality and increase comfort with an expanded repertoire of sexual activity.

Perel identifies the difficulty of melding the domestic with the erotic in long-term relationships.[23,26] As a couple becomes overly familiar, they lose the mystery and lack of predictability that once facilitated sexual excitement. In this model of treatment, the therapist explores each individual's background and its impact on sexuality. Previously held yet unconscious limiting beliefs, assumptions, and inhibitions are illuminated. The partners are helped to see how they enact such irrational beliefs in the shared space of the relationship.

The therapist challenges these assumptions and supports the removal

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of self-imposed prohibitions, promoting new and different opportunities for intimate sexual relating. Perel states that "the rules for desire are not the same as the rules for good citizenship."[25] Each individual is encouraged to explore the fantasy and eroticism that may exist in the quiet recesses of a mind wrapped in a blanket of taboo. The couple is encouraged to explore these fantasies and permit flexibility in their relational dynamics to promote a new eroticism in their relationship.

***Mindfulness Cognitive-Behavioral Therapy***

Mindfulness-based cognitive-behavioral therapy is a means for facilitating body awareness and changing negative automatic thoughts about the self or about sexual activity.[27] Theoretically, this approach could result in changes in sexual behavior, because negative thoughts about sex or body image are repeatedly replaced with more positive cognitions. Mindfulness may also permit a woman to become more aware of her physiologic arousal, thereby facilitating integration with her cognitive and affective experiences.[28] Often, mindfulness and other sensually focused homework exercises are recommended for the woman and her partner.[29] The work of therapy requires a commitment to cognitive and behavioral change, something that is reinforced outside of the office setting.

### Conclusion

Low sexual desire in women is a complex condition involving a variety of issues. Current classifications for diagnosing HSDD fail to consider the larger context in which sexuality is experienced. Furthermore, this condition is extremely common in women; therefore, a reconceptualization of what constitutes a disorder of desire is prudent. This process has ignited a movement toward a more accurate description of the broad range of female sexuality, allowing for its variability and difference from men's sexual functioning.

This will assist clinicians in better treatment of women's sexual difficulties, without being constrained by the ongoing debate over what constitutes a female sexual disorder.

Regardless of the classification debate, there is an increasing interest in treatment of women with HSDD; furthermore, sexuality experts have identified exciting possibilities for successful treatment of women and their partners. Newer approaches to treatment recognize the many forces that comprise a woman's sexual identity, such as her culture, family of origin, psychological issues, personality, and life experiences. All these factors contribute to our understanding of how she sees herself as a sexual being and as a sexual partner. Furthermore, depathologizing women's low sexual desire permits a more accurate portrayal of women's sexuality as fluid, responsive, and contextual. Successful treatment of HSDD will only be possible when this rich context is acknowledged. ■

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COMMENTARY

# Female Sexual Health: Breaking the Silence in Provider–Client Interactions

By Margaret-Rose Agostino, DNP, MSW, RN-BC, IBCLC, Assistant Professor, Delaware State University, Dover

The age-old adage, "Ask me no questions, and I'll tell you no lies" could very well be applied to the lack of discourse between providers and their adult female patients regarding sexual health (ie, sexual functioning). Time constraints of the proverbial 15 minutes of reimbursed time per contact compound the issue. Providers are left with the quandary of starting a very sensitive discussion and not having enough time to provide the safe environment of conducting this discussion in the privacy of the office versus in the examination room, nor the resources to refer the patient if a problem is identified.

Our society claims to be sophisticated regarding sexual freedom, yet the subject of female sexual functioning or sexual health is still viewed as "private" and "taboo" on an individual basis. How do women know what is normal and healthy regarding their sexuality? The classic groundbreaking work of Masters and Johnson in the 1960s did much to dispel the myths regarding female sexual function, yet here we are more than 40 years later, and a clear definition of "normal" remains elusive.

Richard Balon,[1] as well as the present article by Pamela Fawcett Pressman and Nancy Gambescia, provide insight into the lack of clarity that still exists in the *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision* regarding this topic, and the need to more clearly define not only what is normal but also the variances that cause distress for women.

But what is normal? Does the preponderance of sex-laden reality series and sitcoms on television provide a realistic portrayal of women and normal sexual functioning? We are also bombarded with commercials for products dealing with everything from birth control to urinary incontinence. Often these commercials portray conditions that should be discussed with a healthcare provider as part of normal aging; instead, their message is to use an "X, Y, or Z" product and "get on with your active life." The popularity of the television shows by Dr Oz and Dr Phil suggest that the public is hungry for accurate information from a credible source regarding their "whole health," including those "private issues" that many cultures still view as taboo for individual discussion.

The burden of breaking this silence clearly falls on the provider. Sexuality experts Kingsberg and Althof suggest that although data indicate a high prevalence of female sexual disorders, including hypoactive sexual desire disorder, few providers include even a brief screening of sexual health on a routine basis.[2] Kingsberg and Althof further suggest that even with the time constraints of today's provider, a brief assessment can be linked to the assessment of the woman's current reproductive stage.[2] When these screenings are practiced universally with all female patients, screening becomes normative, and the burden of revealing an area of dysfunction shifts away from the patient to the provider.

Depending on the cultural and religious upbringing, some women may still hold to the belief that the plight of women should be borne in silence, so as not to live with shame. An informed, culturally competent approach, which is individualized to the presenting patient, provides the opportunity to break the silence surrounding female sexual health. ■

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