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Hypoactive Sexual Desire Disorder: Understanding the Impact on Midlife Women

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The lack of sexual desire in women not only may cause distress but can have negative effects on personal relationships, quality of life, and general health status. Clinicians need to understand the implications and address the concerns of their patients.

Hypoactive sexual desire disorder (HSDD) is the most prevalent sexual disorder for women of all ages, but it is also one of the most difficult to address. Prevalence rates vary among studies due to differences in definition of hypoactive desire, methods of data collection, age-group studied, and other defined criteria as the reason for such discrepancies.[1,2] Segraves and Woodard suggest that the prevalence of HSDD varies between 5.4% and 13.6%.[2] West et al reported an 8.3% prevalence of HSDD.[3] And, the PRESIDE (Prevalence of Female Sexual Problems Associated with Distress and Determinants of Treatment Seeking) study reported 8.9% of women ages 18 to 44, 12.3% ages 45 to 64, and 7.4% ages 65 and older had HSDD.[4]

In the *Diagnostic and Statistical Manual of Mental Disorders* (4th Edition, Text Revision), HSDD is defined as "a deficiency or absence of sexual fantasies and desire for sexual activity. The disturbance must cause marked distress or interpersonal difficulty."[5] Critical to a diagnosis is the subjective judgment of the health care provider. "The diagnosis must rely on clinical judgment based on the individual's characteristics, the interpersonal determinants, the life context, and the cultural setting."[5]

Midlife women with HSDD typically express a loss or major decline in sexual thoughts, a decline in interest in initiating relations, and a decline in being receptive to a partner's initiation. There are also, however, women who have had lifelong HSDD, and although they do not report a loss of desire, they may be just as distressed or bothered by the absence of desire. They desire to desire.

DIFFERENTIATING HSDD FROM NORMAL FLUCTUATIONS IN SEXUAL DESIRE

In order to determine what is abnormal or dysfunctional, it is helpful to understand what is "normal." It may not be particularly helpful to the clinician to use a statistical norm to determine what is considered low sexual desire. For example, basing "normal" on the average frequency of sexual activity for an American couple may not be appropriate or useful. Even basing normal on the appropriate endpoint of average frequency of desire (as opposed to the often-used endpoint of sexual activity) is not necessarily accurate.

Each woman will have her own definition of what is normal sexual desire based on her culture, her background, and sexual experi-

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ences, as well as on her own biologic drive. Most women will also have some day-to-day variability in sexual interest based on stressors, other life events, and neuroendocrine functions. In addition to expecting day-to-day variability, interest in sex tends to gradually decline over the life span.

The intensity of sexual desire a woman experiences may decline as she ages. Often, these changes are attributed to increasing demands on a woman's time as she gets older (eg, family, career) or the cultural message that older women are no longer sexual beings. Neuroendocrine changes (eg, declining testosterone, changes in neurochemistry, indirect changes from loss of estrogen and resulting vulvovaginal atrophy) may contribute to a declining interest in sex.

In addition to the lack of consensus about what is "normal" desire, female sexual response is variable, with no empirical data to support one theoretical model over another. It may be helpful to understand the prevailing theoretical models used to understand a woman's sexual response. The conceptualization of female sexual response has evolved over time.

The first model, proposed by Masters and Johnson in the mid-1960s, suggests a linear trajectory that is invariant for both males and females.[6] It incorporates a 4-stage process:

- Excitement (psychophysiologic interest and arousal)
- Plateau (reflecting the peak of sexual arousal)
- Orgasm
- Resolution (when the body returns to an unstimulated state).

The second model, Kaplan's tripartite structure proposed in the 1970s, is also linear but emphasizes the importance of the cognitive aspect of desire in contrast to physiologic arousal.[7]

Then, in the late 1990s, Basson developed a nonlinear model of female sexual response that integrates emotional intimacy, sexual stimuli, and relationship satisfaction and takes into account the many reasons women initiate or are receptive to a sexual encounter. Women may enter into sexual activity to increase emotional closeness and commitment, for example, without having had previous desire or thoughts about sexual activities.[8] This decision leads to a willingness to focus on sexual stimulation that is processed in her mind and influenced by various biologic and psychologic factors. Continued stimulation produces increased intensive sexual excitement that produces sexual desire.

RISK FACTORS ASSOCIATED WITH HSDD

In 2008, West et al found that the highest rates of distress about low sexual desire were reported by recently surgically menopausal women, which may be an adjustment to their sudden hormonal changes.[3] Similarly, the Women's International Study of Health and Sexuality (WISHeS) noted that while the prevalence of low desire with distress was 9% for naturally menopausal women, the prevalence in younger (ages 20-49) surgically menopausal women was 26%.[9] Clinicians should discuss sexual concerns when treating women who have recently undergone bilateral oophorectomy.

Two studies by Hayes et al provide information about risk factors:

- A 2007 study of the relationship between HSDD and aging found that the proportion of women reporting low sexual desire increased with age, but the proportion of women reporting distress about their low desire decreased with age, resulting in a relatively constant prevalence for HSDD over time.[10]
- A 2008 publication found that relationship factors were probably the most important risk factor overall—more important than age or menopause status. Low sexual desire was reported more often in women in stable, long-term relationships (20-29 years).[11] In addition, they found that sexual distress was positively associated with depression and inversely associated with better communication of sexual needs.

A woman's medical history can also influence her risk for HSDD. Evidence indicates that certain organic diseases and physical conditions, including breast cancer, pregnancy, diabetes, depression, urinary incontinence, autoimmune disorders, and multiple sclerosis, are associated with HSDD.[12] Assuming that a woman's medical condition per se is the dominant factor, however, is often not correct. For instance, depression is the major factor determining whether women with multiple sclerosis, renal failure, or diabetes have sexual dysfunction.[13]

THE IMPACT OF HSDD

For some midlife women, decline in sexual desire over time may be modest and therefore not a major problem for her overall sense of sexuality and life satisfaction. They therefore do not meet the criteria for a diagnosis of HSDD. However, some women are extremely distressed that their sexual desire is diminished greatly or gone completely. Only a few studies have attempted to systematically characterize the psychologic and emotional impact of HSDD.

The DESIRE (Desire and its Effects on Female Sexuality Including Relationships) study revealed that women distressed about low sexual desire also experienced negative emotional states associated with their low desire.[14] The WISHeS study indicated that women with HSDD experienced large and statistically significant declines in health status, particularly in mental health, social functioning, vitality, and emotional role fulfillment.[9] Biddle et al systematically described that women with HSDD experience greater health burdens, including more comorbid medical conditions, and were nearly twice as likely to report fatigue, depression, memory problems, back pain, and lower quality of life (QOL).[15]

Despite the small number of studies, however, we now have compelling epidemiologic data indicating that HSDD is highly prevalent and is a great burden on health and QOL. Other large-scale surveys, in comparison, have demonstrated that sexual satisfaction in women is associated with general well-being.[16-18]

IMPLICATIONS FOR CLINICAL PRACTICE

Treatment options for HSDD vary, depending on which components of desire are compromised (eg, biologic mediators of drive vs relationship conflict, or both). If the primary factor is psychologic or interpersonal, then sex therapy or psychotherapy would typically be the treatment of choice (either individual or couples). In contrast, a pharmacologic option might be the first-line treatment for women whose primary source of HSDD is physiologic—conditions that have developed as a result of the condition.

There is currently no FDA-approved pharmacologic treatment for HSDD. Many clinicians, however, prescribe testosterone off-label and monitor side effects. The antidepressant bupropion is also sometimes used off-label for the treatment of HSDD; it was shown in one trial to have a mild to moderate effect on promoting sexual response.[19] The drug is also prescribed to treat the sexual side effects of selective serotonin reuptake inhibitors.

Although sexual problems are common to women of all ages, they are underdiagnosed and undertreated.[20] A lack of patient-physician awareness of the high prevalence of sexual problems, inadequate training in sexual medicine, fear of time constraints, poor reimbursement, perception of lack of available treatments, and difficulties with communication have all been cited as major reasons underlying the failure to identify female sexual disorders.[20] The most relevant barrier, however, is that addressing sexual concerns and QOL is not seen as high a priority as other medical issues. We now have data to refute this misperception, and clinicians can no longer plead ignorance about the health burdens of HSDD. Without proper recognition of these sexual problems, women remain untreated and at higher risk for adverse consequences in their personal relationships, QOL, and general health status.

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