

HYPOACTIVE SEXUAL DESIRE

Hypoactive sexual desire, (HSD) is the commonest sexual dysfunction in women and increasingly recognized in men too. 30-55% of women and 20% of men in the general population complain of reduced sexual desire but over 50% of couples attending the clinic have this problem or at least a problematical discrepancy in the level of their sexual desire.

Clearly a major problem is in defining what normal sexual desire is. True libido varies from individual to individual probably following a normal distribution curve. Furthermore a person's libido will vary according to his or her psychological and physical wellbeing, the level of attraction for their sexual partner, the stage in the relationship and the presence or absence of co-existing sexual dysfunction. A desire disorder may not be a problem to the individual but only in the context of a sexual relationship; indeed patients are often prompted to seek treatment by their partner and may find difficulty in gaining sufficient motivation to change what they see as their "normal" behaviour. There is a difference between libido, meaning a background level of sexual interest and desire, and sexual motivation which may be reduced even in a person with normal libido. This can also be described as generalised or specific sexual desire. Recently there has been a realisation that many women in long term relationships experience little or no spontaneous desire until the onset of sexual arousal; this leads to positive reinforcement should sex occur but a long wait if hoping for a sudden resurgence of lustful sexual desire.

Sexual desire begins in puberty with the increasing excretion of sex hormones from the developing testes and ovaries. People whose testes or ovaries are damaged by injury, disease or surgery will often have little or no sexual interest. In boys, high levels of circulating testosterone peak between the ages of 18-25; this is associated with high sexual drive, sexual curiosity and a desire to seek out and pursue potential sexual partners. In girls the onset of the menstrual cycle indicates sufficient levels of hormones to cause a rapid rise in sexual interest and curiosity. In both sexes, fluctuation in sex hormone levels will lead to a concomitant change in libido. Women know well the change in levels of desire and sexual responsiveness that occur at different times in their menstrual cycle, with pregnancy, lactation and menopause. In men, testosterone levels can vary over quite a large range, (8-35 mmol/L) and correlate poorly with levels of sexual interest until they fall into the hypogonadal range. Increased sexual activity may increase levels of sex hormones and men often notice increased beard growth during periods of high sexual activity; conversely when in poor health or during periods of celibacy, levels may fall reducing libido. A surprising fact to many people is that both men and women tend to masturbate more frequently when enjoying an active sex life with their partner than when they are not having much sex. Testosterone can also have a sensitizing effect on the genitals of both sexes making them more responsive to sexual stimulation.

Adrenaline in small amounts will increase sexual motivation and confidence but in larger amounts such as those released in a state of fear, anxiety or stress, sexual desire and motivation evaporate rapidly. Another brain chemical, *dopamine* begins the sexual arousal process and increases sexual motivation. This chemical is antagonized by *prolactin* which is released in a breast feeding woman and explains her relative

INTEGRATED SEXUAL HEALTH

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lack of sexual interest. *Oxytocin* is also released during breast feeding and is thought to help with bonding; it is also released during physical touching, foreplay and arousal helping a couple feel closer emotionally when they are physically intimate.

Reduced libido can occur in up to 90% of people suffering with depression and many with anxiety disorders. Some people, particularly younger men can develop compulsive sexual behaviour which can reach an addictive level. "Sexual Addiction" is increasingly described and can be similarly destructive to the relationship. The benefits of such increased levels of sexual activity seem to be both biological and psychological. Orgasm brings about a surge in *serotonin* and *endorphins* which are known as the brain's "feel-good" chemicals; their release might give a temporary respite from chemical imbalance thought to be behind such psychological conditions. The overwhelming sense of wellbeing and the psychological afterglow of sexual intimacy may lift his feeling of hopelessness and lowered self-esteem

Sexual function and interest can be seen as a barometer for psychological and physical wellbeing. Whilst it might be true that it is not normal to feel "sexy" when unwell or in pain, it is important when assessing a person with desire disorder to exclude medical disease through careful history taking, examination and investigations. It is particularly helpful to see the patient with their sexual partner who may well have a clearer insight into the chronology of the condition as well as its impact on the relationship. Attitudes to sexuality derived from upbringing, cultural or religious beliefs will also colour a person's perception of their problem. A history of similar problems in previous relationships may indicate difficulty in allowing emotional intimacy which becomes increasingly important as the early passionate stage of a relationship inevitably declines.

Sexual preferences such as suppressed homosexuality, bisexuality or gender uncertainty can present as a problem with sexual desire but is not as common as many assume.

Many drugs are associated with reduced libido, most are cerebral depressants and there is considerable overlap with those effecting arousal. The most common culprits are antidepressants, opiate analgesics and drugs used to lower high blood pressure. Alcohol and other recreational drug use can cause increased libido at low levels due to disinhibition, but with heavier use, sexual interest and function progressively declines.

Treatment of hypoactive desire disorder begins with correction of hormonal abnormalities, alteration of drug regimes where possible, and attention to lifestyle factors. Illness should obviously be treated where possible; depression can commonly present with low libido and its treatment is an urgent priority. Aphrodisiacs remain the "holy grail" for the pharmaceutical industry and although many people would prefer a "quick fix," treatment often requires wholesale changes in lifestyle, attitudes and relationships. It can be difficult to get motivated to change particularly where the problem has been longstanding; considerable defence / avoidance mechanisms may have developed which may have to be progressively challenged and broken down using a cognitive behavioural approach, (CBT.) Similarly negative attitudes towards body image, sexuality in general or the sexual partner can be targeted using CBT. Improvements in physical fitness, diet and work pressure will all help to improve a zest for sex and life in general.

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Couples counselling begins with education about sexuality in the context of the relationship. Open communication is encouraged with each noticing and listening to one another more; the couple must talk about their needs, their turn-ons and turn-offs in a non-accusatory fashion. The person suffering low libido should allow themselves to think more sexually, and to try using more sexual fantasy with masturbation. For the couple: non-sexual touching such as hugging, hand-holding and massage is encouraged often with agreement that the couple will not progress to sex for a period of time. This helps break down the “pursuer-distancer cycle” where the lower sexed partner feels pursued or criticized for their lack of sexual drive which can further lower self esteem and confidence. A couple need to find time to be alone which is easier said than done in a busy household with work and family commitments. They also need to understand that sexual desire needs encouragement and may not be an inevitable part of being in an intimate relationship.

Desire discrepancy can be the “drip of acid” on a relationship. A low libido leads to a lack of sexual fulfillment for the sufferer and their partner. HSD may be an indicator of important medical or psychological disease and it is therefore essential to seek a thorough and holistic assessment. Many treatments are now available from hormone supplementation and lifestyle changes to individual and relationship counseling.