Chapter 1

Introduction and Overview

Clinical Perspectives on and Treatment for Sexual Desire Disorders

Sandra R. Leiblum

Sexual desire is the most elusive of passions. While easily ignited in a new relationship or a forbidden encounter, it can also be readily extinguished. Anxiety, hostility, bad memories, or frightening flashbacks can thwart it—even something as simple as the sound of a door opening or a child crying. And yet, when aroused by an image or scent or fantasy or person, it can feel powerfully intense, driven, lively, and life-affirming. Interest in and concerns about absent or diminished desire have never, perhaps, been greater.

Historically, sexual desire has rarely been viewed from a neutral or disinterested stance. Attempts have always been made either to stimulate libido—whether through perfumes, potions, prostitutes, or pictures—or to stifle it. Whereas in previous decades, sexual complaints may have centered on "performance"—erectile or orgasmic problems—in the recent past, concerns about sexual *desire* have become paramount. There are several reasons for this.

An active and satisfying sexual life is widely regarded not only as desirable but as a sign of emotional and physical health. When desire

ebbs, intimate connections seem to diminish as well. Many sexually apathetic individuals worry that their partners will look elsewhere for sexual stimulation or gratification. There is no shortage of technological options for satisfying sexual curiosity and piquing sexual arousal. The availability of pro-erection drugs, arousal creams and gels, vibrators and massage oils provides frequent reminders that sex can and should be part of life. The sexually disinterested person is made to feel deficient, dissatisfied, or dysfunctional. This pressure to conform to current norms has led a growing group of women and men to believe that if they no longer experience sexual interest or desire, something is wrong with *them* rather than with their expectations or with their partner or with society's (and the media's) ever-constant preoccupation with sex.

WHAT IS SEXUAL DESIRE?

For most people, the concept of sexual desire conjures up visions of an energizing force that motivates one to seek out or initiate genital expression and relief. Like hunger or thirst, the so-called sexual "drive" has been regarded traditionally as an instinctive, spontaneous, and insistent source of sexual motivation. It was believed to dwell within the individual and to be biologically based. Linked to this idea is the antiquated belief that if the so-called sexual drive is not permitted free expression, it will seek an outlet through other means. The "drive reduction" model of sexual desire reached its acme with Freud's (1962) libido theory. This view asserted that the primary goal of sexual expression is to relieve libidinal tension and to restore emotional equilibrium. It suggests that sexual desire is endogenous and inevitable: everyone has it, albeit in varying amounts and to various degrees. From a traditional analytic perspective, a lack of desire results from the active repression or inhibition of the spontaneous urge for sexual contact as a result of internal conflict or ambivalence.

Current thinking challenges this view in many instances, even questioning the importance of a biological basis for libido. While the androgens, particularly testosterone, are widely credited in both the professional and popular press as the hormone responsible for libido, many sexual theorists now suggest that relational, cognitive, motivational, and evaluative factors play a more significant role. In young hypogonadal men, testosterone is usually recommended for enhancing quality of life. But there has been greater controversy about the

use of androgens for triggering libido in men with late-onset hypogonadism, principally because other conditions may be responsible for diminished sexual desire, for example diabetes mellitus, hyperprolactinemia, metabolic syndrome, or a host of medications (Wang et al., 2009).

In women, recent research has found that the correlation between testosterone (however measured) and various parameters of sexual behavior is far from clear (Davis, Davison, Donath, & Bell, 2005). While there are several good studies supporting the use of androgen supplementation for increasing desire both in natural and in surgically post-menopausal women (Shifren et al., 2000; Buster et al., 2004; Simon et al., 2005), there is also sound research questioning the significance of serum levels of androgen in motivating sexual behavior (Davis et al., 2005). Given that androgen levels are extremely low in women and difficult to measure precisely, the role of androgens in female sexual drive is hotly debated. At this time, there are no testosterone products approved by the Food and Drug Administration (FDA) that are available for women in the United States, although such products are available for men. While it is beyond the scope of this chapter to review the ongoing controversy surrounding the role of testosterone in stimulating libido, many of the authors in the chapters that follow address this issue in more detail. In particular, Korda, Goldstein, and Goldstein (Chapter 12) discuss the successful use of androgenic therapy in their treatment of a young woman presenting with a chronic lack of both desire and arousal. Basson (Chapter 8) presents a more cautionary view of the conclusions that may be drawn from the current research on androgens and sexuality.

Certainly, a serious flaw in the "drive" theory of desire is the erroneous belief that the internal or spontaneous experience of desire is not only ubiquitous but a necessary prerequisite to the experience of sexual arousal. In fact, several sex researchers persuasively argue the opposite, namely, that desire is more often secondary to arousal. It is the awareness of arousal, whether genital or subjective, that is basic in both triggering and maintaining sexual desire. This position has been eloquently articulated and described by Basson (2001) in her reformulation of the sexual response cycle, although many theorists prior to Basson emphasized the importance of arousability and external motivation as triggers for sexual desire (Beach, 1956; Whalen, 1966).

Finally, there is a growing awareness of *asexuality*, or the absence

of sexual desire or interest, as a normative and legitimate life style and sexual orientation for some women and some men (Bogaert, 2004, 2006). A 1977 paper by Johnson entitled "Asexual and Autoerotic Women: Two Invisible Groups," defined asexuals as those men and women "who, regardless of physical or emotional condition, actual sexual history, and marital status or ideological orientation, *prefer* not to engage in sexual activity." Johnson (1977) contrasted autoerotic women with asexual women: the latter are said to have no sexual desires at all, whereas the "autoerotic woman … recognizes such desires but prefers to satisfy them alone." Johnson's evidence is quite tenuous, consisting mostly of letters to the editors of women's magazines. However, her theorizing concerning asexuality as a distinct sexual orientation received support from analysis of a provocative question included as part of a large-scale survey of more than 18,000 British men and women that was conducted in 2004. A professor at Brock University in Canada, Anthony Bogaert, examined their answers to a question regarding sexual attraction to others, one of whose choices was "I have never felt attracted to anyone at all." He found that about 1% of the respondents reported having no sexual attraction to anyone. While it is unclear whether asexuality represents a distinct sexual orientation, like homosexuality or heterosexuality, or whether it simply represents a variant of hypoactive sexual desire disorder, it is interesting that an online community has developed around the legitimacy of asexuality as a normal lifestyle of healthy but sexually disinterested individuals. There is even an online community and support organization, the *Asexual Visibility and Education Network (AVEN)*, founded in 2001 with two primary goals: to create public acceptance and discussion of asexuality and to facilitate the growth of an asexual community.

The authors of the chapters that follow provide many definitions and theories of sexual desire, its wellsprings, and its mutations. Despite the passage of more than 20 years, a definition of sexual desire presented in the 1988 edition of *Sexual Desire Disorders* (Leiblum & Rosen) still makes some intuitive sense—namely, a view of desire as a subjective and motivating feeling state triggered by both internal and external cues, which may or may not result in overt sexual behavior. Adequate neuroendocrine function seem to be essential for this feeling state to occur, along with exposure to sufficiently intense sexual stimuli, cues, and motives or incentives. These arise from sources within the individual (a stimulating fantasy, a decision or wish to please a partner, an awareness of genital vasocongestion) but also from the

environment—sexy words and provocative touch over a candlelit dinner; a photo of a restrained woman in 6-inch heels and little else; a man in tight briefs with a silky whip. Furthermore, sexual desire appears to be readily conditioned and "scripted" to socially sanctioned as well as to socially proscribed cues. Not surprisingly, in light of this last observation, we are now seeing an ever-increasing number of men and women who have been labeled as sex "addicts" for their obsessive and, at times, compulsive pursuit of both conventional and unconventional sex. It is interesting that concerns about excessive sexual interest (*hypersexual* desire) have now joined the litany of sexual complaints presented to sex therapists.

Finally, it must be acknowledged that the motivations or incentives to either initiate or respond to a sexual invitation or overture are quite varied. In a clever and provocative research study conducted by Meston and Buss (2007), 237 possible reasons for having sex were collected. These ranged from the spiritual ("I wanted to get closer to God") to the instrumental ("I wanted to experience physical pleasure"). A large sample of undergraduates (N = 1,549) were asked to evaluate the degree to which each of the 237 reasons led them to have sexual intercourse. Using factor analysis, four main factors and 13 subfactors emerged: *Physical* (stress reduction, pleasure, physical desirability, and experience seeking), *Goal attainment* (resources, social status, revenge, and utilitarian), and *Emotional* reasons (love and commitment and emotional expression). The three *Insecurity* subfactors were elevation of self-esteem, duty/pressure, and mate guarding.

Past research has repeatedly demonstrated that desire, arousal, and the presence or absence of sexual behavior do not always coincide in women. In 2003, Weijmar Schultz and Van de Wiel observed that despite reports of negative genital sensations, pain, and diminished desire from women who had undergone cervical cancer, these women were statistically no different in terms of frequency and motivation for sexual interaction from an age-matched control group. These authors wondered if women's "love ethos" made them more inclined to adapt to the wishes of their partners. Obviously, it is also possible that the threat of losing a lover as well as the threat of punishment or abuse may lead many disempowered or fearful women to acquiesce to sexual interactions, despite a lack of desire.

Obviously, knowing that a sexual experience has occurred tells us nothing about either the desire accompanying it or the diverse, and not necessarily sexual, motives for engaging in it.

SEXUAL DESIRE: TOO LITTLE, TOO MUCH, TOO DIFFERENT, OR JUST RIGHT?

In some respects, sexual desire complaints resemble the experience of the three bears entering the cottage in the woods and surveying the three beds lying within. "Too big," announces Momma Bear, when gazing at one bed; "Too small," announces Poppa Bear, testing out another; "Just right," pronounces Baby Bear, as he hops up and down on the middle bed. Though our patients are not bears (except perhaps when they become disgruntled), desire problems often fall into these categories as well—too little or too much. "Too little," or hypoactive sexual desire disorder (HSDD), is the most common complaint clinicians encounter, often delivered by a disappointed mate who wants greater sexual frequency and certainly a more enthusiastic sexual partner. "Too much" is also a complaint, typically made by a weary mate who finds himself or herself deflecting the sexual overtures of an indefatigably ardent lover. But "just right" sexual desire is rarely heard by clinicians, although it probably characterizes the majority of individuals who are basically satisfied with their sexual life. It should be pointed out that there is absolutely no frequency of sexual encounters that defines sexual "normality." Recent research (Schneidewind-Skibbe, Hayes, Koochaki, Meyer, & Dennerstein, 2008) highlights the fact that the mean frequency of sexual intercourse, to consider only one measure of sexual behavior, varies significantly cross-globally across all age groups. Higher rates are reported by European and American women and lower rates reported by Asian women. Many factors were found to be associated with these differences in intercourse frequency: age, parity, relationship duration, pregnancy, time, relationship status, fertility intentions, and use of contraception. Given the wide range of frequency reported, as well as the varying cultural and social context in which sexual behavior occurs, it would be arbitrary to establish where "normal" sexual frequency ends and pathologically low or excessive sexual activity starts. As clinicians we are most concerned not with how often or how infrequently our patients engage in sex, but rather with how concordant their sexual preferences and satisfaction are. Clinically, it is "too different" or too discrepant sexual interest that is the problem we must often address, since it is this complaint that leads to relationship discontent, disharmony, and distress.

LACK OF DESIRE: A BRIEF HISTORICAL OVERVIEW

At this juncture, someone might ask whether the attention being paid to sexual desire complaints nowadays is not misguided or excessive. Certainly, there have always been individuals who get along just fine without craving or engaging in sex. Should we even diagnose low sexual interest as a sexual dysfunction, since by so doing we may be pathologizing normal variations in sexual interest that are due to a host of sociocultural and relationship causes? This is certainly the position of Tiefer and Hall, who present their "new view" model in Chapter 7. They acknowledge that whether or not desire problems are ubiquitous, they definitely are *not* indicative of a psychiatric disorder.

Thoughts about this issue have certainly changed over the decades. One hundred years ago, excessive desire was regarded as aberrant. While permitted and even applauded in men, too much sexual desire in women was seen as worrisome. Sexually enthusiastic women ran the risk of being labeled as nymphomaniacs and treated medically.

Times have changed, of course, and today, concerns about sexual apathy are the most common complaint presented to sex therapists. Despite the widespread assumption that it is women who are shortchanged when it comes to libido, nowadays men are as likely as women to be diagnosed with HSDD as defined by the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-IV-TR; American Psychiatric Association, 2000).

In fact, this is not a new diagnosis. Since the mid-1900s, low desire has been considered a psychiatric disorder and it was included as one of the five psychosexual disorders listed in DSM-III (American Psychiatric Association, 1980). In 1980, it was believed that without psychological inhibition, *all* individuals would experience "normal" desire. In DSM-IV (American Psychiatric Association, 1994), psychosexual disorders were elaborated as *disturbances in sexual desire and in the psychophysiologic changes that characterize the sexual response cycle which cause marked distress and interpersonal difficulty.* There was no attempt to specify a particular frequency of sexual behavior or activity as normative or deviant. Rather, it was left to the clinician to determine whether a condition warranted diagnosis, taking into account such factors as the age and experience of the individual, the frequency and chronicity of symptoms, the degree of subjective distress, and the impact on other areas of functioning. In addition, the

clinician was advised to consider the contributions of an individual's ethnic, cultural, religious, and social background that might influence sexual desire, expectations, and attitudes about sexual performance.

In 1998, the Sexual Function Health Council of the American Foundation for Urologic Disease (AFUD) convened a consensus conference to review and update the current classification of female sexual disorders. One goal was to ensure that the diagnostic entities would be applicable in both medical and mental health settings. Another was to determine whether the current descriptions of female sexual disorders reflected clinical reality.

The conference invited a multidisciplinary group of European and North American research and clinical experts in the field of female sexuality, comprising sex therapists, sex researchers, gynecologists, urologists, and experts in sexual psychophysiology, among others. A recommendation emerged from that meeting that the DSM-IV definition of HSDD be amended to reflect the fact that many women never experience spontaneous sexual desire, but rather are *receptive to, and interested in sexual activity* once it is started.

In 2000, a second consensus meeting was held and the recommendation at that time was to rename HSDD as women's sexual interest/desire disorder and to define it as "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" (Basson et al., 2003, p. 224). Even this definition has generated controversy. It is likely that DSM-V (scheduled to be released in 2013) will offer yet another definition of low or absent sexual desire, perhaps combining it with diminished sexual arousal since it is often difficult, particularly for women, to discriminate between arousal and desire complaints.

In recent years, the voices of some who question the legitimacy of (and motives for) for diagnosing low desire have become louder and more insistent. In 2003, for example, an editorial in the *British Journal of Medicine* by Ray Moynihan unleashed a storm of controversy when he assailed and mocked the motives of those who regard, diagnose, and treat HSDD as a sexual dysfunction. Moynihan asserted that the identification of low desire as a psychiatric disorder was merely a ploy by pharmaceutical companies and naive clinicians to create a dysfunction that they might then develop a pill to treat. His

article provoked much media controversy and many letters to the editor, with physicians, patients, and sex therapists supporting or refuting his allegations. Countering his remarks, for example, were letters highlighting the fact that desire complaints were identified as disorders in the DSM decades earlier and that by 1977, lack of desire was already acknowledged as a problem reported to clinicians by their patients (Kaplan, 1977; Lief, 1977; Basson & Leiblum, 2003).

Despite honest debate among clinicians and researchers as to how to define hypoactive sexual desire or whether to diagnose it as a disorder, there can be little doubt that a discrepancy of sexual interest and desire creates significant discontent and problems in the context of a relationship. While judicious and careful assessment must accompany any decision to treat desire complaints, an individual or couple experiencing genuine distress at sexual apathy and lack of arousal must be regarded as legitimately entitled to assistance.

PREVALENCE OF DESIRE DISORDERS

Although it often appears as if every sexually active person complains of sexual disinterest for some period of time, the actual prevalence of desire disorders varies widely, ranging anywhere from a low of 8% to a high of 55% (Deeks & McCabe, 2001; Richters, Grulichade Visser, Smith, & Rissel, 2001). While it is possible that some of the differences are attributable to the unique population studied (e.g., young vs. older individuals, pre- vs. postmenopausal women), much of the variation in prevalence estimates is likely due to differences in the way in which low desire is assessed (Hayes et al., 2007). In one study, for example, Hayes and his colleagues used several different instruments for determining the prevalence of a variety of female sexual dysfunctions. For HSDD, they compared estimates using the Sexual Function Questionnaire (SFQ; Quirk et al., 2002) either alone or in combination with the Female Sexual Distress Scale (FSDS; Derogatis, Rosen, Leiblum, Burnett, & Heiman, 2002), as well as two sets of simple questions concerning sexual interest that were adapted from a large-scale survey of sexual complaints (Laumann, Gagnon, Michael, & Michaels, 1994). Respondents were asked to report on sexual difficulties occurring during the previous month and on sexual difficulties lasting for at least 1 month in the previous year.

Of the 786 women who received the packet of questionnaires

assessing sexual interest, 45% completed the instruments. Of note, when assessed by the SFQ alone, 48% of the respondents reported low desire while 58% reported lack of sexual interest lasting for more than 1 month during the prior year. However, when the FSDS, which assesses distress about sexual desire or function, was included, the figures dropped dramatically. In fact, when assessed by the combined SFQ-FSDS scales, the prevalence of HSDD was only 16%! Moreover, changing the recall period from the previous month to 1 month or more during the previous year approximately doubled the prevalence estimates for all of the sexual complaints, while adding the questions about distress resulted in a nearly two-thirds reduction in prevalence estimates.

What can be learned from this study? First, how one assesses the *duration* of sexual disinterest results in very different estimates of prevalence. If women are asked about lack of desire that lasted 6 months or longer, prevalence estimates of HSDD will be lower than if asked about difficulties that lasted for 1 month or more (Mercer et al., 2003; Hayes, Bennett, Fairley, & Dennerstein, 2006). Moreover, without the experience of significant distress either on the part of the low-desire individual or the partner, it is unlikely that there will be a significant inclination to seek treatment unless the problem is causing relationship discord. Even then, it is likely that there will be ambivalent motives for altering the status quo. Typically, once a pattern of sexual avoidance or sexual apathy has become engrained, it becomes a new status quo. It is for this reason that complaints involving desire are so difficult to treat successfully—lack of desire is usually not experienced as a major problem for the low-desire individual, and many couples adapt to a "sexless" marriage even though they may bemoan the loss of sexual passion.

GENDER DIFFERENCES IN DESIRE

For centuries, it has been believed that women lack strong, resilient, and proactive sexual desire, unlike men, who are "always ready." As Maurice observes (2007, p. 183), "Men not interested in sex? To most, the idea is an oxymoron." The truth is that all women are not limpid, lustless creatures, devoid of lively libidos, and all men are not bursting with testosterone-infused sexual motivation.

In fact, contemporary clinicians report that the numbers of men who are disinterested in sex are not dissimilar from the numbers of

women complaining (or accused) of having low sexual interest. Survey results of data collected during the Massachusetts Male Aging Study of 1,709 men between the ages of 40 and 70 found a "consistent and significant decline with age in feeling desire, in sexual thoughts and dreams, and in the desired level of sexual activity" (McKinlay & Feldman, 1994, p. 271). Clearly male sexual desire, like female sexual desire, declines with age. But it is not only older men who display a decline in sexual interest. Many younger men, too, are identified as lacking libido. While some of these men are secretly pursuing an active masturbatory or fantasy sexual life (as in the case described by McCarthy and Breetz in Chapter 5), it is also the case that there are men with long-standing and generalized low sexual desire. Women partnered with, or married to, such men are not only frustrated and angry, they often feel unattractive and unloved since they cannot comprehend why their partners are avoiding sexual (and, often, physical) intimacy with them. Many such women also feel thwarted in their desire to become pregnant and start a family. While women with low desire can still engage in sexual relations at the insistence of a demanding mate, or in order to forestall guilt and recrimination, men with low libido often have secondary erectile problems and cannot "deliver" sex in order to satisfy an insistent female partner.

Nevertheless, among older adults, the stereotype that women need to be coaxed, seduced, or even coerced into having sex continues to exist. Recall the Ogden Nash verse, "Candy is dandy but liquor is quicker." In fact, even today, some health professionals, frustrated by the absence of a pro-sexual magic elixir, suggest that with a little alcohol-mediated disinhibition or relaxation, women will be more sexually receptive.

Recent research has definitely challenged the notion that female sexual desire is merely a pale imitation of male desire. The work of Meredith Chivers (2005; Chivers, Rieger, Latty, & Bailey, 2004), for example, is a case in point. In a series of clever experiments, she highlighted the fact that women respond physiologically to sexual stimuli as quickly as do men, and, significantly, that they also respond genitally to a broader array of sexual images than men—images that depict both preferred and nonpreferred scenes (e.g., heterosexual and homosexual images, bonobo monkeys, exercising women, and even depictions of rape).

While Chivers believes that women's sexual desire may be more receptive than aggressive, that women may be evolutionarily programmed to have reflexive physiological arousal to a wide array of

stimuli, and that their subjective sexual desire is discordant with their physiological arousal due to cultural or social constraints, others believe that intimacy is the major key to awakening female desire. Rosemary Basson (2001) is an advocate of this position. So is Lisa Diamond (2005). Diamond argues that female desire is quite malleable and is predicated more on emotional closeness than on gender. Flexibility and fluidity are viewed as the essence of female desire by Diamond, who studied the erotic attractions of nearly 100 women over 10 years. While many of these women initially self-identified as lesbian or bisexual, a decade later, two-thirds reported occasional attraction to men. Moreover, many women agreed with the statement "I'm the kind of person who becomes physically attracted to the person rather than his or her gender." While this same research has not been done with men, it is unlikely that one would find the same fluidity in terms of the *objects* of desire.

Finally, still another female sexuality researcher, Marta Meana, has suggested that being desired is the key to women's experience of desire (Bergner, 2009). She believes that female desire is essentially narcissistic—that intimacy is not as much of an aphrodisiac as being lusted after. However, she and other researchers all acknowledge that the variability of desire within genders is greater than the differences between men and women.

AGE-RELATED CHANGES IN SEXUAL DESIRE AND DISTRESS

Most studies find that *sexual desire diminishes with age* for both men and women. What is interesting is that *distress about reduced or lack of sexual desire also tends to diminish with age*. Hayes, Dennerstein, Bennett, and Fairley (2008) compared two populations of women between the ages of 20 and 70 in Europe and in the United States. For both European and American women, the complaint of low desire increased with age—the proportion of European women with lack of desire *increased* from 11% among women ages 20–29 to 53% in women ages 60–70. However, the proportion of women with low desire who were *distressed* about their low desire *decreased* with age. In the 20- to 29-year age group, 65% of European women and 67% of American women with low sexual desire were distressed by it, but these numbers decreased to 22% and 37%, respectively, in the 60- to 70-year age group. Apparently many individuals come to accept the

reality that sexual desire diminishes with age and relationship duration, and there may be less distress about these changes. However, it should be noted that clinically, we continue to see men and women who regret their diminished desire and want to restore or reignite their sexual passion. In Chapter 2, Esther Perel discusses the challenges of maintaining eroticism and desire in the face of domesticity and predictability.

ETIOLOGY OF DESIRE DISORDERS

One of the challenges of treating sexual desire problems is the fact that the etiology is so varied. All of the following may contribute to sexual disinterest:

Biological factors: hormonal imbalance or insufficiencies, neurotransmitter imbalances, medications and their side effects, acute or chronic illnesses.

Developmental factors: lack of sexual education or permission; a childhood or adolescence marked by emotional, physical, verbal, or affectionate deprivation; sexual trauma or coercion.

Psychological factors: anxiety, depression, attachment disorders, personality or other psychiatric disorders.

Interpersonal factors: relationship discord, insults, losses, or partner sexual incompetence or dysfunction.

Cultural factors: religious or cultural mores and beliefs concerning appropriate sexual conduct.

Contextual factors: environmental factors such as privacy, safety, and comfort with surroundings.

Alternatively, desire problems are sometimes viewed as resulting from a variety of predisposing, precipitating, developmental, and maintaining factors (Althof et al., 2004):

Predisposing factors include constitutional attributes such as temperament (shyness vs. impulsivity, anatomical variations or deformities, inhibition vs. excitation, personality traits).

Developmental factors include problematical attachment experiences with parents, exposure to physical or sexual violence, negative early sexual experiences, and so forth.

Precipitating factors can include life-stage stressors such as

divorce, infidelity, menopausal complaints, substance abuse, or humiliating or shameful experiences.

Maintaining factors may include ongoing stress, fatigue, relationship conflict, or body image concerns.

Given the heterogeneity of contributing factors, and the multiplicity of considerations that are relevant to both the initiation and the maintenance of sexual desire difficulties, the clinician must be creative and skillful in planning sensible and effective treatment. It is obvious that there can be no "one-size-fits all" model for therapeutic intervention. As will be evident from the clinical illustrations presented in this volume, each case is unique—every individual has an idiosyncratic erotic blueprint or love map that may complement or conflict with that of a partner. When erotic blueprints are in sync, couples easily negotiate small differences in desire. When they clash, desire problems may be more problematical to treat. And, from another perspective, it is worth noting, as David Schnarch suggests in Chapter 3, that low desire and high desire are often mutable positions in a relationship system. Furthermore, the low-desire individual in one relationship may be the high-desire partner in a new and different relationship.

PRIMARY VERSUS SECONDARY VERSUS SITUATIONAL DESIRE

In diagnosing sexual desire disorders, it is important to ascertain whether the complaint is primary or secondary, acute or chronic, and acquired or generalized. Acute and situational problems usually have a better prognosis than primary, generalized, and chronic lack of desire. While there are many factors that may contribute to a secondary loss of desire, the full range of possible components can be daunting. Such factors can span everything from transient partner conflict or the impact of disease or medication to a primary generalized lack of sexual interest, where there is a total absence of sexual fantasies or thoughts, masturbation, or any manifestation of sexual curiosity or arousal. While some authors in this volume do report success in treating such cases of primary absence (see Chapter 12, by Korda, Goldstein, and Goldstein), the majority of successful cases described in this book deal with situational or secondary lack of desire. In fact, many clinicians report frustration and failure in their attempts to generate sexual interest in cases where the individual reports a lifelong absence of desire.

DIAGNOSTIC ASSESSMENT: INTERVIEW AND INSTRUMENTS

There are several standardized instruments and questionnaires for assessing desire complaints (see Table 1.1), but nothing really replaces the clinical interview where the individual and his or her partner are seen individually and as a couple. Much light can be shed by learning about the upbringing, family relationships, myths, and messages each partner brings to the relationship, as well as by observing the verbal and nonverbal exchanges of a couple together. Most of the chapters in this volume attest to the utility of interviewing and treating desire problems from a relational perspective.

PHARMACOTHERAPY FOR DESIRE DISORDERS

At this time, there are very few pharmacological interventions for enhancing desire. While sildenafil (Viagra) and the other phosphodiesterase (PD5) inhibitors (Levitra and Cialis) have proven extremely useful in treating male erectile dysfunction, they do little for increasing sexual desire itself in men (or women). One recent study did suggest that sildenafil was a helpful adjunct in women experiencing sexual dysfunction associated with antidepressant treatment (Nurnberg et al., 2008). One of the more prosexual antidepressants is bupropion (Wellbutrin), which has a lower incidence of sexual side effects than the selective serotonin reuptake inhibitor antidepressants. There is promising research under way with a new centrally acting drug, flibanserin, for the treatment of HSDD in premenopausal women, but as of this writing it is not FDA approved. In Chapter 13, Bonnie R. Saks provides a useful overview of the adjunctive use of medications in working with individuals with desire problems.

WHY THIS BOOK?

Desire complaints present a genuine conundrum. As we have seen, changes in the amount or intensity of sexual desire are normative and often inevitable over the course of a relationship, with life stresses and developmental milestones, hormonal changes, and medications. Nothing stays the same as we grow older and sexual desire is no exception. The problem is often with false expectations—with the fantasy that sexual desire is somehow immune from the whole array

TABLE 1.1. Scales for Assessing Desire/Arousal Problems

Assessment of sexual desire/arousal problems is critical in planning meaningful and sensible treatment interventions. The most common approach to diagnosing sexual difficulties is via a comprehensive clinical interview of both the identified patient and his or her partner. Such an interview includes discussion about the presenting problem and the predisposing, precipitating, and maintaining factors that govern its appearance and intensity (Grazziotin & Leiblum, 2005). It is also important to explore current contextual factors that affect sexual expression and interest, such as relationship satisfaction, privacy issues, current health of self and partner, medical or psychiatric issues, use of medications or recreational drugs/alcohol that may affect sexual expression, and current stressors.

Many clinicians find that the use of standardized self-report questionnaires can be helpful initially in terms of saving time, identifying problem areas, and providing direction or focus for a more extended clinical interview.

The following brief assessment tools have demonstrated good reliability and validity:

- *Brief Index of Sexual Functioning for Women* (Taylor, Rosen, & Leiblum, 1994). A 22-item questionnaire that provides domain and total scores on the following aspects of sexual function: desire, arousal, frequency of sexual activity, receptivity/initiation, pleasure/orgasm, relationship satisfaction, and problems affecting sexual function.
- *Decreased Sexual Desire Screener* (Clayton et al., 2009). An easy-to-use five-question instrument that provides rapid identification of generalized, acquired female hypoactive sexual desire. It consists of four yes/no questions to determine whether a desire problem and related distress exist. The more inclusive fifth question permits elaboration of possible contributing or maintaining factors.
- *Female Sexual Function Index* (Rosen et al., 2000). A 19-item questionnaire specific to women that assesses six domains (desire, subjective arousal, lubrication, orgasm, satisfaction, and pain). It has been widely used in outcome research and has good validity and reliability for diagnosing a variety of sexual complaints.
- *Female Sexual Distress Scale* (Derogatis et al., 2002). A 12-item assessment instrument used to determine the amount of current distress experienced by a woman with sexual difficulties. A cutoff score of 15 or greater is associated with personal distress.
- *Female Sexual Distress Scale—Revised* (Derogatis, 2008). The most recent validation of the Sexual Distress Scale, which was undertaken in order to enhance the sensitivity of the instrument for patients experiencing HSDD. The new question that was included is: "Are you bothered by low sexual desire?" and the respondent circles never (0), rarely (1), occasionally (2), frequently (3), or always (4).
- *Golombok–Rust Inventory of Sexual Satisfaction* (Rust & Golombok, 1986). A 28-item questionnaire that encompasses five domains relevant to women: anorgasmia, vaginismus, female avoidance, nonsensuality, and female dissatisfaction.
- *HSDD Screener* (Leiblum et al., 2006). A four-item screener that asks about loss of desire and distress in postmenopausal women.
- *Sexual Desire Inventory* (Spector, Carey, & Steinberg, 1996). A 14-item questionnaire that measures domains of dyadic and solitary sexual desire.
- *Sexual Function Questionnaire* (Quirk et al., 2002). A relatively new instrument designed to assess eight domains of women's sexuality: desire, physical arousal/sensation, physical arousal/lubrication, enjoyment, orgasm, pain, partner relationship, and cognition.

of changes that occur with aging, that while we may lose our hair and pack on the pounds, we somehow can maintain the sexual desire we had as 18-year-olds.

Ridiculous, we all agree. And yet, while lack of desire is not a life-threatening problem, it is often distressing and problematical to relationships and to our comfort with and satisfaction in them. A partner who is repeatedly sexually rejected or only reluctantly accepted feels hurt and frustrated and, finally, will often become angry or depressed. Over time, the sense of intimate connection with a partner is compromised. There is less physical teasing or affection, fewer spontaneous hugs or passionate kisses. Physical avoidance may replace affectionate snuggling since affection may be misinterpreted as a sexual invitation.

Alternatively, there may develop a greater reliance on pornography or masturbation. Often, there is the defensive decision on the part of the rejected partner that if any sexual intimacy is to occur, it must be initiated by the low-desire mate; the pain of rejection has become too great. The relationship is described as one of "roommates" rather than "lovers."

Whether seen as a psychiatric diagnosis or a relationship problem, complaints involving too little, too much, or discrepant desire are indeed legitimate concerns that warrant intervention. But how to intervene? Typically, desire concerns are not only frustrating to a client or couple, they are frustrating to the clinician as well. Anecdotally, many therapists say that they "dread" cases involving desire problems because they are uncertain about how to successfully intervene. There are no cookbooks or prescriptions for creating desire.

Clinicians also sometimes wonder if it is even *possible* to ignite desire where none has existed. Can the person who reports lifelong sexual apathy become sexually motivated or receptive? Should he or she be encouraged to? Can sex become lusty when it has become lackluster? What are reasonable expectations or treatment goals in these cases?

These are the questions that prompted this book. In order to find answers, prominent and expert clinicians of varying persuasions, training, and therapeutic philosophies were asked how they approach and treat desire problems. What has (or has not!) worked for these experienced and thoughtful clinicians?

Of course, given the complex and multifactorial etiology of desire complaints, there is not (and never will be) a standardized treatment. But seeing how top-notch therapists think about desire cases is illu-

minating. The contributors to this volume represent a wide spectrum of backgrounds and training. Each is skilled in his or her craft and has earned the title of expert. The chapters that follow are both provocative and stimulating. They challenge stereotypes and they reject the chimera of easy remedies for complex problems. But above all they constitute a thoughtful, nuanced, and pragmatic reflection of the many approaches to the assessment and treatment of desire complaints in current clinical practice.

This book does not attempt to be comprehensive in its overview. While there has been an attempt to balance examples involving men and women, gay and straight, older and younger clients, the authors were free to select cases they believed were representative of their clientele and treatment philosophy. It is to be hoped that the reader will come away from this volume with an increased appreciation of the spectrum of approaches and interventions for assisting individuals and couples with desire issues, and will feel awe and admiration for the artful interventions of these skilled clinicians.

REFERENCES

Althof, S., Leiblum, S., Chevert-Measson, M., Hartman, U., Levine, S., McCabe, M., et al. (2004). Psychological and interpersonal dimensions of sexual function and dysfunction. In T. Lue et al. (Eds.), *Sexual medicine: Sexual dysfunctions in men and women* (pp. 75–115). Paris: Second International Consultation on Sexual Dysfunctions.

American Psychiatric Association. (1980). *Diagnostic and statistical manual of mental disorders* (3rd ed.). Washington, DC: Author.

American Psychiatric Association. (1994). *Diagnostic and statistical manual of mental disorders* (4th ed.). Washington, DC: Author.

American Psychiatric Association. (2000). Diagnostic and statistical manual of mental disorders (4th ed., text rev.). Washington, DC: Author.

Basson, R. (2001). Using a different model for female sexual response to address women's problematic low desire. *Journal of Sex and Marital Therapy, 5*, 395–403.

Basson, R. (2002). Rethinking low sexual desire in women. *British Journal of Obstetrics and Gynecology, 4*, 357–363.

Basson, R., & Leiblum, S. (2003). Letter to the editor re: women's sexual dysfunction. *British Medical Journal, 326*(7390), 658.

Basson, R., Leiblum, S., Brotto, L., Derogatis, L., Fourcroy, J., Fugl-Meyer, K., et. al. (2003). Definitions of women's sexual dysfunctions reconsidered: Advocating expansion and revision. *Journal of Psychosomatic Obstetrics & Gynaecology, 24*, 221–229.

Beach, F. (1956). Characteristics of masculine "sex drive." In M. Jones (Ed.), *Nebraska Symposium on Motivation* (pp. 1–32). Lincoln: University of Nebraska Press.

Bergner, D. (2009, February 3). What do women want? *New York Times Magazine*. Available online *www.nytimes.com/2009/01/23/health/23iht-25desiret.19636765.html*.

Bogaert, A. F. (2004). Asexuality: Prevalence and associated factors in a national probability sample. *Journal of Sex Research*, *41*(3), 279–287.

Bogaert, A. F. (2006). Toward a conceptual understanding of asexuality. *Review of General Psychology*, *10*(3), 241–250.

Buster, J., Kingsberg, S., Aguirre, O., Brown, C., Wekselman, K., & Casso, P. (2004, June 16–19). *Large Phase III study confirms that transdermal testosterone patch 300 pg/day significantly improves sexual function with minimal side effects in surgically menopausal women*. Abstract presented at the annual meeting of the Endocrine Society, New Orleans, LA.

Chivers, M. (2005). A brief review and discussion of sex differences in the specificity of sexual arousal. *Sexual and Relationship Therapy, 20*, 377–390.

Chivers, M., Rieger, G., Latty, E., & Bailey, M. (2004). A sex difference in the specificity of sexual arousal. *Psychological Science, 15*, 736–744.

Clayton, A., Goldfischer, E., Goldstein, I., Derogatis, L., Lewis-D'Agostino, D., & Pyke, R. (2009). Validation of the decreased sexual desire screener (DSDS): A brief diagnostic instrument for generalized acquired female hypoactive sexual desire disorder (HSDD). *Journal of Sexual Medicine, 6,* 730–738.

Davis, S., Davison, S., Donath, S., & Bell, R. (2005). Circulating androgen levels and self-reported sexual function in women. *Journal of the American Medical Association, 294*(1), 91–96.

Deeks, A. A., & McCabe, M. P. (2001). Sexual function and the menopausal woman: The importance of age and partner's sexual functioning. *Journal of Sex Research, 38*, 219–225.

Derogatis, L. (2008). Validation of the Female Sexual Distress Scale—Revised for assessing distress in women with hypoactive sexual desire disorder. *Journal of Sexual Medicine, 5*, 357–364.

Derogatis, L., Rosen, R., Leiblum, S., Burnett, A., & Heiman, J. (2002). The Female Sexual Distress Scale (FSDS): Initial validation of a standardized scale for assessment of sexually related personal distress in women. *Journal of Sex and Marital Therapy, 28*, 317–330.

Diamond, L. (2005). What we got wrong about sexual identity development: Unexpected findings from a longitudinal study of young women. In A. Omoto & H. Kurtzman (Eds.), *Sexual orientation and mental health: Examining identity and development in lesbian, gay, and bisexual people* (pp. 73–94). Washington, DC: American Psychological Association.

Freud, S. (1962). *Three essays on the theory of sexuality*. New York: Avon Books. (Original work published 1905)

Graziottin, A., & Leiblum, S. (2005). Biological and psychosocial pathophysiology of female sexual dysfunction during the menopausal transition. *Journal of Sexual Medicine*, Suppl. 3, 133–145.

Hayes, R., Bennett, C., Fairle, C., & Dennerstein, L. (2006). What can prevalence studies tell us about female sexual difficulty or dysfunction? *Journal of Sexual Medicine*, *3*, 589–595.

Hayes, R., Dennerstein, L., Bennett, C., & Fairley, C. (2008). What is the "true" prevalence of female sexual dysfunctions and does the way we assess these conditions have an impact? *Journal of Sexual Medicine*, *5*, 777–787.

Hayes, R. D., Dennerstein, L., Bennett, C. M., Koochaki, P. E., Leiblum, S. R., & Graziottin, A. (2007). Relationship between hypoactive sexual desire disorder and aging. *Fertility and Sterility, 87*, 107–112.

Johnson, M. T. (1977). Asexual and autoerotic women: Two invisible groups. H. L. Gochros & J. S. Gochros (Eds.), *The sexually oppressed* (pp. 96–109). New York: Associated Press.

Kaplan, H. (1977). Hypoactive sexual desire. *Journal of Sex and Marital Therapy, 3*, 3–9.

Laumann, E., Gagnon, J., Michael, R., & Michaels, S. (1994). *The social organization of sexuality: Sexual practices in the United States*. Chicago: University of Chicago Press.

Leiblum, S. R., & Rosen, R. C. (1988). Introduction: Changing perspectives on sexual desire. In S. R. Leiblum & R. C. Rosen (Eds.), *Sexual desire disorders* (pp. 1–17). New York: Guilford Press.

Leiblum, S. R., Symonds, T., Moore, J., Soni, P., Steinberg, S., & Sisson, M. (2006). A methodology study to develop and validate a screener for hypoactive sexual desire disorder in postmenopausal women. *Journal of Sexual Medicine, 3*, 455–464.

Lief, H. (1977). Inhibited sexual desire. *Medical Aspects of Human Sexuality, 7*, 94–95.

Maurice, W. L. (2007). Sexual desire disorders in men. In S. R. Leiblum (Ed.), *Principles and practice of sex therapy* (4th ed., pp. 181–211). New York: Guilford Press.

McKinlay, J., & Feldman, H. (1994). Age-related variation in sexual activity and interest in normal men: Results from the Massachusetts Male Aging Study. In A. S. Rossi (Ed.), *Sexuality across the life course* (pp. 261–285). Chicago: University of Chicago Press.

Mercer, C., Fenton, K., Johnson, A., Wellings, K., Macdowall, W., McManus, S., et al. (2003). Sexual function problems and help seeking behaviors in Britain: National probability sample survey. *British Medical Journal*, *327*, 426–427.

Meston, C., & Buss, D. (2007). Why humans have sex. *Archives of Sexual Behavior, 36*(4), 477–507.

Moynihan, R. (2003). The making of a disease: Female sexual dysfunction. *British Medical Journal, 326*, 45–47.

Nurnberg, H., Hensley, P., Heiman, J., Croft, H., Debattista, C., & Paine, S. (2008). Sildenafil treatment of women with antidepressant-associated sexual dysfunction: A randomized controlled trial. *Journal of the American Medical Association, 300*(4), 395–404.

Quirk, F. H., Heiman, J. R., Rosen, R. C., Laan, E., Smith, M. D., & Boolell, M. (2002). Development of a Sexual Function Questionnaire for Clinical Trials of Female Sexual Dysfunction. *Journal of Women's Health and Gender-Based Medicine, 11*(3), 277–289.

Richters, J., Grulich, A. E., de Visser, R. O., Smith, A. M. A., & Rissel, C. E. (2001). Sex in Australia: Sexual difficulties in a representative sample of adults. *Australian and New Zealand Journal of Public Health, 27*, 164–170.

Rosen, R., Brown, C., Heiman, J., Leiblum, S., Meston, C., Shabsigh, R., et al. (2000). The Female Sexual Function Index (FSFI): A multidimensional self-report instrument for the assessment of female sexual function. *Journal of Sex and Marital Therapy, 26*, 191–208.

Rust, J., & Golombok, S. (1986). The GRISS: A psychometric instrument for the assessment of sexual dysfunction. *Archives of Sexual Behavior, 15*, 157–165.

Schneidewind-Skibbe, A., Hayes, R., Koochaki, P., Meyer, J., & Dennerstein, L. (2008). The frequency of sexual intercourse reported by women: A review of community-based studies and factors limiting their conclusions. *Journal of Sexual Medicine, 5,* 301–335.

Shifren, J., Davis, S., Moreau, M., Waldbaum, A., Bouchard, C. D., DeRogatis, L., et. al. (2006). Testosterone path for the treatment of hypoactive sexual desire disorder in naturally menopausal women: Results from the INTIMATE NM1 Study. *Menopause, 13*(5), 770–779.

Simon, J., Braunstein, G., Nachtigall, L., Utian, W., Katz, M., Miller, S., et al. (2005). Testosterone patch increases sexual activity and desire in surgically menopausal women with hypoactive sexual desire disorder. *Journal of Clinical Endocrinology and Metabolism*, *90*(9), 5226–5233.

Simon, J., Nachtigall, L., Davis, S., Utian, W., Lucas, J., & Braunstein, G. (2004). Transdermal testosterone patch improves sexual activity and desire in surgically menopausal women. *Obstetrics & Gynecology*, *103*(Suppl. 4), 64S.

Spector, I., Carey, M., & Steinberg, L. (1996). The sexual desire inventory: Development, factor structure, and evidence of reliability. *Journal of Sex and Marital Therapy, 22*, 175–190.

Taylor, J., Rosen, R., & Leiblum, S. (1994). Self-report assessment of female sexual function: Psychometric evaluation of the brief index of sexual functioning for women. *Archives of Sexual Behavior, 23*(6), 627–643.

Wang, C., Nieschlag, E., Swerdloff, R., Behre, H., Hellstrom, W., Gooren, L., et al. (2009). ISA, ISSAM, EAU, EAA and ASA recommendations:

Investigation, treatment and monitoring of late-onset hypogonadism in males. *International Journal of Impotence Research*, *21*(1), 1–8.

Weijmar Schultz, W. C. M., & Van de Wiel, H. (1991). Sexual functioning after gyneacecological cancer treatment. Unpublished doctoral dissertation, Rijksuniversiteit Groningen, the Netherlands.

Weijmar Schultz, W. C. M., & Van de Wiel, H. B. M. (2003). Sexuality, intimacy, and gynecological cancer. *Journal of Sex and Marital Therapy, 29*, 121–128.

Whalen, R. (1966). Sexual motivation. *Psychological Review, 73*, 151–163.