

# Clarifying the complaint of low sexual desire in men and women

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**ABSTRACT** Initiating discussion about sexual function or desire can often be uncomfortable or embarrassing for clinicians and for patients. But low sexual desire is a common problem that can cause great distress to the patient and to the partner. Dr Basson outlines the reasons why a discussion is sometimes relevant to the clinical situation at hand, when such an inquiry is necessary, and what questions to ask the patient.

**L**ow sexual desire is the most common sexual problem presented to the primary care physician. This is not surprising, given the apparent prevalence of distress regarding low desire—33% and 17% in nonclinical samples of women and men, respectively.<sup>1</sup>

## Reasons for inquiring about sexual desire

**Distress.** A healthy and satisfying sex life is now recognized as an integral part of overall happiness and well-being. Ongoing low sexual desire often leads to personal and relationship distress. Your patient may feel inadequate and substandard, and so may the partner, who consequently often feels unattractive, insecure, and frustrated. When the etiology of the low desire is unclear to the patient—and this is usually the case—it becomes easy for the partner to accept responsibility for this perceived lack of interest.

**Underlying medical condition.** Serious illness, most commonly depression, may also be signaled by low sexual desire. However, any debilitating illness with vague symptoms may cause a person with previously high sexual desire to notice a dramatic loss in sexual wanting. Infrequently, but significantly, low desire could be the presenting symptom of a prolactinoma or any cause of secondary hypogonadism in men. The underlying pathology may well be life threatening—for example in hemochromatosis, where excess iron is deposited in the pituitary gland as well as in the liver, heart, joints, and pancreas. In women, the more likely presenting feature of primary or secondary gonadal failure is a disturbance in menstruation or infertility.

**Erectile dysfunction.** Low desire is a major cause of apparent failure to manage erectile dysfunction with sildenafil (Viagra®).<sup>2</sup> The latter is designed to augment the action of nitric oxide that is released from the autonomic nerve endings in the penile sinusoidal smooth muscle when the man is aroused from sexual stimulation. The nitric oxide initiates the cascade of chemical changes that allows the dilatation of the sinusoids and cavernosal filling resulting in erection. Apart from actual destruction of peripheral autonomic nerves, as

## Practice Tips

- | When prescribing medications that are known to reduce sexual desire, remember to inform the patient of this possibility along with any potential nonsexual side effects.
- | Also inform patients when their medical condition is often associated with low sexual desire.
- | Clarify exactly what the patient means by low sexual desire, to ensure it is truly a desire disorder.
- | The duration of low desire can be the first indication of the type of treatment needed.
- | Inquire about autoerotic practices. Loss of desire to self-stimulate in men implies a biological etiology.

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with non-nerve sparing radical prostatectomy, the most common cause of apparent “failure” of sildenafil therapy is insufficient mental sexual arousal. If a patient is insufficiently mentally aroused, the neurotransmission to the spinal centers governing erection is such that only low levels of nitric oxide are released and sildenafil is ineffective. Insufficient mental sexual arousal is often related to low sexual desire—indeed the two may not truly be separate entities.<sup>3</sup>

**Women’s testosterone levels.** In the last few years media attention has focused on one aspect of women’s sexual desire; that is, that innate sexual urging and the mind’s processing of sexual stimuli require a minimum of testosterone. Consequently, patients have followed suit by asking for testosterone supplementations from their physicians. Unfortunately, accompanying all this attention has been a great deal of misinformation. The message from the media suggests that even premenopausal women with regular menses should be requesting that you check their testosterone levels with view to supplementation. As a primary care physician, you know otherwise, and it has become your role to explain this to misled patients.<sup>4</sup>

There is no known disease state whereby regularly menstruating younger women do not produce testosterone, given that it is a precursor of estrogen. A lack of the necessary enzyme (17- $\beta$ hydroxylase, converting androstenedione to testosterone) in the ovary has been postulated as a cause of “low” testosterone levels in women presenting with low desire despite having regular menses and being fertile.<sup>5</sup> It is difficult to explain these same women’s regular cycles and fertility and the presumed ability of this same enzyme to convert estrone to estradiol (Figure 2 in A. Guay’s article, this issue, p 34). We lack data comparing testosterone levels in large cohorts of women with and without desire problems. Women with high normal or slightly above normal levels of testosterone with polycystic ovarian syndrome do not report particularly robust sexual drives. Furthermore, there are no safety data on giving premenopausal women in their 40s—who do indeed make perhaps only 50% of the testosterone they made in their 20s—supplemental testosterone. Also, although testosterone replacement may be indicated post surgical menopause,<sup>4,6</sup> it is usually not indicated post natural menopause, as levels of free testosterone may actually rise. This is because sex hormone-binding globulin decreases with age, so that free testosterone may simultaneously rise, especially when estrogen replacement therapy

is withheld, as estrogen replacement therapy increases sex hormone-binding globulin.

With this knowledge, you will decline prescribing testosterone in women in most instances, but the patient still needs an explanation of her low desire and so further detailed assessment is needed.

### When to ask about sexual desire?

**General assessment.** In the context of a general health assessment, you can ask, “Do you have any concerns in the sexual area, such as difficulties with sexual desire, arousal, lubrication (erection, ejaculation) or any pain?” Never assume that a patient who has not expressed any difficulty up to this point does not have any problems. Patients are much more likely to discuss sexual problems when you inquire directly.

**Prescribing medications.** Some medications are known to reduce sexual desire. Among these are many antidepressants and antihypertensives, such as beta-blockers and spironolactone. Therefore, when prescribing such an agent, remember to inform the patient of this possibility, along with any potential nonsexual side effects. You may say, “This medication is usually fairly well tolerated and any side effects are generally only temporary, but they may include (for example) headache, fatigue, or loss of sexual desire. Let me know if any such problem persists.”

**Disease state.** Certain medical conditions are frequently associated with low sexual desire. These include depression, chronic neurological disease such as MS, head injury, Parkinson’s disease (even though occasionally patients with Parkinson’s disease will notice increased desire coincident with their dopaminergic medication), chronic infertility, chronic dyspareunia (even if the pain has been addressed), a history of past sexual and/or physical abuse, early surgical or medical menopause, or prostate cancer treated with medical or surgical castration. Patients with these conditions will appreciate your willingness to help them understand and adapt to the likely discrepant desire between the partners. In some situations, such as depression, the low desire is treatable, but the patient may not realize this and so will not initiate the discussion.

### What to ask? Two levels of questioning

In addition to clarifying the medical context and checking medications that may reduce desire, specific questions

Any debilitating illness with vague symptoms may cause a dramatic loss in sexual wanting.

can be considered at two levels. The focus of the first level is to clarify what is actually missing in a patient's sexual desire, and how long the condition has been present. The second level of assessment is the context of these sexual symptoms, such that any value of the current situation to the patient or to the couple becomes clear. Sometimes inquiry reveals that the level of desire for sexual intimacy is quite appropriate for the couple's level of emotional intimacy (ie, their closeness, their ability to share their feelings, hopes, and fears, and be vulnerable in each other's presence).

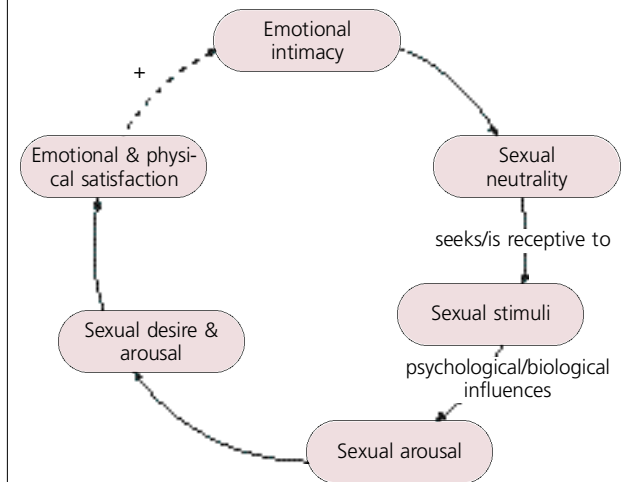
### Level I questions

**True desire disorder?** To be sure that this truly is a desire disorder, clarify exactly what the patient means by low sexual desire. You need to know whether it is lack of wanting sexual activity with the patient's partner, or if it is a lack of awareness that any thing or any person is sexually attractive or has sexual meaning for the patient. You may ask, "Can erotic cues in movies, books, music, or conversation trigger sexual feelings for you?" Note that some men may present with symptoms they assume constitute erectile dysfunction when they speak about lack of awareness of penile swellings throughout the day. However, your inquiry may clarify that they are not registering or focusing on the sexual cues or triggers in their life, namely, they have hypoactive desire disorder. This lack of penile "response" is, in reality, lack of nerve messages signaling the penis to respond.

Be sure that when you identify a condition as a desire disorder it is not simply a matter of desire discrepancy between two partners that they are unable to negotiate. Also, it is important to clarify that the issue is not more accurately lost motivation specifically to engage in one component of sex—sexual intercourse—because of a negative outcome, for instance, from pain or lack of erection.

**Duration of symptoms?** The duration of low desire can be the first indication of the type of treatment that is needed. Lifelong low desire is difficult to manage, usually complex, and may well require help from a psychologist or psychiatrist. If low desire occurs after a number of months or years into a relationship, determine whether this has been a pattern in previous relationships or if it is specific to this relationship. When it is a pattern, it may suggest that the individual is unaware of the need to nurture emotional intimacy, provide sexual and erotic contexts, or foster the nonsexual aspect of the relationship, having only been used to the easy, exciting, "spontaneous" desire typical of new liaisons.

**FIGURE** Intimacy-based model of human sexual response



Deliberate seeking or receptivity to sexual stimuli allows the person to move from sexual neutrality to arousal. If the mind continues to process the stimuli on to further arousal, sexual desire to continue the experience for sexual satisfaction—as well as intimacy fostering—is accessed. A positive outcome reinforces sexual motivation.

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**Autoerotic practices?** There is a definite need to inquire about autoerotic practices. For men, loss of desire to self-stimulate and fantasize, in addition to not wanting sexual activity with the partner, implies a generalized loss of desire, and a biological etiology, such as depression, is likely. For women, the situation is more complex. Sexually healthy women generally have lower levels of sexual thoughts, fantasies, and masturbatory practices than men, and, significantly, the frequencies are highly variable.<sup>1,7</sup> Therefore, lack of sexual thinking, fantasizing, or self-stimulation may not be a change in sexual desire or in any way abnormal for the individual woman.

**Emotional intimacy?** Women's desire (perhaps more so than men's) has a particularly large responsive (receptive) component<sup>8,9</sup> that is intimacy driven<sup>9-11</sup>; you will therefore need to inquire about a patient's emotional intimacy with her partner. Ask about the context in which she feels she "should" have some sexual desire. What has happened during her day that could be expected to trigger sexual feelings? What are the specific sexual stimuli at the time of potential interaction with her partner—

are they sufficient? Is there enough nongenital stimulation, mental stimulation, and genital nonintercourse stimulation? Can she guide her partner? Is she aroused or is she only neutral or even offended by stimulating her partner? Had she thought it was abnormal to begin a sexual experience “neutral” and simply be open-minded or willing to become aroused and only later to actually feel sexual desire?

You might even draw the cycle of her responsive desire provided in the Figure, to facilitate the completion of the assessment. Can she focus and concentrate during sexual intimacy? Could there be too many distractions, fears of being substandard, both sexually and generally, fears of pregnancy, of contracting sexually transmitted infections, of children waking up, of being overheard? Is there a repeatedly negative outcome, for instance, dyspareunia, frustration from lack of orgasm? Is there a dysfunction in her partner—perhaps lack of orgasm in a female partner or premature ejaculation with subsequent cessation of all activity with a male partner?

By clarifying these components of her responsive desire, your assessment shows her the logic of her situation. In fact, your assessment itself may prove to be therapeutic. Your patient and her partner may or may not choose to address the missing components, but she can now stop unnecessarily labeling herself as dysfunctional. She may also likely speak less about testosterone supplementation, if this was something that she requested.

Explore this potential responsive desire with your male patients as well. True, men are to some degree “protected” by their more obvious spontaneous or intrinsic sexual hunger. However, the needs for emotional closeness with a partner, for useful stimuli, the need for a mind free from distractions or low self-image, and the expectation for a rewarding outcome—all these apply to men as much as to women.

### Looking at the larger picture: level II questions

When concerns are longstanding, you may need to look at the larger context of the patient’s developmental history, past relationships, and the present relationship. You may elect to refer the patient or the couple to a relationship counselor if you feel that the current status quo, for instance, allows the partner with low desire some power in their relationship that is otherwise lacking. His or her control over the number of times they

are sexual may be the only decision that individual (as opposed to the partner) makes in the relationship.

Sometimes you may feel the low desire is entirely appropriate for the low level of emotional intimacy in a relationship. You must then explain that for most people in ongoing sexual relationships, a moderate degree of emotional intimacy is a fundamental prerequisite and that if this level of intimacy is unattainable, they are not, in fact, sexually dysfunctional.

When the larger context indicates a long-term tendency to deny emotions and simply to be strong, work hard, and get on with life, frequently in midlife, men perhaps more than women find this philosophy is no longer working for them. These men typically present with low sexual desire. In reality, the lack of desire is just one of the emotions they have chronically avoided, and with less robust erections (simply with age), it is the sexual aspect of their paucity of emotions that becomes the obvious symptom. You may wish to refer the patient to a psychologist or a psychiatrist in these cases.

**The duration of low desire can be the first indication of the type of treatment that is needed.**

### Conclusion

Moving away from the notion that sexual desire is only a “spontaneous entity” aids the assessment of low desire. Addressing the components needed for responsive desire, including emotional intimacy, sexual context, specific sexual stimuli, psychological and biological factors governing the mind’s processing of the stimuli, and the ultimate outcome of the experience, provides logic to the situation such that the assessment is itself, to some degree, therapeutic. ♀

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