



TOOLBOX

Female sexual problems: loss of desire

Josie Butcher, University of Central Lancashire and Withington Hospital, Manchester, UK

Loss of desire for sexual activity is the female sexual dysfunction most commonly presented. It is also often the hardest to treat. Much literature is available on female loss of desire. The American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders (DSM-IV), which gives our working classification of psychosexual dysfunction, would classify it as hypoactive sexual desire disorder and sexual aversion disorder. It has long been debated whether such a loss of sexual desire should be seen as abnormal or simply as a variation of normal.

Masters and Johnson's original "human sexual response curve" helps us understand loss of desire in the context of the normal sexual response. This diagrammatic representation describes increasing sexual pleasure against time—desire for sexual activity followed by arousal, orgasm, and finally resolution. It is important to remember, however, that the physiologies of desire, arousal, and orgasm are separate entities and therefore not dependent on each other. Women with a loss of desire (hypoactive sexual desire disorder) can have good sexual functioning. In essence, they will not initiate sexual contact.

Is desire a thought or a feeling? The answer is not clear. Certainly, early in loving relationships, physical arousal closely follows any sexual thought. We have a sexual thought, which then facilitates the

Possible causes of hyperprolactinemia

- Pituitary tumors
- Hypothyroidism
- Cirrhosis
- Stress
- Hypothalamic disease
- Hepatic disease
- Breast surgery
- Drug treatments

arousal mechanism through neurological pathways. The thought could be anticipation of the evening ahead or a memory of a previous sexual encounter. Women who do not desire sexual activity can operate quite well sexually once engaged in the sexual encounter. Touch around the clitoris and genital area facilitates neurological pathways, producing good arousal and good lubrication, moving on to orgasm.

Illnesses that may result in a loss of sexual desire

- Gynecological disorders causing pain on sexual intercourse
- Obstetric disorders causing pain on sexual intercourse
- Urological disorders causing pain on sexual intercourse
- Alcohol and substance misuse
- Stress and chronic anxiety
- Endocrine disorders
- Neurological disorders
- Psychiatric disorders
- Depression
- Fatigue

CAUSES OF LOSS OF DESIRE

Much research into sexual desire is now underway, but the subject is still poorly understood. We know that certain medical conditions affect sexual desire. Depressive illness, for example, often dramatically reduces it, as do stress and fatigue.

Organic causes

Testosterone has a part to play in women's sexual desire, although much smaller amounts are required than in men. In women, testosterone production is split evenly between the ovaries and the adrenal gland. Androgen deficiency syndrome should be considered after hysterectomy and bilateral salpingo-oophorectomy and

after chemotherapy for cancer, when treatment with testosterone can improve loss of desire. Conditions and drugs that cause hyperprolactinemia have a direct effect on reducing sexual drive (see box).

The effect of changing hormone patterns at different life stages is poorly understood, but it is well known that loss of desire is more common with premenstrual tension, in the postnatal period, and around menopause. Many drugs can also cause loss of desire. Loss of desire can also be secondary to poor sexual arousal and lack of orgasm (see box).

Any health problem that might affect sexual anatomy, the vascular system, the neurological system, and the endocrine system must be considered. Indirect causes are conditions that can cause dyspareunia; conditions that cause chronic pain, fatigue, and malaise; and conditions that interfere with the vascular and neurological pathways.

Psychological causes

It is often difficult to disentangle organic possibilities from the psychogenic variables in women at different life stages that affect

Drugs that can affect women's sexual function

- Anti-androgens
 - Cyproterone
 - Gonadotropin-releasing hormone analogs
- Anti-estrogens and other hormones
 - Tamoxifen
 - Contraceptive drugs
- Cytotoxic drugs
- Psychoactive drugs
- Sedatives
- Narcotics
- Antidepressants
- Neuroleptics
- Stimulants



Tony Stone Images

Loss of desire is part of the normal female sexual response.

how they see sexuality fitting into their lives. It is important to consider these points and not to allow ourselves to be dragged into the medical model. We should look at the importance of the different roles that women have in their lives and how they prioritize them.

Many women have several roles—the professional or worker, housewife, mother, daughter, friend, and lover. This last role seems to fade away as the demands of the others increase. When a woman meets her first serious partner, she has fewer of these other roles. She may be only a worker and a daughter. In later years, she will have more roles to contend with. She may be a mother and housewife as well. For many women it seems that as the responsibilities of other roles increase, the importance of the lover role diminishes.

Looking at these issues can be quite revealing. One way to give structure to this interpretation is to undertake a process that we can call the “timetable of life.” Both partners in the relationship are asked to fill in a timetable representing a typical week. They are then asked to look at the week in terms of time spent in different categories: family time (that is, with children and partners), work time (both at work and work in the house), extended family time

(with parents and relations), social time, personal time, and relationship time (time spent together alone, as a couple). This last category is, of course, the time when sexual activity is most likely to be realized successfully.

A timetable almost always shows that the elements missing are relationship time and personal time. Roles are, of course, not only about the practicalities of who does what but also about how a woman feels about her responsibility for the roles she takes on.

Sexual learning

It is useful to ask a woman about her experiences of learning about sexuality and their influence in the development of her sexuality. Sexual learning and role prioritization are often intertwined. An example of this is the woman who found that she had lost sexual desire after the birth of her first child. Discussion showed that she had, not unnaturally, made the responsibility of being a mother a high priority, but coupled with this was the clear message that she had received when learning about her sexuality that “mothers are not sexual beings.”

Many misunderstandings and myths can be acquired during learning about sexuality: for example, a man is always ready and able to have sex; sex is natural and spontaneous; and sex equals intercourse. Sexual myths are held by women as well as men (see box).

It is useful to repeat the “timetable” for different times in a woman’s life, comparing it during courtship, when sexual desire

was probably high, with the times when sexual desire was low. This study shows how priorities change and how these changes can influence the desire for sexual activity.

Looking at what happens in a sexual situation often gives much information about the defenses erected when a patient engages in sexual activity. We can look at what turns a patient on and off, how absorbed she becomes in the sexual experience, whether loss of desire occurs on every occasion, or whether it is situational. Discussing other topics, such as sexual fantasy, masturbation,



Mother & Baby Picture Library

As a woman takes on the roles of mother and housewife, the importance of her role as lover may diminish.

Ten myths about sex

- In general, a man should not express certain emotions
- In sex, as elsewhere, it is performance that counts
- An erection is essential for a satisfying sexual experience
- All physical contact must lead to sex
- Sex equals intercourse
- Good sex must follow a linear progression of increasing excitement and terminate in orgasm
- Sex should be natural and spontaneous
- On the whole, the man must take charge of and orchestrate sex
- A man wants and is always ready for sex
- We no longer believe the above myths

Adapted from Zilbergeld B. *Men and sex: a guide to sexual fulfilment*. London: HarperCollins; 1995.

genital functioning, and contraception can also give great insight.

TREATMENT OPTIONS

An integrated approach to medical and psychological treatments is optimal. Any medical elements of the problem, if present, must be treated to achieve a positive outcome. In secondary loss of desire for sexual activity, a psychogenic aspect often remains after the medical elements have been treated (see box).

Most of the treatment will involve cognitive behavioral approaches and psychodynamic approaches, based on the discussions previously described. One of the most difficult areas to approach and affect is loss of attrac-



Callipygeus Eve and Adoring Adam (1510) by Albrecht Dürer

We expect our partners to feel the same as we feel and to know when we feel sexual.

tion for the partner, which can lead to serious difficulties and have serious consequences.

Working with the couple when there is loss of sexual desire allows both partners' understanding of the problem to be examined by some of the techniques above. As partners begin to realize that they can no longer assume that they know how their partner feels, or should feel, the differences in sexuality and sexual needs can be explored. We expect our partners to feel the same as we feel and to know when we feel sexual. We expect them to be able to provide for our needs sexually without neces-

sarily discussing them. With counseling, the aim is to encourage acceptance of differences, a concept sometimes described as "benign variation."

Further reading

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Diagnostic checklist for women's loss of sexual desire

- Physical illness
- Integrity of anatomy
- Integrity of vascular system
- Integrity of neurological system
- Integrity of endocrine system
- Drugs and treatments
- Psychological characteristics
- Relationship issues
- Life changes
- Sexual history
- Sexual knowledge
- Attraction to partner

"Frigidity" is not featured in this discussion nor is it featured in any classification of female sexual dysfunction. The term is more a reflection of women's feelings about themselves or of men's feelings about women. When a woman describes herself as frigid, she is really describing how she feels about herself as a sexual being and is often comparing her feelings and behavior with her own or others' expectations of how she should feel. Because frigidity is not a medical term, we should no longer use it.