Keeping the Home Fires Burning: *Treatment Approaches to Distressing Low Sexual Desire in Women*

BY PEBBLE KRANZ, MD, FECSM

Your partner is your best friend and you are in perfect alignment on every aspect of your partnership except one-- sex. Sex used to be fun! Sex brought you closer to your partner and you anticipated it with pleasure. Now, it feels like a chore, an obligation, and if you are totally honest with yourself, the idea fills you with dread. Maybe you've even started avoiding spending time alone with your partner-- that's how much you do NOT look forward to sex now.

This is a story I hear every day in my sexual medicine practice. "I want to want." "I feel bad for my partner but I also feel bad for me-- this used to be an important and wonderful part of my life." Changes in sexual desire can have a tremendous impact on individuals and relationships-- leading to depression and anxiety or relational disruption. Sex therapist Barry McCarthy reports that when sex goes well it adds about 15-20% to couples vitality and satisfaction. However, when sexuality is dysfunctional it assumes a very powerful role, decreasing relationship vitality and satisfaction by 50-70%[1] . So, it makes sense that people want solutions for their concerns about sexual desire.

In the 25 years since the introduction of Viagra, our understanding of the neurological, hormonal, and even anatomic aspects of sexual function has blossomed. The developments are even more substantial for the sexual function of people assigned female at birth.[2] Yes, medical science has thankfully come a long way from the idea that the only "real" orgasms are vaginal. Thanks to the establishment of international organizations like ISSWSH (the International Society for the Study of Women's Sexual Health) we have means to disseminate new information. Among the discoveries, we have a more refined understanding of the hormonal influences on vulvar skin[3], a more clinically and scientifically relevant diagnostic classification system for female sexual dysfunction[4], two peer-reviewed medical journals devoted to the scientific study of sexual function, and (FINALLY!) in January 2019, the Center for Medicare and Medicaid Services agreed to cover topical medications for vaginal dryness and other genital complications of menopause. And, we have a new understanding of the neurobiology of sexual function leading to the development of 2 FDA-approved medications for low sexual desire in women[5].

Low sexual desire, classified by ISSWSH and in the upcoming ICD-11 as Hypoactive Sexual Desire Disorder (HSDD), is the most prevalent female sexual concern affecting 14-26% of females aged 20-49 years and 9-14% of females aged 50 to 70 years[6]. HSDD is associated with significant negative emotional and psychological states, as well as medical conditions.

HSDD is defined as any of the following for a minimum of 6 months:

- Lack of motivation for sexual activity. Decreased or absent spontaneous desire (sexual thoughts or fantasies) or decreased or absent responsive desire to erotic cues and stimulation or inability to maintain desire through sexual activity.
- Loss of desire to initiate or participate in sexual activity, including behavioral responses such as avoidance of situations that could lead to sexual activity, that are not secondary to sexual pain disorders and combined with clinically significant personal distress.
- *And* is combined with clinically significant personal distress[7]

The evaluation of HSDD is fundamentally complex-- it requires a true biopsychosocial perspective. Desire is best understood as being composed of three key components: Sexual "drive," sexual beliefs, and sexual motivation[8].

Sexual "drive" includes cravings for sexual activity, sexual dreams and thoughts, and genital sensations. It is influenced by the nervous system and hormonal environment. Many general medical conditions (diabetes, thyroid dysfunction, cancer and its treatments, etc.) as well as many medications and surgical procedures affect this system.

Sexual beliefs are expectations about sex reflecting beliefs and values about sex. This can have an impact on desire related to cultural ideas about what sexual desire should look and feel like at different ages and stages in our lives. This also can have an impact on desire when our values conflict with the sex we want.

Sexual motivation includes the interpersonal and emotional aspects of desire that contribute to the willingness to

engage in sexual activity. This is influenced by psychological function, relationship quality, and other life concerns such as health, career, and family. Motivation for sex is more varied than one might think-- sex researchers Meston and Buss have identified 237 reasons that people are motivated to have sex[9]. So, there's a lot more to sexual motivation than desire for emotional closeness or orgasmic release.

Sex therapy researchers recognize other components to sexual desire such as an orientation of 'anticipation vs dread' as it pertains to sexual experience as well as sexual boredom. There may be a lack of specific stimulation needed for enjoyment of sex or a lack of trust, intimacy, or psychosexual and relational skills. These aspects may be crucial to sexual desire. In Dr. Peggy Kleinplatz' words: "Low sexual desire may be a healthy response to sex that doesn't meet our needs."[10] We also must recognize that sometimes a concern about low desire may be a matter of a discrepancy in desire levels within a relationship and not something fundamentally wrong with any one party. We accept the need to negotiate differences in parenting, financial, and housekeeping styles as a typical part of being in a relationship. Why should sexual desire be any different?

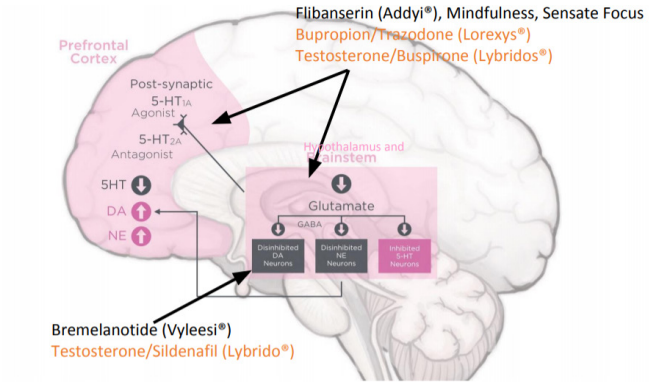
So there is a lot to think about when a person has a concern of low sexual desire. And yet, here is a concern that is widely prevalent and can be deeply distressing. What can we do?

There are some excellent books available on understanding and working on sexual desire on your own. *Come As You Are* by Emily Nagoski, PhD, is a phenomenal resource for the latest in sexual science. Jennifer Gunsaullus, PhD, also provides concrete approaches to desire concerns in *From Madness to Mindfulness: Reinventing Sex for Women. Magnificent Sex: Lessons from Extraordinary Lovers* is a recently released book from Dr. Peggy Kleinplatz whose Optimal Sexual Experiences Research Team has developed an effective and novel group treatment for couples with sexual desire concerns.

There are a wide variety of psychotherapy approaches to desire concerns, from interventions to help couples talk about their sexual concerns and needs to methods involving psychoeducation and "homeplay." Most people trained in the US in mental health get very little training in sexual issues, so it is important to find a therapist who is certified in sex therapy. AASECT (American Association of Sexuality Educators, Counselors, and Therapists) is the certifying body in the US. AASECT certified therapists and counselors have had extensive training in sexual psychology and physiology.

And, what about those medications?

In 2017, the Mayo Clinic Proceedings published the first-ever set of guidelines on treatment of distressing low sexual desire (HSDD) for frontline women's health providers. This provides rational, evidence- based guidelines for evaluation and management of HSDD[11]. The process of care guides clinicians in choosing appropriate situations for trials of medical interventions for HSDD such as FDA approved flibanserin (Addyi)--a daily oral medication which works on serotonin and dopamine in the brain-- for those who are premenopausal, and unapproved but clinically useful transdermal testosterone in postmenopausal individuals. Attesting to the rapidity of development, this 2017 article does not include a 2019 FDA-approved medication for HSDD, bremelanotide (Vyleesi), an as-needed injectable medication, which also works on the neuroendocrine environment to increase sexual desire. Manipulation of the neuroendocrine environment does appear to have effects on female sexual desire particularly when other contributing concerns are addressed. Mechanisms for these medications and several others under development are outlined in figure 2.



Items in black are FDA approved or in active use in clinical practice. Items in orange are under investigation at this time.
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Figure 2

Medications to treat low sexual desire have been surrounded by controversy. An attempt to summarize that controversy is daunting. It encompasses complicated social concerns. Are

medications for low desire pathologizing and antifeminist (and heterosexist)-- an effort to make women please men? Or are efforts against interventions yet more evidence of the unequal medical treatment of women? As a society, how do we construe female sexuality and what impact does that have on providing treatments for sexual concerns? The FDA has yet to approve a testosterone formulation for postmenopausal females, despite clinical efficacy and safety when used off-label[12] in large part because of the much higher regulatory controls on medication trials in females-- is this for our protection or control over our sexuality?

Initially after the release of flibanserin there were concerns about flibanserin's safety. At first, there was guidance that women who used flibanserin needed to abstain entirely from alcohol use. However, the studies that led to these concerns were conducted in non-realistic environments with male subjects. Postapproval studies performed in females with more typical alcohol use showed minimal effect of concurrent alcohol ingestion and have led to removal of the requirement to have patients attest to avoiding alcohol while on flibanserin. Flibanserin's initial safety trials were conducted in comparison to medications without primary central nervous system activity. When compared with similar medications like SSRIs, SNRIs, and bupropion, flibanserin had similar side effects[13].

These medications have been proven to increase a subjective feeling of sexual desire and decrease distress, with flibanserin showing additionally a modest increase in the number of sexually satisfying events. An 8 week trial of daily flibanserin or as needed bremelanotide is necessary to assess efficacy. Flibanserin is reported to be effective in about 50% of appropriately selected individuals.

So, these medications are not a cure-all but they may have a role in addressing low sexual desire. People who are having painfree, stimulating sex with partners with whom they want to have sex, without modifiable interpersonal, psychological, medical or medication factors may benefit greatly from these medications. When using desire medications, I stress the critical importance of engaging in a variety of methods to improve sexual experience and the many factors that may be contributing to low desire.

So, if you think there aren't options for low sexual desire aside from a lengthy psychoanalysis or advice to "have a glass of wine" or "use it or lose it" (please don't say those things), or that it's not worth asking your doctor because nothing can be done, think again. Solutions exist for this prevalent, distressing concern. And stay tuned, discoveries in sexual medicine are only beginning.

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Resources:

Metz, M., McCarthy, B. (2010). Enduring desire. New York, NY: Routledge. ● From this point, for ease of reading, I will refer to people assigned female at birth as "female." This may include people who have vulvas, vaginas and other typically "female" sexual and reproductive organs and may include people who do not have these anatomic structures. "Female" here is not meant to be a designation of identity but attempts to encompass many different gender identities ● Traish, Abdulmaged M. et al. Role of Androgens in Female Genitourinary Tissue Structure and Function: Implications in the Genitourinary Syndrome of Menopause. Sex Med Rev 2018; 6: 558-571 ● Derogatis, Leonard R. et al. Toward a More Evidence-Based Nosology and Nomenclature for Female Sexual Dysfunctions—Part I. J Sex Med 2016; 13(12):1881-1887 and Parish, Sharon J. et al. Toward a More Evidence-Based Nosology and Nomenclature for Female Sexual Dysfunctions—Part II. J Sex Med 2016; 13(12):1888-1906 and Parish, Sharon J. et al. Toward a More Evidence-Based Nosology and Nomenclature for Female Sexual Dysfunctions—Part III. J Sex Med 2019; 16 (3):452-462 ● Pfaus, James G. REVIEWS: Pathways of Sexual Desire. J Sex Med 2009;6(6):1506-1533 ● Leiblum et al. Hypoactive Sexual Desire Disorder in Postmenopausal Women: US results from the Women's International Study of Health and Sexuality (WISHeS). Menopause 2006;1:46-56 ● Clayton A, Goldstein I, Kim N et al. The International Society for the Study of Women's Sexual Health Process of Care for Management of Hypoactive Sexual Desire Disorder in Women. Mayo Clin Proc. 2018;93(4):467-487. ● Kingsberg S, Rezaee R. Hypoactive sexual desire in women. Menopause. 2013;20(12):1284-1300● Meston, C.M., Buss, D.M. Why Humans Have Sex. Arch Sex Behav 36, 477–507 (2007). ● Kleinplatz, P. Personal communication. ● Clayton A, Goldstein I, Kim N et al. The International Society for the Study of Women's Sexual Health Process of Care for Management of Hypoactive Sexual Desire Disorder in Women. Mayo Clin Proc. 2018;93(4):467-487. ● Davis S, Baber R, Panay N et al. Global Consensus Position Statement on the Use of Testosterone Therapy for Women. J Sex Med. 2019;16(9):1331-1337. ● Kingsberg SA et al., Evaluation of Flibanserin Safety: Comparison with other Serotonergic Medications. Sex Med Rev 2019;7:380-392