# Hypo Active Desire Disorder

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دانشیار بهداشت باروری از علوم پزشکی اراک

- Hypoactive sexual desire disorder (HSDD) was found to have the highest lifetime prevalence in both men (16%) and women (26%).
- recent findings demonstrate the universality of low desire, stating that 27% to 40% of women and 10% to 20% of men experience distress regarding their sexual desire .
- approximately 20% higher in postmenopausal than in premenopausal women

# DSM-5 defines

- deficient or absent thoughts or erotic fantasies and must cause clinically significant distress in the individual, and relationship and  lack of desire for sexual activity.
- These symptoms must have been present for a minimum of six months, and cannot be explained by another disorder or other stressors

DSM-5 instructs the clinician to specify whether the HSDD is:

1) lifelong or acquired;

2) generalized or situational and;

3) mild, moderate or severe in severity.

# DSM-5 suggests that clinicians consider five factors in assessing HSDD:

1) partner factors (e.g., partner's sexual problems, partner's health status);

2) relationship factors (e.g., poor communication, discrepancies between partners in desire for sexual activity);

3) individual vulnerability factors (e.g., poor body image, history of sexual or emotional abuse), psychiatric comorbidity (e.g., depression, anxiety), or stressors (e.g., job loss, bereavement);

4) cultural/religious factors (e.g., prohibitions against sexual activity; attitudes toward sexuality).

5) medical factors relevant to prognosis, course, or treatment. Each of these factors may contribute differently to the presenting symptoms of different men with this disorder

# Levine posits that sexual desire in men or women consists of three elements:

1) drive; 2) wish and; 3) motivation.

drive is the biological component based on neuroendocrine mechanisms and experienced as spontaneous sexual interest.

Drive is apparent through the man's sexual thoughts, fantasies, dreams, sensations

The wish or cognitive component refers to the expectations,

beliefs and values about sex.

For instance, men might say, “We should have sex twice a week”, or “It's our anniversary, we should have sex tonight”, or “When the kids are in the house, we shouldn't have sex. The words “should” or “shouldn't” point the clinician in the direction of cognitive concerns.

motivation is the emotional or interpersonal aspect of desire.

It reflects the willingness of the man to engage in sexual behavior alone or with a particular partner.

It is influenced by the quality of his relationship, psychological functioning, worries about health

# General Assessment

- 1. Was there a time that you experienced sexual desire?
- 2. Was the onset of the symptom gradual or sudden?
- 3. When did you first experience low sexual desire?
- 4. What was going on in your or your family's life at the time the symptom started?
- 5. Did you experience other sexual problems? Do you now?
- 6. What was the progression of the symptom e.g. did it get better or worse?
- 7. Does the low desire manifest itself in your masturbatory life?
- 8. What images and fantasies are exciting to you?
- 9. What is the impact of low desire on your partner?
- 10. Are you diagnosed with any medical conditions, taking medication, or have a history of any surgeries?
- 11. What have you done to try to improve the situation?
- 12. What do you think underlies the problem?

# Biological Assessment

Aging, illness, medication, and surgery can affect sexual desire.

man who undergoes a radical prostatectomy.

Prior to surgery he had no problems with desire, arousal or orgasm. After surgery, he is likely to have erectile dysfunction, which eventually will lead to diminished desire.

When a man complains of having little to no sexual desire for masturbation or with a partner, obtain a testosterone level

# Psychological Assessment

- The list of psychological factors that may contribute to low sexual desire is quite long—
- depressed mood,
- struggles regarding sexual orientation,
- unconventional or paraphilic sexual fantasies,
- gender identity conflicts,
- sexual secrets from his partner, pornography use,
- transferential (e.g. “She is just like my mother!”) and, psychological issues related to physical or sexual abuse, attachment disruptions, etc

# Cultural Assessment

- I have seen men whose religious/cultural beliefs inhibit their sexual interest. They have adopted beliefs that sexual desire is bad that pre-marital sexual relations are sinful, or that sex for any reason except procreation is unacceptable.

# Interpersonal Assessment

- resentment towards his partner , looking at his partner differently after having children, requiring the partner to fulfill specific sexual needs, lack of communication, intimacy, anger, hostility, dominance, or control issues.

# Contextual Assessment

- financial hardship or losing a job,. Stresses such as worries about ill parents and children may also diminish sexual interest.

# Jack Annon's PLISSIT model as a valuable paradigm for designing a sound treatment intervention

- “P” for permission, “LI” for limited information, “SS” for specific suggestions, and “IT” for Intensive Therapy.

# Treatment

- A man with lifelong low desire either has an untreated endocrine disorder or, more likely has developmentally failed to surmount the psychological hurdles necessary to regularly and pleasurably experience sexual desire.

- If biological issues can be ruled out, this man would best be treated in an individual psychotherapy where these developmental concerns could be addressed. Conjoint treatment is the wrong venue to address these historical concerns as they likely have little to do with the partner or the present day relationship.

- Acquired desire problems health and medication issues that occurred contemporaneously with the genesis of the desire problem should be examined as well as possible relational or contextual issues. If the medical concerns can be ruled out, then acquired disorders that began while in the relationship are often best treated in conjoint psychotherapy.

**Sex therapy is a specialized form of psychotherapy that draws on an array of behavioral interventions known to effectively treat male and female sexual dysfunction.**

- Behavioral interventions for low sexual desire may include sensate focus exercises to try to help either or both partners recapture erotic feeling while diminishing anxiety.

# Sex therapy

- encouraging the couple to explore and develop their sexual interests.
- A homework assignment may involve browsing through sex books or manuals, shopping (even if not buying), sex toys, lingerie, etc. During the exercise the clients are prompted
- to be curious—“What would this be like? What would this feel like? Would I enjoy this?”

# encouraged to develop the fantasy

client is advised to pay attention to any sexual feelings that occur

throughout the day.

he is advised to recall the fantasy and to re-engage with it several times

a day if possible.

After he can do this exercise successfully, he is advised to incorporate his partner into his fantasy, essentially fantasizing about his partner and then ultimately

initiating some sexual activity (letting his partner know in advance that he would like to be sexual).

# CBT

CBT for HSDD focuses on the interaction between maladaptive thoughts (e.g., “I am a bad sexual partner”), feelings (e.g., guilt), and behaviors (e.g., avoiding physical affection with partner). Techniques used in CBT include cognitive restructuring (i.e., identification and challenge of maladaptive thoughts)

and exercises such as communication skills training, with the premise that shifts in negative thinking will also produce changes in related feelings and behaviors.

# mindfulness-based therapy

mindfulness-based therapy has been tested for women with desire and arousal problems. Mindfulness is a practice that is described as "paying attention in a particular way: on purpose, in the present moment, and non-judgmentally

# Drug treatment

- In addition to testosterone,
- medications such as buproprion and flibanserin that were originally developed for treating depression.

- Flibanserin is a serotonin receptor type 5-HT1A agonist
- and a 5-HT2A , and it selectively
- acts on monoamines in specific regions of the brain.
- For example, flibanserin decreases serotonin levels
- and increases dopamine and norephinephrine levels

# با تشکر از توجه شما