ABC of sexual health

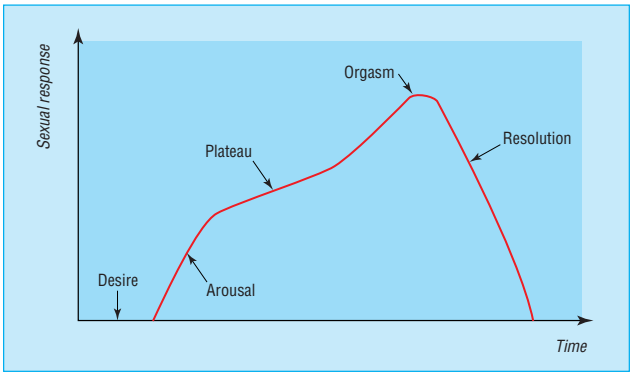
Female sexual problems I: Loss of desire—what about the fun?

Josie Butcher

Loss of desire for sexual activity is the commonest presenting female sexual dysfunction and often the hardest to treat. Whether this loss of sexual desire should be seen as abnormal or simply as a variation of normal has long been debated. Much literature is available on female loss of desire, considering sexuality for women from various angles. 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.

Masters and Johnson's original "human sexual response curve" helps us to 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 are not dependent on each other. Women with 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, and, certainly early in loving relationships, physical arousal closely follows any sexual thought. Initially, we have a sexual thought, which then facilitates the 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, good lubrication, and on to orgasm.



The normal female sexual response. (Adapted from Masters WH, Johnson VE. *Human sexual response.* Boston, MA: Little, Brown, 1966)

Causes of loss of desire

Much research into sexual desire is being undertaken, but it is still poorly understood. We know that certain medical conditions affect it. For example depressive illness 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 both hysterectomy and bilateral salpingo-oophorectomy, and chemotherapy for cancer, when treatment with testosterone can improve loss of desire. Conditions and drugs that cause hyperprolactinaemia have a direct effect on reducing sexual drive.

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, postnatally, and around the menopause. Many drugs can also cause loss of desire, and it can be secondary to poor sexual arousal and lack of orgasm.

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

Possible causes of hyperprolactinaemia

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

Drugs that can affect women's sexual function

- Antiandrogens
  - Cyproterone
  - Gonadotrophin releasing hormone analogues
- Antioestrogens and other hormones
  - Tamoxifen
  - Contraceptive drugs
- Cytotoxic drugs
- Psychoactive drugs
  - Sedatives
  - Narcotics
  - Antidepressants
  - Neuroleptics
  - Stimulants

can cause dyspareunia; that cause chronic pain, fatigue, and malaise; and that interfere with the vascular and neurological pathways.

Psychological causes

It is often difficult to disentangle organic possibilities from psychogenic variables that occur in women at different life stages and the effect that these may have on how women 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 prioritise 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 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 responsibility of roles increases, the importance of the lover role diminishes.

Looking at these issues can be quite revealing, and an easy way to give structure to this 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 more likely to be realised successfully.

A timetable almost always shows the elements missing to be relationship time and personal time. Roles are, of course, not just about the practicalities of who does what but about the responsibilities a woman feels for the roles she takes on.

It is useful to ask a woman her views on her learning about sexuality and the influences that have played a part in the development of her sexuality. Sexual learning and role prioritisation 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, such as that a man is always ready and able to have sex, that sex is natural and spontaneous, and that sex equals intercourse. Sexual myths are held by women as well as men.

Repeating the "timetable" for different times in a woman's life and comparing it during courtship, when sexual desire was probably good, with the timetable for a time when sexual desire was low is useful and shows how priorities change and how this can influence desire for sexual activity.

Looking at what happens in a sexual situation often gives much information about the defences erected when a patient engages in sexual activity. One can look at what turns a patient on and off, how absorbed she becomes in the sexual experience, and whether loss of desire occurs on every occasion or whether it is situational. Areas such as sexual fantasy, masturbation, genital functioning, and contraception can be discussed and give great insight.

Illnesses that may result in loss of sexual desire

- Gynaecological 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

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

Possible sources for sexual learning include parental values, religious teaching, cultural mores, and life events

Ten myths about sex

- In general, a man should not be seen to 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: Harper Collins, 1995

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.

Most of the treatment will involve cognitive behavioural approaches and psychodynamic approaches based on the discussions previously described. One of the most difficult areas to approach and deal with is loss of attraction for the partner, which can lead to serious difficulties and consequences.

Working with people as a couple when there is loss of sexual desire allows both partners' understanding of the problem to be examined by means of some of the techniques described above. As partners begin to realise 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 way as we feel and to know when we feel sexual. We expect them to be able to provide for our needs sexually without necessarily discussing them. With counselling, the aim is to encourage acceptance of difference, a concept sometimes described as "benign variation."

Frigidity does not feature in this discussion, nor does it feature 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 it is often a comparison with her or others' expectations of how she should feel and be. Frigidity is not a medical term, and we should no longer use it.

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

We expect our partners to feel the same way as we feel and to know when we feel sexual. (*Callipygous Eve and Adoring Adam* (1510) by Albrecht Dürer)

Further reading

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BMJ 1999;318:41-3

One hundred years ago

Special correspondence: Paris

According to statistics presented to the Antialcohol Congress recently held at Nantes, France of all the European nations consumes the largest amount of alcohol. Her requirements reach 14.19 litres of alcohol at 100° yearly for each inhabitant, the Belgians and Germans consume yearly 10.50 litres per head, the English 9.25 litres, the Italians 6.60 litres, the Swedes 4.50 litres, and the Canadians 2. If it is true that the birth-rate diminishes in proportion that alcoholism increases, the decrease in the French population is explained by the existence of an important factor. Increase in insanity has also coincided with the increase in alcoholism. In 1838 there were from 14,000 to 15,000 patients in the lunatic asylums, now there are 100,000. Suicides which have their origin in alcoholism are also becoming more frequent. In the North department these suicides have increased sixfold.
(*BMJ* 1899;i:1058)