William I. Morse

# Inhibited Sexual Desire and Sexual Avoidance


## SUMMARY

Inhibited sexual desire (ISD) is one of the most common sexual dysfunctions, especially in women. Family physicians have an opportunity to recognize ISD before the associated problems become entrenched, and to guide couples toward satisfactory resolution. A summary is presented of current thinking on ISD and its causes. Case reports and observations about frequency of and treatment for ISD are included. Much less has been written about sexual avoidance in the presence of desire. A definition is offered of simple sexual avoidance in the absence of genital dysfunction. Frequency, treatment response, and specific cases are described. A newly identified entity—mutual unwillingness to importune for sex—is discussed briefly. Counselling which focuses on communication, self responsibility, and sex edcuation is very helpful to patients with sexual problems. (Can Fam Physician 1985; 31:781-786)

## SOMMAIRE

L'inhibition du désir sexuel (IDS) est l'une des causes les plus fréquentes de dysfonction sexuelle chez les femmes. Les médecins de famille ont l'opportunité de l'identifier avant que les problèmes qui y sont associés ne deviennent enracinés, et de guider les couples vers une résolution satisfaisante. Cet article présente un résumé de la pensée actuelle sur l'IDS et ses nombreuses causes. On y retrouve aussi des observations sur la fréquence relative de l'ISD, la réponse au traitement, des histoires de cas et des commentaires concernant le traitement. Il existe peu d'articles sur la résistance au désir sexuel. On propose une définition de cette résistance simple au désir sexuel, en l'absence de dysfonction génitale, de même que des observations concernant la fréquence relative, la réponse au traitement et quelques histoires de cas. Une nouvelle entité—l'accord mutuel pour ne pas réclamer de relations sexuelles—est brièvement discutée.


**Key words:** Inhibited sexual desire, sexual avoidance, counselling

**Dr. Morse is a physician and certified sex therapist, currently on leave from private practice in Paradise, NS. Reprint requests to: P.O. Box 28, Paradise, NS. B0S 1R0.**

INHIBITED SEXUAL DESIRE (ISD) is one of the most common sexual problems. Family physicians have opportunities to recognize this distressing problem and to guide couples toward satisfactory resolution. All too often, the diagnosis is missed unless specific questions are asked during routine visits about sexual interest and satisfaction.

Sexual avoidance, which may respond to counselling, is less common, but physicians should be familiar with it.

Distinguishing different causes of low sexual frequency is important, because in each case entirely different treatment approaches are required.[1]

## What Are ISD and Sexual Avoidance?

Kaplan[2] and Lief[3] identified ISD as a clinical entity eight years ago. These authors considered desire to be the first phase of the sexual response cycle, followed by the excitement phase and finally orgasm.

Sexual desire is probably an instinct or appetite, but also a learned response involving psychosocial conditioning.[4] It is almost certainly associated with physiological changes in the brain. When these recur with much reduced frequency, the patient often has ISD. The Diagnostic and Statistical Manual of Mental Disorders (DSM III) defines ISD as a psychosexual dysfunction which inhibits the appetitive or psychophysiological changes characterizing the complete sexual response

cycle.[5] Hypoactive sexual desire can also result from certain medications or physical diseases but, in these instances, there is no unrelated psychological inhibition, so the term ISD would be incorrect.

The patient who rarely experiences desire in response to any thought or external stimulus, and is distressed by it, has global ISD. This appears to be a true 'sexual anorexia'. The term situational ISD applies when the individual experiences desire in response to some sexual stimuli, but not to others. I find it difficult to believe that situational ISD is a true psychosexual dysfunction. In the selected population which I see, most cases of ISD are situational, the usual complaint being lack of desire for sex with a specific partner.

ISD should not be diagnosed unless it is persistent, pervasive and considered to be a problem by one or both partners.

The criteria for diagnosing ISD differ, at least slightly, from one clinic to another. DSM III states that frequently the diagnosis of ISD will be used in conjunction with one or more of the other psychophysiological dysfunction categories.[5] This statement needs clarification. In my experience, inhibited desire is reported so frequently by one or both spouses when the couple has been contending with an entrenched genital dysfunction that I have a policy of not recording the diagnosis of ISD in this circumstance. To record it when genital dysfunction is the major cause reduces the specificity and usefulness of ISD as a diagnostic category.

Sexual avoidance is a common result of ISD but in this article, the term will be reserved for distressing avoidance concurrent with awareness of desire. Avoidance often accompanies the sexual performance fears which follow repeated past occasions of genital dysfunction.[5] These dysfunctions include erectile failure, premature ejaculation, anorgasmia and vaginismus. I will focus on avoidance which is usually due to other fears or unrealistic sexual expectations in the presence of normal sexual function.

Kaplan[1] has recently drawn attention to phobic avoidance, sometimes associated with a panic disorder.[1]

## Patients for this Study

Only three of the 478 men and 443 women referred to us privately or at Fundy Mental Health Centre (now Valley Health Services) were excluded from this report. These three were fully functional women who visited to discuss a partner's sexual dysfunction. My coworker, social worker and sex therapist Jean Morse and I each interviewed 426 couples. I did a complete physical examination for most of these men and women. Two hundred and ten couples returned for one to 20 (mean 7.1) sex therapy sessions. I also assessed 52 men alone because they had no committed partner or the partner was unwilling or unable to join them. My cotherapist assessed 17 women alone for similar reasons. Very few of these seen alone received further counselling after the initial visit.

## Diagnostic Criteria

*Inhibited sexual desire*

We diagnose ISD when desire is persistently below the normal range for age, sex, etc.[6], when one or both partners consider lack of desire to be a problem, and when genital dysfunction is judged not to be a *major* contributing factor. No patient with hypoactive desire due to an organic cause was diagnosed as having ISD. Nor would we include low libido due to fatigue or impaired general wellbeing, as might occur after menopause, and improve with estrogen replacement therapy.[7]

*Simple avoidance*

As a rule, sexual avoidance is appropriate behavior when desire is absent or when an informed judgment is made that some other activity deserves priority—at least for the moment. Avoidance is inappropriate when a person desires the sexual encounter, but responds to an irrational fear, societal myths, misinformation about the partner's hopes and expectations, or is unaware of a more effective behavior. The patient refuses most of the partner's sexual invitations. Simple avoidance is that which occurs in the presence of normal genital function for both partners.

*Neither will invite*

Sexual frequency is low because both partners are unwilling to importune, even though both remain receptive, at least some of the time, to sexual invitation.

## Study Methods

What follows is a modification of the format we learned at the Masters and Johnson Institute[8] nine years ago.

During our seven and a half years of joint practice in Nova Scotia, assessment of couples involved two interviews for each spouse, followed by physical examinations for both. My first interview was with the man and usually lasted an hour or more. My cotherapist interviewed the woman at the same time.

During this first interview, we asked for considerable detail about the dysfunction and its course to date. We regularly inquired about relevant early life experiences and non-sexual aspects of the present relationship. We inquired carefully about communication of feelings and hopes, and asked about each partner's motivation to attempt change in destructive interpersonal behavior. We found this type of information essential to planning and predicting possible benefit from the counselling sessions which might follow assessment. I also elicited a relevant medical history from the man.

At the second interview, my cotherapist talked with the man, while I talked with the woman. These sessions were shorter but no less essential if we were to earn the couple's confidence and trust. I learned a lot about the man by talking to his partner. A relevant medical history was elicited.

After the physical examinations, the assessment wound up with our summary of the problem(s) as we saw them; both spouses and both therapists were present. We discussed the probability of benefit if they decided on counselling for the sexual problem and, almost invariably, for relationship concerns as well. If the couple decided in favor of counselling, immediately or later, we held a series of one hour therapeutic sessions. With few exceptions, both therapists and both spouses were present at all therapy sessions. We shared concepts relevant to problems identified and often assigned reading material. Structured, sensual touching experiences were suggested, to be carried out in their home or motel. Each was to have a turn touching the partner's body for as long as both wanted it, with emphasis on touching for self rather than trying to guess what the partner might like. This non-demand touching was to be continued only as long as both spouses were comfortable. Sometimes it was necessary to delay these 'sensate focus' exercises[8] until hostility between them had abated and mutual

trust was returning. Progress of the program toward the goals which the couple had identified at the outset (or modified later) depended on the reports they brought back at subsequent therapy sessions.

Treatment results were based on my evaluation of the improvement (or otherwise) reported by each couple at their last therapeutic interview or follow-up phone call. Sometimes the couples failed to contact us after a series of clustered therapy sessions, but usually our last interview or phone call was several weeks or months later. For approximately half the couples, my cotherapist made an independent evaluation and, when available, this was given the same weight as my own. If we had evidence at the last interview that early improvement was followed by relapse, the counselling program was recorded as a failure.

## Results

Table 1 shows that 41% of women with sexual problems were contending with ISD—13% global and 28% situational. A relatively small number were also averse to touching or being touched by their partner, a finding not included in the table. Twenty-three percent of women with sexual problems had ISD without associated genital dysfunction. On the other hand, if we had included those instances of low female desire which were mostly secondary to genital dysfunction, the total would have increased to 57% of the women with sexual problems.

Table 1 shows that ISD is much less common among the men, only 9% fulfilling our criteria for this diagnosis. But this number more than doubles (to 22%) if one includes low desire largely secondary to genital dysfunction. For most of the men in the latter group, the loss of desire was global. Perhaps persisting loss of desire is more closely related to genital dysfunction for men than it is for women.

Table 2 shows the number of persons with diagnoses resulting in low sexual frequency in the absence of genital dysfunction. Most of these people had inhibited desire, but a few had simple sexual avoidance. We also assessed five couples with low sexual frequency, because neither would invite the other to make love. Although not included in the table, for many people, avoidance was secondary to fears generated by a genital dysfunction. We also saw a few couples where non-inviting behavior was secondary to genital dysfunction for one or both partners.

The avoiding and non-inviting patterns sometimes resulted from unfounded fears of sexual failure, sexual rejection or the partner's sexual reluctance. Others were afraid of intimacy or dependence on the spouse. Most of the female non-inviters had believed since childhood that the man always issues the sexual invitations. Two avoiders were aware that their fears were excessive and irrational, but had been unable to alter the distressing behavior before assessment. (Case 5 deals with one of these.) Both spouses in one non-inviting dyad were also aware that the behavior was inappropriate (see Case 7). Avoiders' spouses were usually emotionally stable and confident about their own sexuality—hence their willingness to invite despite repeated refusals. Some partners had identified the fear which was interfering with the sexual relationship and pointed out its irrational nature, but without convincing the avoiding spouse.

Table 3 shows the treatment results for couples with distressing, low sexual frequency where there was no major genital dysfunction. Most of these patients had ISD, but results for the small number of avoiders and non-inviters have been included in the table. Approximately 50% of the couples who were assessed returned for counselling. About 50% of these were judged at the last therapeutic session or follow-up phone call to have improved.

*Case No. 1*

The wife had situational ISD. She was lonely because the couple had moved to unfamiliar surroundings, and her husband was often away from home for several days. Her discontent was compounded by his failure to share thoughts, hopes and feelings with her, or to listen attentively to her concerns. He tended to withdraw when an argument was developing. It is probably significant that he stopped confiding in his parents and peers during a difficult period in his childhood. Sex was rewarding for both partners early in the relationship but recently the wife had been losing desire for marital sex. Both spouses used masturbation as a substitute. She felt guilty about not satisfying him and had faked orgasm during their infrequent sexual

**TABLE 1**
**Contribution of Genital Dysfunction to Pathogenesis of Inhibited Sexual Desire.**

| | None | Minor | Major |
|---|---|---|---|
| **Women (N=277)** | | | 55* |
| Global (%) | 8 | 5 | 7 |
| Situational (%) | 15 | 13 | 9 |
| **Men (N=265)** | | | 57* |
| Global (%) | 2 | 3 | 11 |
| Situational (%) | 2 | 2 | 2 |

*Random partial sample

**Table 2**
**Patients Assessed With Distressing Low Sexual Frequency and Normal Genital Function**

| | |
|---|---|
| **Women (N=277)** | |
| Global ISD | 21 |
| Situational ISD | 41 |
| Simple avoidance | 4 |
| **Men (N=265)** | |
| Global ISD | 6 |
| Situational ISD | 5 |
| Simple avoidance | 7 |
| **Neither will invite** | 6 |

**Table 3**
**Treatment Results for Couples with Distressing Low Sexual Frequency Probably Unrelated to Genital Dysfunction**

| | Assessed | Treated | Improved |
|---|---|---|---|
| **Women** | | | |
| Global ISD | 34 | 14 | 10 |
| Situational ISD | 72 | 37 | 16 |
| Simple avoidance | 4 | 4 | 2 |
| **Men** | | | |
| Global ISD | 13 | 8 | 4 |
| Situational ISD | 12 | 8 | 3 |
| Simple avoidance | 7 | 6 | 2 |
| **Neither will invite** | 6 | 3 | 1 |

encounters. She preferred non-coital stimulation, but supposed that her husband would not be satisfied without intercourse.

Medical history and physical examination of both partners added no relevant information. This couple returned for 11 counselling sessions, during which we stressed the importance of more open communication; the husband was advised to express feelings and general concerns, and the wife her sexual preferences, including the option of refusal. We also suggested that the man listen more effectively. The relationship gradually strengthened and her interest in marital sexual encounters returned.

*Case No. 2*

The wife had global ISD with aversion. The couple were in their late 50s, and their long marriage had been satisfying in many respects. Both partners had enjoyed sex and for several years the wife had usually reached orgasm during lovemaking. A stressful period followed and she became chronically depressed. This was associated with loss of sexual interest and most of the time she did not want her husband to touch her or to cuddle in bed. Before assessment, the couple made love about once a month. On these occasions she did not desire sex until the encounter was already under way, and orgasms with coital or clitoral stimulation were infrequent. Both spouses were poorly informed about sexual response in later life and about lovemaking options, until a chance conversation with friends made them aware of what they had been missing for many years. Their physical examinations added nothing relevant. Eight therapeutic interviews followed our assessment and the wife soon learned to relax during sensate focus touching experiences. A few days later she was reporting arousal and orgasm in response to manual clitoral stimulation. Counselling interviews included sex education. They were enthusiastic about these, and about the reading assignments we gave them. Communication and problem solving were not major concerns for this couple and their sexual goals had been realized at the end of the daily counselling period.

*Case No. 3*

This middle-aged couple were referred because of the man's loss of interest in sexual activity with his partner or any other person. We diagnosed global ISD. Both partners had enjoyed sex early in the three-year relationship, but lovemaking was now infrequent. They continued to enjoy each other's company but the woman was unwilling to continue a relationship which did not include sex. The man had grown up with low self-esteem and was constantly criticized by his father. He felt the need to excel in business and also as a lover. During all his dating relationships he had focused on the woman's pleasure and prolonged lovemaking encounters, but was not highly aroused himself. He was pleased about his reputation as a skillful lover, but he was deriving relatively little erotic pleasure. Sexual boredom followed. No physical problem or medication could be implicated. He was ambivalent about counselling and they returned for only one therapeutic session.

*Case No. 4*

This obsessive man was an avoider. He had entered marriage believing it was the husband's prerogative to importune. At first he did so almost every night. A few months later his wife requested intercourse in the female astride position, but this was not consistent with his need to be the dominant partner at all times. He stopped importuning when aroused, and refused her invitations with increasing frequency. He also concluded that he could not meet her sexual needs and usually chose solo masturbation for his sexual release. The sexual problem responded temporarily to ten daily counselling sessions, but the problem gradually recurred during several months of follow-up.

*Case No. 5*

This man was an avoider with aversion and panic disorder. He had very few panic attacks after amitriptyline, 175 mg hs, was prescribed. He felt the need to dominate the relationship but the resulting behavior differed from that of the patient in Case No. 4. He found it very difficult to invite for sex because it made him feel dependent on his wife's acceptance. He wanted her to identify his moments of sexual desire by guessing, and resented her if she failed to do so. Many of her invitations were refused and he was often averse to her touch. This man had been in psychotherapy before our assessment, and was well aware that his fear of dependence was irrational and excessive. The wife was fully committed to the marriage and confident about her own sexuality. Because of strong motivation, the man's poor communication and sexual avoidance improved during nine daily counselling visits, but the unreasonable fears were not eliminated.

*Case No. 6*

This woman was a masochistic avoider. She refused most of her lover's sexual invitations, blaming him for rapid coital ejaculation, despite his assurance that this was due to the infrequency of sex. She admitted to my cotherapist that she held herself back and didn't tell her lover when sex had given her pleasure. She wanted him to be more sexually aggressive but this behavior was not acceptable to him. In the past she had enjoyed lovemaking most when she was "overpowered by the man". It had been difficult for her to admit that she wanted sex herself. At the end of six daily therapy sessions she had recognized the importance of more self-responsibility during sexual encounters. His ejaculatory control had improved and both were pleased with the outcome.

*Case No. 7*

Neither partner would invite the other for sex. Both were egocentric and the husband had atypical depression. During childhood, the wife was warned by her "cold" mother about the "male animal". Communication of feelings and hopes was very poor in this marriage. Each partner was defensive with the other, and there were numerous misunderstandings which led to lack of trust. The husband lacked self confidence and wouldn't invite for lovemaking, but would have been receptive to her invitation and desired more physical closeness. The wife had always feared intimacy and did not invite for sex when she felt mild spontaneous arousal—but would have been receptive to his invitations from time to time. This couple had received conjoint psychotherapy before our assessment and both were aware that their non-inviting behavior was irrational. Some improvement occurred during eight days of daily counselling, but we recommended further psychotherapy.

## Discussion

We have reservations about our method of judging improvement. The results cannot be compared with prospective studies where patients have completed suitable questionnaires before and after treatment, or been interviewed by an outside referee. However, we believe the results in Table 3 demonstrate that a trial of counselling is worthwhile if both spouses are motivated. The findings also suggest to us that the number of couples improved by treatment is lower for ISD than for those with common genital dysfunctions. (Our treatment results for the latter have not been published).

The number of our patients with simple avoidance, and non-inviters with normal genital function are too small to evaluate treatment outcome, but we suspect these results are not better than those for IDS.

Kaplan[6] reported that ISD often requires a longer period of counselling than genital dysfunctions. McCarthy[9] suggested that this is because couples allow ISD to become entrenched for years before seeking treatment.

I believe that family physicians who are willing and able to set aside the time can develop their counselling skills and assist some couples distressed by ISD or avoidance. The family doctor has more opportunity than the specialist to recognize the problem before it becomes entrenched and, in some instances, this should make treatment easier.

The key to successful counselling is for the physician to understand the dynamics which have caused and perpetuated the problem—hence the importance of thorough assessment. Inquiry about early life experiences will often shed light on the expectations each brought to the marriage and their sexual encounters. The scenario in a romantic novel is not realistic—and there are plenty of myths in 'men's magazines' which stand in the way of letting sex be a natural function. Most of us have to unlearn some notions that were shared by parents and others, often with the best of intentions, during our childhood. Nowinski[10] recently summarized the relationship between male socialization in early life and men's sexual malaise.

For many couples with ISD, the major problem is ineffective communication resulting in misunderstandings and hostility. More often, each spouse wants to please the other but neither has much idea what the other wants or needs. Useful suggestions can be offered, and the physician should never overlook the long list of possible physical and pharmacogenic causes of hypoactive desire.[4]

The assessment will guide the physician's decision of whether to proceed with counselling sessions or refer the couple to a specialist. If referral seems indicated, the family doctor should seek out a physician, social worker, psychologist or member of the clergy with specific training in marital and sexual problems. If psychopathology is suspected in one or both spouses, a psychiatric opinion may be necessary. Psychotherapy by a psychiatrist or psychologist may be most effective. Longstanding hostility between partners (along with real desire to rebuild the marriage) or ingrained sexual fears may be handled best by a sex therapist with training in marital therapy.

If counselling is undertaken, emphasize the fact that the relationship is in therapy.[4] This lessens the likelihood that one partner will be singled out as 'the patient', and encourages both partners to try to alter problem behavior.

The more they focus on the present, and the less time given to past disappointments, the more likely it is that there will be productive change in the marriage. An attitude of neutrality about the future is also useful (i.e., the couple shouldn't predict, but attempt to live one day at a time for a trial period, during which they apply counselling suggestions).

## Verbal Communication

Many spouses with situational ISD have been editing what they say to each other and may have become defensive. (This can also occur with an avoider or non-inviter. See Case No. 7). More vulnerability or openness and willingness to share feelings should be encouraged, even at the risk of being hurt by the other. Hurt is seldom intended but if a deliberate attempt to cause emotional or physical injury is discovered, the clinician must confront the offender about the destructive behavior. Starting sentences with "I" facilitates self-representation and therefore communication.[11] We have found that couples who apply this suggestion at every opportunity soon become aware of improvement in mutual understanding. Arguments are less likely to occur when decisions are negotiated with "I" sentences.

It is to be hoped that each partner is trying to strengthen the relationship rather than trying to get his or her own way. It may be helpful to advise them: "Don't ever try to win" unless the relationship is also winning.

## Self Responsibility

In our experience, it usually helps to encourage more self responsibility—although there will be times when each spouse will appropriately find themselves dependent and the partner may welcome the opportunity to be needed. Self responsibility can also be encouraged in lovemaking for many couples distressed by ISD. (This requirement was totally foreign to the man in Case No. 3). Clearly, this guideline will not exclude willingness to accommodate a partner's request to be touched, unless the toucher is uncomfortable with the request. Self stimulation to orgasm is a logical extension of self responsibility when the need is felt and the spouse is not interested in further sexual activity—providing this option does not generate destructive guilt. Egalitarianism should also be encouraged during sensate focus exercises, with each partner touching for self.

## Sex Education

Sex education can be an important component of counselling when couples are contending with ISD or avoidance. Myths about sexual behavior may have to be addressed—such as the concept that men are experts on women's sexual preferences and responsible for the success of any sexual encounter. The myth that every sexual exchange should include intercourse adds unnecessary performance demand and may increase the likelihood of ISD or a genital dysfunction. We have found Bernie Zilbergeld's[12] and Lonnie Barbach's[13] books very helpful. For instance, Zilbergeld's chapters about conditions for good sex and how to get them, and dealing with a partner, can be very useful to the man (or woman) contending with ISD. Physicians should become familiar with books of their choice before rec-

ommending them to patients; the reading assignments must supplement, not conflict with, counselling suggestions.

The family physician may have to rearrange some priorities in order to offer sexual counselling, but a successful outcome can be very rewarding. ◉

## References


*1. Kaplan HS. The evaluation of sexual disorders. New York, Brunner/Mazel, 1983.*

*2. Kaplan HS. Hypoactive sexual desire. J Sex Marital Ther 1977; 3:3-9.*

*3. Lief HI. Inhibited sexual desire. Med Aspects Hum Sexuality 1977; 11:94-5.*

*4. Kolodny RC, Masters WH, Johnson VE. Textbook of sexual medicine. Boston: Little, Brown, 1979.*

*5. American Psychiatric Association. Diagnostic and statistical manual of mental disorders. 3rd ed. Washington, 1980.*

*6. Kaplan HS. Disorders of sexual desire and other new concepts and techniques in sex therapy. New York: Brunner/Mazel, 1979.*

*7. Dow MCT, Hart DM, Forrest CA. Hormonal treatment of sexual unresponsiveness in postmenopausal women: a comparative study. Br J Obstet Gynaecol 1983; 90:361-6.*

*8. Masters WH, Johnson VE. Human sexual inadequacy. Boston: Little, Brown, 1970.*

*9. McCarthy BW, Strategies and techniques for the treatment of inhibited sexual desire. J Sex Marital Ther 1984; 10:97-104.*

*10. Nowinski J. Male socialization and men's sexual malaise. In: Swanson JM, Forrest KA, eds. Men's reproductive health. New York: Springer, 1984, vol 3:285-95.*

*11. Gordon T. Parent effectiveness training. New York: New American Library, 1970.*

*12. Zilbergeld B. Male sexuality. New York: Bantam Books, 1978.*

*13. Barbach LG. For yourself. The fulfillment of female sexuality New York: New American Library, 1976.*