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Current Thinking in How to Help Couples and Individuals  
Struggling with Low Sexual Desire

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## Abstract

Low sexual desire, or hypoactive sexual desire disorder (HSDD), is the most common sexual problem presenting to counselors. It is also the most difficult to treat successfully. Much of the difficulty in successfully treating HSDD is the complexity of this issue. This article provides an outline of potential interventions that will not only help counselors think through the complexity of HSDD, but also provide some initial steps in giving hope to couples presenting with this issue.

Current Thinking in How to Help Couples and Individuals  
Struggling with Low Sexual Desire

Problems of sexual desire are the most common sexual presenting problem bringing couples into sex therapy (and marital therapy for sexual issues) today. A recent article in the *Journal of the American Medical Association* states that 43% of women and 31% of men experience difficulty with sexual desire (Laumann, Paik, & Rosen, 1999). In the University of Chicago study published as *Sex In America* (Michael, 1994), approximately one in three women and one in six men reported difficulty with sexual desire. Almost one in three of the married women in the National Study on the Sexuality of Christian Women (NSSCW) reported experiencing difficulty feeling sexual desire (Hart, Weber, & Taylor, 1998).

Zilbergeld (1999), observed that “Desire problems are often more complex than they seem on the surface and many people cannot work them out on their own”. Yet, when they seek professional help, many couples are disappointed in the results. Low sexual desire, or Hypoactive Sexual Desire Disorder (HSDD), is one of the most difficult diagnoses for therapists to effectively treat. Current efficacy studies in treatments for HSDD show poor outcome with standardized treatment approaches (Ronan, 1991). This reality makes HSDD an especially difficult issue for the typical mental health or marriage counselor who doesn’t specialize in sex therapy.

One of the difficulties in addressing problems of low sexual desire is due to the complexity of the issue. The failure of traditional sex therapy methods in treating this disorder suggests sexual desire “is not learned as other sexual dysfunctions are” (Moser, 1992). Also, unlike some therapy issues, there are myriad factors that contribute to low sexual desire. Many of these factors correlate highly with each other in research studies suggesting treatment for one factor alone may be a prescription for failure as related variables fight to maintain or return to a homeostasis that includes low sexual desire.

Instead of providing a cookie cutter approach to addressing problems with low sexual desire, this article suggests a number of interventions that may need to be considered. These interventions include skills and techniques therapists who haven’t specialized in treating sexual dysfunction may find beneficial when referral to a certified sex therapist is impractical

or impossible. In addition to the list that follows, the reader is encouraged to explore the references listed for more comprehensive discussions.

### Be Informed as a Therapist

The first step in being an effective helper for any issue is to be informed yourself. Research and theories on sexual desire are a hot topic with writers exploring etiology, diagnosis, and treatment from all related disciplines. Ethical and effective helping requires staying current with changes in the field.

One such change is a recent modification in the definition of desire disorders. One of the serious difficulties in researching or treating desire disorders is that there are no agreed upon definitions for what constitutes deficient sexual desire in women or men. Various research studies often use disparate measures to gauge sexual desire. Genital vasocongestion (Tuiten et al., 2000), vaginal lubrication (Michelson, Bancroft, Targum, Kim, & Tepner, 2000), sexual frequency (Schiavi, 1992), and a combination of a lack of need for sexual activity of any nature, an absence of sexual daydreams, and an inability to contrive sexual fantasies (Riley & Riley, 2000) are examples of various criteria used recently in studies of deficient sexual desire. Frequently, responses used to measure desire are more characteristic of male sexual desire, such as sexual fantasies, a need for sexual activity (Riley & Riley, 2000), a need to self-stimulate, and genital responses (Leiblum, 1998; Tiefer, 1991).

This ignores the fact that women's sexual responses are most often motivated by intimacy needs rather than a need for physical sexual arousal or release (Basson, 2000; Leiblum, 1998). Leiblum and Rosen (2000) write: "Part of the difficulty in assessing desire disorders is the absence of agreed-on norms as to what constitutes 'normal' sexual interest in individuals of various ages or lifestyles. Especially for women, desire often manifests itself as receptivity or willingness to be sexually engaged rather than active sexual initiative" (p. 57).

The Masters & Johnson/Helen Singer Kaplan model of sexual response (Kaplan, 1995; Masters & Johnson, 1970), which is seen as Desire -> Arousal -> Orgasm -> Resolution is essentially a model for male sexuality. It does not really "fit" female sexuality, especially the sexual response of women in long-term relationships. More clinicians and researchers are recognizing a need to look at the sexuality of males and females differently. John Bancroft, current director of the Kinsey Institute says "We have yet to conceptualize women's sexuality

in ways that do not impose categories that may only be applicable to masculinity and men. Women's sexuality is different in a variety of important ways, but we are still trapped in male conceptual boundaries." (Bancroft, 2000, p. 1).

A better definition of female sexual dysfunction has been discussed for inclusion in the next revision of the Diagnostic & Statistical Manual of Mental Disorders (American Psychiatric Association, 1994). The proposed definition for lack of desire (Hypoactive Sexual Desire) is: "The persistent or recurrent deficiency (or absence) of sexual fantasies/**thoughts** and/or desire for or **receptivity to** sexual activity which causes personal distress." (Basson et al., 2000) [emphasis added to show proposed changes].

### Explore the Definition of the Problem

Couples who seek help with desire issues provide a wide range of standards for their problem. Many men set their sexual desire as the standard their wife must meet. Other individuals and couples use information from friends, the media, or the current culture to set their belief of what "should be". Failure to meet whatever standard they accept suggests an inadequacy in themselves or their spouse. Unfortunately, the standards that clients choose are rarely appropriate. Historically the Church has taught that women (and often men) should not have sexual desire. Today, not only is sex "okay", but "now, you're *supposed* to want it" (Schnarch, 2000). Neither message is accurate.

The media's depiction of sex has added a great deal of pressure to many women's lives, and planted false expectations in men's and women's minds. The media shows us perfect bodies, and no one too stressed, too tired, or too ill to want sex. Partners are always eager, no discussion is needed, no one struggles to become aroused, no one objects to the mess, no one has to find a babysitter, no one has to set the mood, and everyone has fantastic orgasms. With these unreal expectations ingrained in each of us, a sexual relationship in the real world will most likely produce feelings of inferiority and dissatisfaction. One or both partners begins to wonder, "what's wrong with us?"

Often a first step in treating couples struggling with desire disorders or desire discrepancy is to educate them to the reality of the differences between male and female sexuality. Husbands and wives will rarely (if ever) have the same sexual desire. "Studies of human sexuality in cultures around the world have shown that most men think about sex more

often, are more easily aroused, want sex more frequently, desire more partners, and masturbate more often than most women. Even in these days when people scrutinize gender differences for any hint of bias, experts still maintain that biologically men are the more highly sexed gender” (Love, 1994).

The complexity of sexual desire, particularly in women, cannot be underestimated. Many elements can sabotage a woman’s sexual desire: her physical health, energy level, whether or not she is depressed, the ages of her children, hormones, breastfeeding, how she feels about her appearance, how she perceives her marriage partner, how she feels about her other relationships (friends or extended family), whether or not she has been sexually abused, how her family of origin viewed sexuality, any medications she may be taking, and whether or not sex has ever been painful—physically or emotionally. Any or all of these factors and their interactions combine to create, enhance, or diminish a woman’s sexual desire.

Rosenau (2002) identifies two types of “normal” desire – assertive and receptive. Assertive desire is more typical of male desire, while receptive desire is more typical of female desire. Often couples believe both partners should *crave* and *seek* sex with their partner (assertive desire). Many wives are relieved to find that being receptive to sex and enjoying the closeness it can bring is more typical of women. In other words, sometimes the issue isn’t that her sexual desire is dysfunctional, just misunderstood (Basson, 2002).

### Consider the Sexual History

Taking a comprehensive sexual history with the couple can be a powerful intervention (Rosenau, Sytsma, & Taylor, 2002). Many couples struggle to discuss sexual issues in an open and calm manner. As the therapist mediates this discussion, couples are often able to share previously untold things about their sexuality with one another. The therapist should teach and model constructive sexual discussion while eliciting this information.

A thorough sexual history will also reveal to the therapist numerous variables empirically correlated with sexual desire issues. Painful intercourse, sexual abuse, and other sexual dysfunctions are associated with sexual desire problems (Kaplan, 1995; Phillips, 2000). Affairs, use of pornography, and masturbation practices (for husbands and wives) are also important to explore as they can lead to situational low desire (i.e. lack of desire for sex with the spouse). Recent work continues to explore the connection between hypoactive sexual

desire, sexual aversion and high sexual desire (Katz & Jardine, 1999; Moser, 1992). Finally, some individuals may lack skill at being an adept sexual partner and this may discourage sexual desire.

A couple's sexual history is also a great place to explore their meaning of sex. Beliefs about the meaning and purpose of sex can increase or decrease sexual desire in an individual or their spouse. Distorted beliefs like "sex is dirty" or unholy or is only for procreation or is a way of using or being used will understandably decrease desire.

While exploring the couple's sexual history, the therapist should take care not to identify a single issue as the scapegoat or full reason for low sexual desire. Refuse to play the simplistic single cause or "one right answer" game, as it will create false expectations of a quick and easy cure. The complex and systemic nature of sexual desire necessitates the identification of major contributors, as well as the distantly correlated variables that may also have an impact on the sexual relationship of a couple.

#### Investigate Medical Issues When Necessary

Illness, especially chronic illness, takes a toll on sexual desire. All medications have side effects; most have sexual side effects. Birth control pills, hormones, antihormones, antidepressants, antipsychotics, tranquilizers, mood stabilizers, blood pressure medications, antacids, antialcohol, antibiotics, anticholesterol, antiepileptics, antifungals, antihistamines, anti-inflammatories, and "recreational drugs" can and do affect sexuality. When they do, it is usually with an inhibiting effect. Something as "small" as taking an antihistamine may contribute to discomfort by causing or adding to vaginal dryness. Clients need to be encouraged to talk to their physicians and pharmacists about the possible sexual side effects of prescription and over-the-counter medications they take.

Hormones are another critical factor in sexual desire. Almost 50% of the women in the NSSCW cited Premenstrual Syndrome (PMS) or Menopause as affecting their sexual desire. The most common symptoms of PMS are anger, anxiety, bloating, breast tenderness, clumsiness, depression, difficulty concentrating, emotional sensitivity, fatigue, food cravings, headaches, and insomnia. A few of these symptoms in any combination tends to inhibit sexual desire.

As a woman goes through the process of menopause she may experience increased depression, emotional instability, hot flashes, irregular periods, memory lapses, skin breakouts, and vaginal dryness or pain. These symptoms often inhibit desire.

Pregnancy, childbirth and nursing also disrupt the hormonal cycle. Besides the fatigue and stress associated with this period of time, couples need to be aware that hormone shifts can prompt dramatic changes in sexual desire during pregnancy and nursing. These changes are normal and can last for weeks or months after childbirth and breast-feeding ceases.

Hormones are also a critical variable in sexual desire for men. Testosterone and other androgens play a large role in aggressive sexual desire by engaging the circuit in the human brain that prompts us to seek out sexual activity (Panksepp, 1998). If testosterone is abnormally low, individuals will experience a decrease in sexual desire. Encouraging exercise and generally healthy behavior (sleep, eating) can dramatically change testosterone levels for some (particularly men), which may resolve sexual desire issues.

### Diagnose and Treat Depression

While depression could be listed under “physical issues,” it is a critical enough factor to warrant it’s own category. Research consistently shows a high correlation between depression and sexual desire (Schreiner-Engel & Schiavi, 1986; Trudel, Landry, & Larose, 1997). As important as the depression is itself, anti-depressants, particularly the SSRIs, often have an inhibitory impact on arousal or orgasm, which can further complicate desire.

### Conquer Fatigue

One of the surprising discoveries in the NSSCW (Hart et al., 1998) was that lack of sexual desire was not the most frequently cited sexual difficulty. Forty-five per cent of the married women said their greatest difficulty was finding the energy for sex. Children contributed to the depletion of their energy. Over half of the mothers with children living at home reported “finding energy for sex” was difficult.

Although many men somehow have enough energy to desire and engage in sex even though they are exhausted and sleep deprived, women do not. Usually the more exhausted a woman feels, the less she desires sex and the less she enjoys sex. When 400 women were asked to describe their ideal sexual experience, many specifically wrote about their need to be

rested or relaxed; some even wrote about napping as a part of their ideal sexual experience (Hart et al., 1998). In informal audience surveys of men, none have expressed a need for a nap or rest prior to sex.

#### Explore Issues of Attractiveness and Body Image

Two-thirds of the married women in the NSSCW specifically identified their body image and weight concerns as an issue that impacts their sexual desire. Ninety-five percent of American women cannot measure up to our culture's current ideal female body (the thinnest 5% of a normal weight distribution).

Women are masters of comparison, which leads to insecurity, body loathing, anxiety, depression, and a belief they are "too fat for sex" (Reichman, 1998, p. 53-55). In cultures that support a "thinner is better" belief, problems exist with eating disorders and there is twice as much depression in women than in men (Seligman, 1994). Both eating disorders (which disrupt hormone balance) and depression decreases sexual desire.

Our culture's nearly impossible standard for beauty is also taking a toll on men. Due to the bombardment of media images, both men and women are finding it difficult to be interested in and attracted to "real women" in the "real world" (Levine & Marano, 2001).

#### Explore Brakes and Accelerators

In her model of sexual response, Kaplan (Kaplan, 1995; see also Hart et. al., 1998, p. 67) postulated that the anatomy and physiology of hunger and sexual motivation are analogous in many respects. Both operate with "dual controls," which involve inciters and suppressors that keep these "appetites" in balance. Kaplan believed that normal sexual desire depends on a balance between the "erotic motor," which stimulates the desire for sex, and the "sexual brakes," which keeps sexual urges in check so that humans do not "crash headlong into disaster." When the normal control mechanism goes awry, a person will experience an "abnormal or dysfunctional increase or decrease of sexual desire" (Kaplan, 1995, p. 17-19).

One valuable exercise is to have couples explore their own brakes and accelerators for each stage of the lovemaking process. Simple models such as that by McCluskey (2000), where the sexual process is broken down into four stages (atmosphere, arousal, apex, and

afterglow), can provide the structure for discussion on internal and external inhibitors and enhancers of sexual desire.

How partners initiate sexual activity, the sights, sounds, smells, words said (or not said), location, time of day, pace, and a host of other factors can be listed as brakes or accelerators (see Hart et. Al., 1998 for a list of common brakes and accelerators in women). Couples should also be advised that what is an accelerator one day might be a brake the next. While this can be frustrating, it is especially normal in women and often due to hormonal shifts that occur throughout the day and month.

### Address Fear

In a culture that adores the successful and ignores those who struggle, fear can be a restricting brake on sexual desire. Therapists will approach fear issues depending upon their theory of therapy. Traditional cognitive/behavioral methods seek to reduce fear while systems theorist Schnarch (1991, 1993, 2000) believes the key is anxiety tolerance. However the counselor chooses to handle fear, it cannot be ignored as a hinderance to sexual desire. Fear manifests itself in a variety of ways, but there are several common categories:

*Performance anxiety.* Men can be particularly sensitive to sexual pressure. If a man has an episode of erectile difficulty—due to exhaustion, stress, alcohol, or medication, he may become overly concerned regarding future erections. Sometimes this decreases his desire, as he anticipates potential problems in the future. If a man has difficulty with rapid ejaculation and his partner becomes frustrated or angry, this can also influence him to avoid sexual interaction. The fear of failure in his eyes, or his partner’s eyes, may reduce his desire to even become involved in sex.

*Intimacy.* Negotiating the physical aspects of sex is one thing, but negotiating the emotional impact of sex with one’s spouse can be far more intimidating. As a relationship moves past the initial excitement stage, individuals who are afraid of intimacy or who have never learned to negotiate deeper intimacy in themselves or their relationships may lose the desire to engage sexually when deep emotion is needed to intensify the sexual experience.

*Pregnancy.* Couples often remark about the increase of sexual desire once permanent birth control measures have been adopted. Therapists are encouraged to explore the couple’s level of confidence in their birth control. For couples who have experienced a miscarriage the

fear of pregnancy is more complicated. Often these couples desire children but they also fear sex will lead to pregnancy and another painful miscarriage. The resulting internal struggle can decrease sexual desire.

### Relationship Issues

“The interpersonal dimensions of a dysfunction often prove to be the dominant factor in its etiology and maintenance” (Lief, 1985, p. 60). Even if the relationship isn’t the direct cause of low sexual desire, the resulting marital conflict often intensifies a lack of desire. Counselors must assess and treat not only the relationship issues that might have led to the low desire, but also the impact of the low desire (Davies, Katz, & Jackson, 1999; Fish, Busby, & Killian, 1994; Fish, Fish, & Sprenkle, 1984).

Traditional marital therapy techniques of teaching forgiveness, assertiveness, communication skills, and conflict resolution skills, as well as working through control issues are all important techniques when addressing the relational issues inherent in sexual desire disorders. The following three specific relationship issues are also important factors:

*Emotional connection.* The most enjoyable part of sex for 90% of the married women in the NSSCW was closeness: physical, emotional, or both. Gottman and Silver (1999), in their research with over 650 couples, found the quality of the couple’s friendship determines whether or not wives and husbands feel satisfied with the sex, romance, and passion in their marriage.

*Polarization.* As couples seek to adjust to differing levels of sexual desire, they often begin to polarize: one partner feels they have sex “hardly ever” and the other believes they have sex “all the time.” This conflict and exaggeration in perception leads to further conflict, feelings of rejection, and fear (that the spouse is unfaithful, that they themselves are no longer attractive). This can prompt destructive arguing, accusations, and further hurt or hostility. A negative pattern develops which further inhibits sexual desire.

*Non-sexual touch and togetherness.* Oxytocin is a peptide secreted in the brain that flows to various parts of the brain and throughout the reproductive organs of both men and women. It rises in response to touch and promotes touching. Oxytocin also promotes bonding between lovers, as well as parents and children. It sensitizes the skin to touch, spikes at orgasm, causes uterine contractions during orgasm and labor, increases sexual receptivity,

penile sensitivity, and speeds ejaculation. Oxytocin effects are increased by the presence of estrogen, which has led researchers to hypothesize that oxytocin may be especially important in sexual desire in women.

Unfortunately, as couples struggle with sexual desire issues it is not uncommon for them to withdraw from each other and cease touching. Hugs, massages, and intimate kisses fade away. Without touch, oxytocin production falls, as does the bonding in the relationship, lowering sexual desire even further (Crenshaw, 1996; Panksepp, 1998).

### Monitor and Confront Issues of the Heart

Some of the most difficult situations to address in sexual desire are those where sex is used as a commodity in the relationship. Frequently referred to is the relational rule from systems theory that states “the individual with the least desire is in control.” This means the spouse with the least desire will be in control of the sexual relationship and often their partner’s mood. A spouse who is withholding sex or using their lack of desire to punish their spouse can be especially damaging. Boaz & Wiseman (2001) refer to scriptural principles and encourage counselors not to neglect low sexual desire when it is a “problem of the heart,” and to confront it as sin.

While it is important to note this possibility, contrary to what some theorists suggest, using lack of desire to punish a spouse is not a dominant motivation in many cases of hypoactive sexual desire disorder. Many individuals truly dislike the control that their low desire places upon them. However, it is important that the therapist assess these control issues and the role they might play in the disorder.

### Encourage Continued Work on Sexual Desire

Since desire issues are complex and currently difficult to treat, couples will often become discouraged. An important role for the therapist is to continue to provide hope, and to help moderate the tension. Encourage the spouse with more desire not to give up, escalate, or withdraw. Teach and model ways for the couple to keep addressing the issue respectfully. Encourage the spouse with lower desire to keep a personal focus on the issue. They need to remain focused on themselves and their own task, not on blaming their spouse for what they aren’t doing.

## LAUGH!

Not only do couples who struggle with sexual desire discrepancies frequently stop touching, they also tend to become so discouraged or angry that they begin to focus on the negatives in the relationship. Therapists must help couples focus on the positive aspects of their relationship, as well as help them create other bonds to sustain the relationship through the therapy process. (See section on Brakes and Accelerators, above, as well as Hart, et. al., p. 67, 82-83).

Laughter is “good medicine” (Proverbs 17:22, NIV) and one way couples can be more positive. Laughter strengthens the immune system, increases intellectual performance and information retention, and helps to create a connection between partners (Galloway & Cropley, 1999; Weisenberg, Tepper, & Schwarzwald, 1995). Encourage couples to recall and explore activities or pastimes that will allow them to share non-sarcastic, non-derisive laughter and humorous experiences with each other.

## PRAY!

There is a growing body of scientific literature that documents the healing power of prayer (Koenig, 1999; Koenig, McCullough, & Larson, 2001). Couples who pray together and share common religious beliefs have stronger marriages (Koenig, 1999). Sexuality and sexual expression were God’s idea and His gift to us. When we, or those we try to help, encounter sexual problems, we need to turn to God for help, hope, and healing. Encourage couples to pray, individually and together, for the growth and health of their sexual relationship.

## Conclusion

Counseling individuals or couples with complaints about low sexual desire is a complex puzzle. Many times, they may have unrealistic expectations of their spouse, themselves, or of marriage. Sometimes they will need to be educated on normal sexual desire, a subject we are still exploring and defining as professionals. A careful and thorough sex history is critical, as well as good marital therapy for both cause and effect of the presenting problem. Finally, the counselor is encouraged to keep an open mind and not blame low sexual desire on any one issue. Instead, professional helpers need to be aware of the complex web of

issues that complicate low sexual desire and encourage the couple to attack the problem from a variety of fronts.

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