THE AMERICAN ACADEMY OF CLINICAL SEXOLOGISTS

Hypoactive Sexual Desire Disorder:

"I think my vagina is dead…"

A look into the world of women with low libido

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DISSERTATION APPROVAL

This dissertation submitted by Lisa Abbie Regnensburg-Paz has been read and approved by three faculty members of the American Academy of Clinical Sexologists at Maimonides University.

The final copies have been examined by the Dissertation Committee and the signatures, which appear here, verify the fact that any necessary changes have been incorporated and that the dissertation is now given the final approval with reference to content, form and mechanical accuracy.

The dissertation is therefore accepted in partial fulfillment of the requirements for the degree of Doctor of Philosophy.

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CHAPTER 1

Introduction

Sexual Desire is a Human Condition

"I think my vagina is dead. What's wrong with me? Why don't I want to have sex – I mean it's ruining my relationship? My Ob/GYN tells me I just need a vacation, my friends tell me to 'get over it' and my husband tells me to 'go to a shrink so they can fix me since it's obviously in my head.' Please help me! "

This is the typical heartache of a woman who is dealing with Hypoactive Sexual Desire Disorder (HSDD). Since there is no standard of what is "normal" when it comes to frequency of sex between people, it is hard to establish a baseline empirical answer for how much sex is too little. What we do know is that when it is causing marked distress, such as in the above case, it is considered clinically significant and merits further exploration. But until recently exploration of female desire was viewed as either taboo, blasphemous, or irrelevant. Thus, there leaves much to be explored by way of norms, explanations and solutions for the under-stimulated female. This paper aspires toward illuminating these subjects.

Historically, women's sexual desire was not much cared about one way or the other. The predominant global view for most of time was that women had a duty to fulfill, like it or not. In fact, cultural and religious mores would often question the honor of a woman who seemed to like sex TOO much (Maines, 1999). Thus, females of the Western world were trapped in the Madonna/whore complex; you either love sex or hate it and either way you'll be judged for it. This sexist paradigm left the field of women's sexuality as a moot issue because it simply didn't matter.

Enter the field of gynecology, the advance of science, Alfred Kinsey, Masters and Johnson, Shere Hite and women's liberation, the sexual revolution, mass media and sex education and all of the sudden the world became privy to the collective female sexual voice. A voice that is hard to ignore and thus science and research have been moving forward where sexual function and pathology are concerned (Bachmann, 2006). It should be noted that The Hite Report (Hite, 1976) was a seminal piece of work that is almost exclusively responsible for elevating women's sexuality to a place it had not been prior to 1976. It disproved myths about female intimacy and offered a never before seen look into the world of the female sexual psyche.

In spite of the classical obligation women have felt towards being "pleasing" and "accommodating," there are many women that simply don't feel a sense of desire. Ten years after Dr. Hite published the aforementioned Hite Report, she authored a third research book examining the importance of women's emotions, love, and their relationships with men. At the price of heartache, relational discord, personal loathing and frustration, they are unable to shift their desire dial. This is the heart of Hypoactive Sexual Desire Disorder.

Concerns about desire are the most frequent sexual problem among women in the United States (Anger, Brown, & Amundsen, 2007, Bachmann, 2006, Bradford & Meston, 2007, Hayes, Bennet, Failrey, et al., 2006, McCall & Meston, 2006, Seagraves & Woodward, 2006, & Sills, Wunderlich, et al, 2005). Notwithstanding the aforementioned, there is currently no statistically validated treatment for HSDD and health professionals remain hesitant to assess for, or acknowledge, female sexual desire disorders (Bachmann, 2006 & Heiman, Guess, Connell, et al., 2004.) Ironically or

perhaps not, male sexual disorders have enjoyed a bevy of attention and subsequent pharmacological solutions, the female counterparts remain painfully unexamined.

This paper will aim to examine Hypoactive Sexual Desire Disorder in pre-menopausal women. The following pages will offer an overview of the disorder - from previous definitions to current diagnostic criteria. In this section there will also be brief notes on the opinions of desire by some of the most respected sex researchers of our time.

A section on female anatomy will be introduced followed by a discussion on anatomical misconceptions about the female genitalia and the impact this has on psychological functions. Also, in the forthcoming chapters, we will examine causes of HSDD and the subsequent psychological and interpersonal impact.

The final chapters will explore treatment methods, both psychological and pharmacological, though I promise the latter is painfully deficient. What will be most exciting in this section are the appendices to the psychological treatment. I have put together worksheets for anyone looking to discover and uncover her Inner Isis, or goddess of love and sexual healing. These exercises are designed to help a woman realize the desire that lie within her and give her the tools to access that passion.

Sexual Desire is a human condition and for this reason it must be explored and examined with reckless devotion.

CHAPTER 2

The Human Sexual Response Cycle: Female Models Examined

To understand Hypoactive Sexual Desire Disorder and the concept of Sexual Dysfunction in general, it is first helpful to consider the Human Sexual Response Cycle. Different dysfunctions interfere with different phases of a woman's sexual response and so it is important for researchers to be able to identify where in the cycle a woman gets blocked. The human sexual response cycle is an organizational tool and roadmap to our different states of arousal.

Originally put forth my William Masters and Virginia Johnson, the (first) Human Sexual Response Cycle model suggests that there are four stages of sexual response. Over the course of two decades Masters and Johnson examined almost 700 subjects in their laboratories and were the first to document physical features associated with human sexual arousal. Below is the classical Human Sexual Response Cycle, still in wide use today:

1) **Excitement**: This phase is the result of sexual stimulation which may be psychological, physiological, or both. It is marked by increased blood flow to the genital region also called vasocongestion, which then leads to vaginal lubrication. The vasocongenstion in the walls of the vagina causes moisture to trickle across the vaginal lining. This progression is called transudation. The clitoris becomes erect during this time, as do the nipples. Heart rate increases, blood pressure rises, and the labia majora and minor enlarge and

open. (Berman & Berman, 2002, Kelly, 2006 & Masters, Johnson, & Kolodny, 1988).

2) **Plateau:** The plateau phase begins to really stimulate the parasympathetic nervous system (Cervenka, 2003). This phase is considered a more progressive state of arousal and potentially heralds orgasm. The uterus becomes entirely elevated and the vaginal tissues swell to their maximum and the opening actually narrows – this is called the orgasmic platform. The breasts increase in size and nipples become erect. Masters, Johnson, & Kolodny (1998) note that women who have not breast fed, may actually experience a 20-25 percent increase in their breast size during this phase. Often women get what is known as a sex flush across their chest, abdomen, and back. They attribute this flush to changes in the blood flow just below the epidermis (1998). Additionally, respiration, heart rate and blood pressure continue to increase (Miracle, Miracle, & Baumeister, 2003, & Kelly, 2006).

3) **Orgasm:** If efficient stimulation to the clitoris or pressure on the walls of the vagina endure throughout the plateau phase, the body experiences a build-up of sexual tension and energy followed by a release known as an orgasm, also sometimes referred to as a *climax* or as *cumming.* This is the shortest phase of the cycle (Masters, Johnson, Kolodny, 1998). During the orgasmic phase, a woman's uterus undergoes wavelike muscular contractions as does the sphincter muscle; The body expels blood flow out of the genital region back into the body for circulation (Berman & Berman, 2002) the rest of the body may also enjoy rhythmic muscle tremors. The first of these contractions are

often rapid and close together, gradually decreasing in frequency and intensity. At the point of climax, a woman's sex flush deepens (Miracle, Miracle, & Baumeister, 2003, & Kelly, 2006) Also, some women release liquid from their Skene's glands out of their urethra, and thus engage in an ejaculatory phenomenon.

4) **Resolution:** During this phase the body returns to its normal, non-aroused stated of functioning. Muscle tension in the body, also called myotonia, decreases, and tension in the genitals caused by increased blood flow disappear; nipples also lose their erection and the breasts, if enlarged return to their baseline state. The uterus returns to a lower position and the labia return to their normal hue. Blood pressure, heart rate, and respiration return back to normal (Miracle, Miracle, & Baumeister, 2003, & Kelly, 2006).

Masters and Johnson's four-phase model is still widely regarded as having merit and as a pragmatic examination tool. There was however some dissent to their prototype.

In the Hite Report (1976) Dr. Hite critiqued the Masters and Johnson model stating that it erroneously resembled a Rube Goldberg model, whereby orgasm could be reached through penile thrusting in the vagina (to circuitous a route to be regularly succesful). This thrusting action was assumed to create traction on the labia minora, which would in turn cause the clitoral hood to move enough over the clitoral glans and create sufficient stimulation to produce orgasm. While Hite affirmed this model's focus on the necessity for clitoral stimulation in female orgasm, she disagreed with the model

insofar as it seemed to assert the normalcy of orgasm during intercourse is still to be expected as part of the automatic "normal" course of things" (Hite, 1976).

Of the people who disagreed with the structure of Masters& Johnsons sexual response cycle, Dr. Helen Singer Kaplan might be the most notable. Building on their idea, but revising the construction Dr. Kaplan developed her own rendition of the human sexual response cycle. This one included only three stages, not four.

Kaplan's primary criticism of the four-phase model was that it was too linear, especially for female sexuality. Additionally, Dr. Kaplan went on to state that the four phase model proposed by Masters and Johnson does not take into account enough of the psychology behind sex. Specifically, she stated that you can not get excited unless you are mentally experiencing desire (Kelly, 2006). Thus Kaplan's model emphasized the role desire plays in our sexual response cycle. Instead of making the assumption that human desire stems from an internal force or drive, this model proposes that there is a unique interaction between external stimuli, our emotions, our experiences, our social norms, and our interpretations that affect our levels of desire (Miracle, Miracle, & Baumeister, 2003). Kaplan emphasized the cognitive aspect of sexual response.

The other chief difference between her model and Masters and Johnson's model was that she stated each of the three phases may exist separately and one does not have to precede the other. For instance, you may have an orgasm without much desire or you may feel desire after you are physiologically excited. In summation, this model is not as linear or sequential as the Masters and Johnson one and focuses much more on the psychological role of desire in sexual response. For these reasons, this prototype is very

practical for sex therapists dealing with HSDD. The following is a breakdown of the Kaplan triphasic model.

1. **Desire:** During this phase, the brain and it's interpretations of stimuli are the driving force. The interactions between the environment and our mind come together to initiate or inhibit desire.
2. **Excitement:** This phase mirrors the characteristics as outlined in the Masters and Johnson model. Here the body starts to make a shift from an un-aroused state to an aroused state. Physical characteristics discussed above are the same.
3. **Orgasm:** This stage mirrors the orgasmic stage introduced by Masters and Johnson. However, Kaplan did not emphasize that this stage needed to exist in every sexual interaction.

As the field progressed, other professionals proposed ancillary models aimed at being more thorough and accurate. Miracle, Miracle, & Baumesiter (2003) discuss one such proposition by David Reed. He called his the Erotic Stimulus Pathway (ESP). Reed uses a four phase model that combines elements of Kaplan and Masters and Johnson. The model breaks down as follows:

1. **Seduction:** This phase looks at how an individual attracts someone. A seduction has to do with memories and rituals. The better you feel about yourself the better you are at attracting others and engaging in these rituals. Such positive feelings are then manifested into sexual desire and arousal.

2. **Sensations:** In this phase the senses improve excitement and prolong it into the plateau phase. This leads us to want to sustain the pleasurable feeling over a long period of time. These first two phases are analogous to the psychological components found within Kaplan's model.
3. **Surrender:** This is the phase where orgasm takes place. Reed supposes that people who are anorgasmic may be in a place where they have not adequately integrated outside messages from society and partner with their internal dialogue.
4. **Reflection:** The reflection phase suggests that this is where we bring actual meaning to the sexual experience. This is the phase where we appraise it as positive or negative and it will subsequently effect our desire for future interactions under similar circumstances (Miracle, Miracle, & Baumeister, 2003).

While the aforementioned views initiated a shift in the conception of female sexuality, later researchers would go on to note that all of the above use a rather linear design - essentially, we wound up with over thirty years of work by prominent researchers, all relying on a "straight-line" explanation. The 1990s marked a time when new theories were being proposed. Several researchers began to contend that the previous models assumed men and women had almost identical response cycles and relied too heavily on biological functioning.

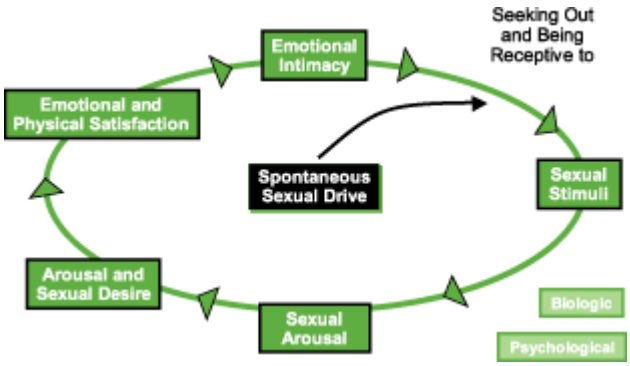
In 1997, Beverly Whipple and Brash-McGreer proposed a true circular sexual response cycle for females; they built it on the Reed model. Whipple and Brash-McGreer essentially took Reeds four-phase model of seduction, sensation, reflection and placed it

in a circular formation, such that one phase may reinforce or inhibit the other as opposed to one *causing* the other. This departure from a linear causation prototype will come to be a key feature in understanding women's sexuality because the following pages will illuminate the circuitous nature of female sexuality and refute linear suppositions. The Whipple-Brash McGreer model supposes that women may enter the sexual cycle at several different points – therefore, this offers a framework that supports a more circular notion. Their assessment of the satisfaction at any stage will either propel or discourage additional interactions.

Rosemary Basson also put forth a novel and circular model of female sexual response (Basson, Leiblum, Brotto et al., 2004). She included factors such as emotional closeness, sexual stimuli, and relational satisfaction (See Figure 2). Basson argues that female sexuality is more multifaceted and circular as compared to male sexuality. Further, she states women may have many reasons for embarking on a sexual activity such as need to be connected emotionally, desire to increase their own sense of attractiveness or well-being, to become pregnant, or experience higher order intimacy (Basson, Leiblum, Brotto et al., 2004 & Basson, Brotto, Laan, et al., 2005).

The earlier models suppose that sex is a human drive like thirst and hunger. Basson, on the other hand, says that this may not always be a female's motivation for sexual activity. She examines the idea of spontaneous desire versus planned or responsive desire, and concludes that often women do not experience spontaneous desire. Instead women will respond to their partner's request or experience pleasure once sexual activity has been initiated, even if there was no initial desire. Otherwise stated, a

women's sexual response cycle is comprised of "overlapping phases of variable order" (Basson, Leiblum, Brotto et al., 2004 & Basson, Brotto, Laan, et al., 2005).



As you can see, there are a variety of different ways to conceptualize the sexual response cycle, and there are many features that influence the definition of each phase (Althof, Dean, Derogotis, et al., 2005). Foregoing, this paper is principally concerned with the desire phase of human sexuality. Further, it is important to recognize the female sexual response cycle as a circular pattern, rather than a cause-effect linear one (Laine & Jones, 2007).

Current views acknowledge that female functioning is more complicated and often affected by psychological factors. Additionally, and building off of Kaplan, Whipple, and Basson's suppositions, women are more likely to enter a cycle at any of the given phases outlined and orgasm may not always be the principal goal (2007). In fact, according to Laine & Jones (2007) women's sexual activity often doesn't occur because of some innate drive, but rather from a place of impartiality which, if approached "right" sparks a sexual response. Therefore, it is important to consider desire and psychological climate when assessing female sexual functioning.

Now that we have established a working understanding on the cycles of sexual response, let's move into examining how to define and discuss hypoactive sexual desire.

CHAPTER 3

Current Definitions and Diagnosis

Hypoactive Sexual Desire Disorder (HSDD) has varying criteria and subsequently varying definitions. This chapter will examine different clinical definitions and the criteria of which they are comprised. The prevalence rates of HSDD vary greatly because of the diagnostic discrepancies (Hayes, Bennet, Fairely et al., 2006). Hite (1976), Masters and Johnson (1967, and Kinsey, 1953 were among the principle researchers to discus prevalence rates of female sexual dysfunction. However, current diagnostic criteria has shifted and thus concrete data is difficult to ascertain.

Laine and Jones (2007) cite a statistic from the National Health and Social Life Survey 5 that determined 22% of women and 5% of men reported low sexual desire. They go on to note that ironically, the same study cited 43% of women as having sexual dysfunction. Quirk, Haughie, & Symonds (2005) state that prevalence rates of female sexual dysfunction are inconsistent overall. The inconsistent and awkward figures are presumably a result of cloudy and variable definitions

"I think my vagina is dead". This seems to be the prevailing, albeit not so elegant, description women offer when conveying their lack of desire. Hypoactive sexual desire disorder is the mechanical term for lack of interest in sex. This lack of interest may include lack of sexual fantasies, lack of sexual thoughts, and overall disinterest in sexual activities. Not so long ago, this was referred to as "frigidity". In fact in Helen Singer Kaplan's book, The Illustrated Manual of Sex Therapy 2nd ed. (1985), she profiled "Frigidity: the unresponsive woman" as opposed to the "Woman with HSDD."

The problem with this term is that it labels the woman in a negative tone and places the blame directly on her shoulders. This word leaves little room to allow outside considerations such as society, past experience, media, and physiology as potential contributors to her low libido. A shift was made in the late seventies to refer to disorders of sexual desire as either *inhibited sexual desire or sexual aversion*, the latter of which still exists as a subcategory in DSM-IV.

A key feature of the definition is that it must be causing personal and/or interpersonal distress, as opposed to a voluntary choice made by the individual, in which case it would not be classified as disordered (Graziottin, 2007). Almost all people have a period of time when they are not as interested in sexual stimuli or activity as they once were. As stated in the following DSM-IV breakdown, it is prudent to examine the onset, duration, and etiology of the distress prior to making a definitive conclusion. Often, if the onset is sudden and duration short, it may very well be due to one specific stressor and is often not considered a true disordered path.

Current day clinicians rely on the Diagnostic and Statistical Manual of Mental Disorders 4th Ed. (DSM-IV). This is the bible of the mental health field and also the place in which practitioners may find the ever-coveted insurance codes. In light of the academic and clinical respect this book enjoys, I find it suiting that we start with the definition-discussion as found therein.

The DSM-IV (APA, 1994) recognizes Hypoactive Sexual Desire Disorder (insurance code 302.71) as a "deficiency or absence in sexual fantasies and desire for sexual activity". The desire deficiency can not be better accounted for by physiological effects of substance, including medication or a medical condition. The DSM-IV (APA,

1994) takes caution to categorize into four subtypes whereby the first two address the onset of the dysfunction and the latter two address the context in which said dysfunction occurs.

> ***Lifelong Type:*** This applies if the sexual dysfunction has been present since the onset of sexual functioning.
>
> ***Acquire Type:*** This subtype applies if the sexual dysfunction develops only after a period of normal functioning
>
> ***Generalized Type:*** This subtype applies if the sexual dysfunction is not limited to certain types of stimulation, situations, or partners.
>
> ***Situational Type:*** This subtype applies if the sexual dysfunction is limited to certain types of stimulation, situations, or partners.

The DSM-IV (APA 1994) further classifies etiological factors into the following two categories:

> ***Due to Psychological Factors:*** This subtype applies where psychological factors are judged to have the major role in the onset, severity, exacerbation, or maintenance of the HSDD, and general medical conditions and substances play no role.
>
> ***Due to Combined Factors:*** This subtype applies when 1) psychological factors are judged to have a role in the onset, severity, exacerbation, maintenance, of the HSDD; and 2) a general medical condition or substance use is also judged to be contributory but is not sufficient to account for the HSDD. If general medical conditions or substance is sufficient enough, then they define HSDD due to a General Medical Condition and/or Substance Abuse.

In addition to the DSM-IV, the other prevailing clinical classification system is the International Classification of Diseases (ICD-10). The ICD-10 is an international diagnostic classification system for diseases and other health issues. The ICD-10 addresses sexual dysfunction in Appendix 1 and states that sexual function relates to the different ways a person is able to partake in sexual interactions as they wish (Hatzimouratidis & Hatczichristou, 2007). The ICD-10 further distinguishes sexual dysfunction between organic (N-series) and nonorganic (F-series) dysfunctions. Hatzimouratidis and Hatczichristou (2007) note that there are biases in this classification system, whereby women's desire is placed primarily in the category of organic vaginal physiology, whereas male diagnoses encompass more regard for psychogenic etiologies. The F-series definition is as follows:

> ***F52: Sexual dysfunction, not caused by organic disorder or disease***
>
> Sexual dysfunction covers the various ways in which an individual is unable to participate in a sexual relationship as he or she would wish. Sexual response is a psychosomatic process and both psychological and somatic processes are usually involved in the causation of sexual dysfunction.
>
> ***F52.0: Lack loss of sexual desire***
>
> Loss of sexual desire is the principal problem and is not secondary to other sexual difficulties, such as erectile failure or dyspareunia.

Aside from the aforementioned diagnostic manuals, there have been other clinical efforts made to better categorize female sexual dysfunctions. For example, in the nineties

there was a panel prepared by the American Foundation for Urological Disease (AFUD) to formulate recommendations for new and improved diagnostic and classification criteria for female sexual dysfunction. These recommendations were born out of acknowledging alternative models to the female sexual response cycle. The models in question relied heavily on examining women's interpersonal and intrapersonal relationships and the subsequent effects they have on sexual health. While this holistic view was a step in the right direction, it was agreed that there still needs to be a more structured and objective classification system if it is to be universally regarded. Therefore, they put forth a variety of definitions and made sure to include a dimension of "personal distress." Thus, their final classification system was structured similarly to the DSM-IV and and the ICD-10, citing the four main categories of dysfunction as desire, arousal, orgasmic, and pain disorders but with a "personal distress" axis (Laine & Jones, 2007, Hatzimouratidis & Hatczichristou, 2007).

Building on the work that was done at the above referenced AFUD panel, the International Consultation met in 1999 and then again in 2003. This group was comprised of over 200 experts from 60 different countries. They worked for an excess of 24 months to produce the most recent book of sexual medicine. They defined sexual/interest desire dysfunctions in the following manner:

> Diminished or absent feelings of sexual interest or desire, absent sexual thoughts or fantasies, and lack of responsive desire. Motivations (here defined as reasons/incentives) for attempting to become sexually aroused are scarce or absent. The lack of interest is considered to be beyond normative lessening with life cycle and relationship duration.

The previous discussion was introduced to offer the current clinical definitions and classifications of HSDD. However, there are a lot of nuances that go into defining and discussing this topic. As the AFUD acknowledged, intrapersonal and interpersonal satisfaction play huge roles in sexual desire in women. These subtleties are difficult to quantify and therefore do not necessarily show up in the broad clinical diagnostic manuals. There is a host of work, however, that is examining the "other" parts of HSDD.

There has been a lot of research recently that is looking to clarify whether HSDD encompasses lack of spontaneous desire or lack of desire in response to a partner's sexual advances and efforts. Quirk, Haughie, & Symonds (2005) further this supposition by opening their paper with a discussion about HSDD being examined in a multi-definitive framework of a lack of initiative, a lack of response, or both.

Interestingly, the majority of women presenting in my office with hypoactive desire are sexually responsive to the degree that they are usually orgasmic with themselves and they can lubricate once aroused. This leaves the door for psychological and interpersonal etiologies wide open.

CHAPTER 4

Female Anatomy

Female anatomy and lack of knowledge about it may be one of the reasons women experience low sexual desire. I am always shocked by the genuine lack of knowledge modern-day, educated, and "liberal" women have about their bodies. "The vagina is not the sex organ? What do you mean?" asks the shocked and confused woman. I have actually had men sit in my office and blatantly argue this simple anatomical fact. The misconceptions about the female genitalia are prohibitive to women and the men that love them (Hite, 1976). The Hite Report (1976) was the first publication to underscore, via research findings, that society had the female genitalia and its sexual functions confused. The findings of this report highlighted the clitoris as the primary point to produce orgasm and not the internal vaginal walls. Upon realization of the clitoris, women often experience a whole new world of sexual pleasure – which as we know from Basson's circular model, may often increase the desire portion of the sex.

Unlike men, who have their sexual organ protruding from them – they hold it when they urinate, they are taught to fondle it when they are young and it is visible to them at almost all times, women have a much more clandestine and demure organ structure. Though it is no less the powerful or pleasurable (Hite, 1976). The following pages will aim to give a brief anatomy lesson of the female genitalia and discuss the prevailing misconceptions surrounding it.

***The Vulva*:**

What most people refer to as the "vagina" is actually the vulva. This is the entire external structure of the female genitalia. The size, shape, and color of the vulva vary

between women. The most noticeable anatomical features on the vulva include the labia majora and minora, the mons pubis, the prepuce, the perenium, the anus, the urethra, and the clitoral glans.

The purpose of the vulva is to protect the internal reproductive organs and to enhance sexual pleasure for both female and partner (Miracle, Miracle, & Baumeister, 2003.)

The Mons Pubis or Mons Veneris:

This is the fatty tissue that covers the pelvic bone and rests above the other sex organs. Mons veneris is the Latin term for mound of Venus, Roman goddess of love. There are a host of nerve endings in the mons and direct pressure may sometimes lead to sexual arousal (Sherfey, 1972, Berman & Berman, 2001, Miracle, Miracle, & Baumeister, 2003).

It is covered by pubic hair; the amount of hair will vary depending on age and genetics. Some women have a few small wisps of hair, while other women have hair that begins at the mons pubis and extends to their outer thighs. The mons splits into the labia majora and minora.

The Labia Majora and Minora:

The labia majora refer to the outer lips, while the labia minora refer to the inner lips of the vulva. These are the folds of skin that cover the opening of the vagina (Hite, 1976). The outer lips are covered with pubic hair and comprised of rougher skin, while the inner lips are silky and smooth. This textural disparity is due to the difference in

mucous surface of each structure. Chia & Chia (1986) liken the inner lips to the surface of our inner cheek and the outer lips to the surface of our face. The labia, particularly the labia minora, have a large network of nerve endings that make this structure a point of arousal for females.

Labial appearance changes with arousal states. The more aroused and engorged a woman is the darker her inner labial folds will be – sometimes they will get a deep shade of maroon or crimson. Pregnancy also has an effect on the labial hue for some women. Additionally, the more aroused a women is, the larger her labia will appear. The labia majora has erectile tissue beneath the layer of fatty tissue (Sherfey, 1972). This enables blood to engorge the lips and offer a swollen appearance (Miracle, Miracle, & Baumeister, 2003). The inner lips will swell to two or three times their non-aroused size (Chia & Chia, 1986.)

The labia are the male equivalent of scrotum. In fact when women have sex reassignment surgeries, prosthetic testicles will be placed into the labia majora in an effort to mimic the appearance of scrotum.

The Vagina:

The vagina is located in between the urethra and anus. Miracle, Miracle, & Baumeister (2003) cite three primary functions of the vagina: to receive the penis during intercourse, the pathway for menstrual flow, and the birth canal for the baby to come out.

The vagina is tube shaped and composed of muscles. Two muscle groups encircle the vaginal opening: the levator ani and the sphincter vaginae (Kelly, 2006.) The former serve the purpose of tightening around the penis upon insertion; they are also part of the

structure that supports the pelvic floor (Berman & Berman, 2001.) Involuntary activity of these muscles can lead to certain sexual dysfunction, namely vaginismus.

The vagina is usually about five to seven inches long (Berman & Berman, 2001), although this measurement varies. It tilts upward toward the lower-back. The inner walls of the vagina remain in a collapsed state until something is inserted, at which point relative expansion takes place – the vagina can accommodate something as small as a tampon or something as large as a newborn baby. The vaginal wall is smooth and moist and there are small ridges along the tissue; these ridges are called rugae. If rugae are not present it signifies a decline of smooth muscle (Berman & Berman, 2001& Kelly, 2006.)

The lining of the vaginal walls are mucous surfaces, similar to that of the inside of the mouth. Women have the ability to lubricate, making insertion of a penis easier. The process which causes the lubrication is called transudation. Essentially, the engorged vaginal walls cause beads to form on the already mucousa vaginal lining – this can be considered analogous to a sweating process. Together they develop into a glaze of sorts providing a smooth and pleasant entry into the vaginal canal.

Interestingly, and contrary to what popular culture emphasizes, there are not a lot of nerve endings in the vagina and the highest concentration of the nerves that are in the vagina are located towards the opening. Still there are a host of women that report sensitivity throughout the entire vaginal canal, we will see in the coming pages that the clitoris is the actual palace of pleasure for most women.

The Urethra:

The urethra, which is the hole out of which urine is expelled, is situated below the clitoral glans and above the vagina. Women, do not have an ejaculatory response, however, some women do expel a liquid substance out of their urethra while they orgasm. The liquid is thought to be released from the Skene's glands, which are the equivalent of a male prostate. They are positioned on the upper vaginal wall and they drain into the urethra. Researchers have tested this liquid and determined it is of a different pH balance than urine even though it is released through the urethra.

The Perineum:

The strip of skin that runs between the anus and the bottom of the labia is called the perineum. This is the structure that is often purposely torn during child birth in a procedure called an episiotomy. The perineum is also laden with nerve endings which may lead to arousal in some women upon stimulation. Taoist sexual practice has recognized the perenium as having powerful potential to incite lust and gratification. Taoist sexual practices have even coined the term Perenium Power, which refers to specific breathing exercises involving stomach, anal, and perineum focus (Chia & Chia, 1986, & Yudelove, 2005.)

The Clitoris:

The clitoris enjoys the title of "most sensitive organ" of the female genitalia (Crosby, 1985). The reason it is the most sensitive structure is because of the concentrated amount of nerve endings found there. This is the male equivalent of the

penis-head (or glans). As aforementioned, The Hite Report (1976) was pivotal in raising societal awareness that the vagina is not in fact the anatomical structure by which most women reach orgasm. This fact liberated women to discover and/or claim their sexuality in a newfound way.

Dr. Sherfey (1972) introduced the idea of a clitoral network and has since set the stage for other medical researchers such as O'Connell and Berman to build upon her suppositions and pay particular attention to the complicated internal clitoral system. Sherfey noted that the clitoral network was analogous to the penile structure, having parallel functions and process, however the clitoral network was internal and the penile one external.

The clitoris is located below the mons pubis and above the urethra. Most of the clitoris is not visible. The entire clitoral structure, as described by urological surgeon Laura Berman, consists of a shaft, leg-like structures that go up into the body, and smooth muscles (Berman & Berman, 2001, Chia & Chia, 1986, Kelly, 2006.) Berman also draws her anatomical description from the work of Dr. Helen O'Connell (1998) who dissected many cadavers and used three-dimensional imaging techniques.

The part that is visible is called the clitoral glans. It is covered by a small hood of skin called the prepuce, which retracts upon reaching an aroused state. The clitoris glans is a small rounded "button" of skin – it is about the size of a small pea in its resting state. Berman and Berman (2001) note that medical books erroneously refer to the visible pea-like structure as the clitoris, instead of the clitoral glans.

The shaft of the clitoris feels like a small semi-hard cord-like structure that lengthens from the glans in and under the muscle tissue behind the mons. The shaft then

divides into two separate structures, or crura which separate and attach to the pubic bone. Several researchers have likened the shape to a wishbone (Berman & Berman, 2001).

While in an aroused state the entire clitoral structure becomes erect and engorged with blood. Stimulation of the clitoris leads most women to orgasm. Therefore, the clitoris is actually the female sexual organ and not the vaginal canal (Hite, 1976). Luckily, recent medical and sexological literature has given more attention and importance to the clitoris. Further, sex education is incorporating the notion that clitoral stimulation is an essential part of the female arousal process.

The Anus and Buttocks:

Many women report the anus and buttocks to be a source of sexual excitement and pleasure. Touching the outside area of the anus during foreplay or inserting a finger or a penis are activities that have been found to be satisfying to some and taboo for others. The anus and rectum do not self lubricate so it can be painful if a synthetic lubricant is not employed.

There are few nerve ending in the buttocks, however strong massaging and rubbing have been considered erotic and satisfying to women.

The Breasts:

Different societies have different views on breasts and sexuality. The Western world finds them erotic and enticing, in spite of the fact that they are not considered a sex organ. The primary function of the breast is to lactate, post childbirth and provide nourishment to a newborn.

There is no baseline for "normal" response to breast stimulation and subsequently there are a wide spectrum of opinions regarding breasts and arousal. What does seem to be consistent is that nipple stimulation seems to receive the most positive rating from women. This is not surprising considering most of the nerve endings of the breast are housed there.

Certain Tantric practices consider breasts to be extremely important in love making and consider them to be the positive energy pole in female (Richardson, 2003).

Berman & Berman on Female Anatomy:

While there have been vast strides in the medical field to more accurately identify and discuss female genitalia, much is left to be desired. Funding to examine female anatomy as it relates to sexuality is less than that of the male counterpart. While we know virtually every in-and-out of the male genitals and the way they work, we are just beginning to examine female anatomy and sexual response. Doctors Laura Berman and Jennifer Berman are on the forefront of this field. They are employing a vast array of new technology such as "pH probes to measure lubrication; a balloon device to evaluate the ability of the vagina to relax and dilate; vibratory and heat and cold sensation measures of the external and internal genitalia; and high frequency Doppler imaging, or ultrasound, to measure blood flow to the vagina and clitoris during arousal" (Berman & Berman, 2001.)

They are using some of the most sophisticated, innovative, and pioneering techniques and consequently they are producing seminal information about female

anatomy and sexual response. Some of their most notable findings in the early half of this decade include: the role of blood flow, aging, and hysterectomy, nerve damage, or other vascular problems and how they inhibit sexual response. They were also among the first to pay particular attention to the importance of testosterone and sexual function in females.

Understanding the female parts and their functions better equips women to "use them properly" and enjoy. Ironically, women with Hypoactive Sexual Desire Disorder have healthy physiology. That is, all of the above discussed anatomy "checks-out" as functioning properly. Why then do women experience low or absent desire? The following section will examine the possible psychological causes for Hypoactive Sexual Desire Disorder.

CHAPTER 5

Contemplating causes: "What's wrong with me?

As we are beginning to see, women's sexuality is a multidimensional concept. Therefore any relevant dysfunction most likely has more than one etiology (Basson, Leiblum, Brotto et al., 2004, Nijland, Davis, Laan, et al., 2006 & Quirk, Haughie, & Symonds, 2005). Rarely can a clinician trace the cause of HSDD back to one definitive moment or malfunction (Graziottin, 2007). Often, there is a culmination of several negative events that lead to the onset and maintenance of inhibited or absent desire. This ambiguous root often leaves women wondering "What's wrong with me? Why can't I just get over my issues?"

I am always amazed at how many women come into my office telling me that they don't have any desire - it is their problem, the partner "works just fine." "Can you please just fix ME?" Upon initial intake I learn that rarely, if ever, is low/no desire the only issue. Instead, these women (although they had not put two and two together yet) are dissatisfied in their relationship, feeling bad about their body, stressed about money, struggling with being an adult survivor of sexual abuse, have never masturbated or hardly ever have sex unless intoxicated – and then they wonder why desire is low. When people identify female sexuality as being multi-dimensional they are saying that sexual desire is tied to the aforementioned issues in profound ways. They all have an effect on the desire portion of the sexual response cycle. The following section will examine different causes of HSDD. Putting the negative pieces of the puzzle together will inevitably point to the cause(s) of the inhibited or absent desire.

Relational Satisfaction

In the words of Tina Turner: "What's love got to do with it?" Well, when one is discussing sexual desire the answer is: "A LOT!"

Studies indicate that women are much more emotional than men. This sounds cliché but scientists are beginning to uncover anatomical differences in the brain structure of males and females. Shere Hite (1987) devoted an entire research book to uncovering the relationship between women's feeling and sexuality; she entitled the piece Women and Love. Hite compiled seven years of comprehensive research of 4500 women and their self-report on emotions and relationships into a poignant piece of work that highlighted the importance of relational and emotional satisfaction as it pertains to sexuality.

Additionally, researchers such as Paul Ekman (1994) and Deborah Tannen (1990) who examine emotion and communication are asserting that there are fundamental differences in the way each gender emotes and communicates. Ekman's (1994) research also examines the *motivation* behind emoting. When placed in a sexual context, it becomes interesting and revealing to examine male and female differences in motivation.

Men are less complicated when it comes to sex. Most men do not need to feel loved and "cuddled" to want sex. They can be in a fight with their partner, they can be disappointed in them, they can be uncommunicative and yet most men will still experience a lustful longing – despite poor relational satisfaction.

Women on the other hand are not this cut and dry. As the research around HSDD increases, results for causes are pointing more and more towards relational satisfaction as being a primary factor in the presence or absence of sexual desire (Basson, Leiblum,

Brotto et al., 2004 & Basson, Brotto, Laan, et al, 2005). The Rosemary Basson sexual response model, discussed in Chapter 2, is among the first that is speaking to the notion that women may have many reasons for wanting to engage in sexual activity and outright desire may not be one of them. Instead, we are seeing that female desire may in fact be a bi-product of feeling satisfied in the partnership and wanting to be close and connected. Berman & Berman (2005) assuredly declare: "For sexually satisfied women, intimacy and closeness are the foundation for sexual satisfaction and sexual feelings. It's the commitment, security, affection, and caring that arouse women most."

Dr. Cervenka (2003) discusses what she calls "fire extinguishers." These are relational points of dissatisfaction that lead to low desire. She cites relational inequality, insecurity as a result of extra-relational flirting, infidelity, and libido discrepancy as some of the issues that contribute to inhibited desire. Althof, Leiblum, Chevret-Measson, et al., (2005) echo these suppositions that relational satisfaction is a key feature in bolstering desire. They introduce a discussion on love and intimacy whereby they argue that emotional feelings of love and intimacy undoubtedly inaugurate and sustain sexual desire. They do note however, that this is a culturally bound feature and may not hold true in societies where love is not a principle feature of relationships.

Schiller (1977) highlights the importance of relational harmony as it relates to sexual desire also. She states that issues such as lack of respect, finances, parenting-differences, inability to effectively communicate, and power struggles are all potential contributing factors to sexual dysfunction.

One of the reasons that relational satisfaction and love, as a diagnostic set, does not enjoy much scientific attention is because it is difficult to measure in evidence based

research. Love and relational happiness are challenging items to quantify. That said, they are a key factor in the cause of Hypoactive Sexual Desire Disorder. When seeking treatment, it is important that women get help not just for their "disorder" but for the relational inconsistencies as well. Otherwise the problem will resurface. The intimacy will break down, the avoidance will be magnified, the communication will become strained and sporadic, and the overall emotional security of the relationship will decline (Berman & Berman, 2005 & McCarthy & McCarthy, 2003).

Lack of Self Knowledge

Another cause of HSDD may be a genuine lack of self-knowledge. The dance of sex and relationships seems to be led by the male. Women will do this -follow the male lead- through college, into their twenties, and the early part of their thirties until all of the sudden they are dissatisfied and they don't know how to address it. They are unsure of what they like and need. They did not take the time or have the permission to self-discover (Hite, 1976, 1987) and now they are presenting with no desire. And they don't know how to change the steps of the proverbial dance.

When I am talking with women who are having desire issues I always ask for their wish list. "What would make you happy? What turns you on? What do you want done to you? When? How? Where? With Whom? And I am always shocked at the genuine unknowing that many women experience. A lot of females are simply unaware of what they like because they were either never given permission to discover their pleasures, they were following someone's lead, or they were scared due to societal influence (Hite, 1976).

It is very difficult to expect your partner to know what you like, what you want and what turns you on, when you yourself do not know. This lack of knowing leads to sexual indifference (Basson, Brotto, Laan, et al, 2005). This leads to avoidance, which often morphs into dysfunction. There are two main reasons women do not have sexual self-knowledge: they don't know about the clitoris and they have trouble accessing their fantasies.

A man's genitalia protrude. It hangs out of their bodies. They hold it when they urinate, they scratch, rub, tug, play and no one ever corrects them for it. Women on the other hand have much more concealed genitals. They do not hang out of us, we do not have to touch them, save for a piece of toilet paper here and there and the occasional tampon (if you use one). And we are told from a very early age to "sit with our legs crossed," ostensibly not to be too genitally suggestive and of course to exercise good manners. All of these manners and demure genitalia have led to generations of women who do not know their bodies.

Many women are unaware of how to have an orgasm and it is because they do not know that the clitoral glans is the true sexual organ and not the vaginal canal. Those that do know how to orgasm through clitoral stimulation are embarrassed to communicate same (Hite, 1976). Sadly, many women do not even know how to locate their own clitoris. They sit and wonder why they are unable to feel orgasmic pleasure, or pleasure at all for that matter during conventional intercourse. Further, they have never stuck their fingers inside of themselves and explored their g-spot and its sensitivity. Masturbation, although uncomfortable for some women, is an important part of bolstering your sexuality and your desire (Hite, 1976 & Berman & Berman, 2005).

Unlike little boys, little girls are not encouraged to touch themselves and thus they grow up unacquainted with the very body part that makes them women. Females are not given societal, religious, or familial permission to learn their private anatomy (Hite, 1976 & Maines, 1999). Therefore, they end up relying on their partner to show them what they like. Or they think sexual activity is for men and it is simply a womanly duty to oblige when solicited. Maines (1999) calls this the Androcentric Model of Sexuality: one where orgasm should be achieved through intercourse and female masturbation is unnecessary if not blasphemous (Hite, 1976).

This collective lack of body knowledge has trickled down through history and present day women still report deficient self knowledge. Sadly, desire is not cultivated or nourished and HSDD presents.

Since masturbation is a rare activity in the female population as compared to males, not only do women not know their physical body but they often do not know their psychological sexuality either. Women that have sexual fantasies and know how to access them experience greater desire.

Cervenka (2003) defines sexual fantasy as "a mental process that represents our most passionate sexual desires and wishes." She notes that in the absence of fantasy it is difficult to activate the sex centers in your brain.

According to Kelly (2006) there are four main categories of sexual fantasy:

1. Exploratory-these include ideas of group sex, swinging, and homosexual activity;

2. Intimate- these include topics of adoring kisses, oral sex, outdoor sexual play, simultaneous masturbation;

3. *Impersonal*- these include sex with strangers, watching pornography, voyeurism and fetishism;

4. Sadomasochistic- which includes themes of forceful activity, whipping, spanking, being tied up.

Women most often engage in the intimate themed fantasy. Again, when women do not have a fantasy or know what they want to think about, desire may diminish – especially in longer term relationships where the initial 'desire-and-love' for 'desire-and-love' sake has evaporated.

I had a woman come into my office and she said "I don't want to have sex with my husband. I can't reach orgasm, and I have tried masturbating over and over again. I have read books, I know all about the clitoris. But I feel silly when I use a vibrator because I am just laying there thinking 'okay there is this thing moving around on my clitoris – now what'?"

So here was a woman who knew her body – anatomically speaking. She had touched herself, she understood her different organ systems, and yet this was not enough to incite desire. Why? Because she did not have a psycho-sexual space to enter. She was able to go through the motions in the right way, but she was unable to connect them to anything erotic in her mind. The psychological self-knowledge is as important as the physical.

Women often experience guilt or discomfort about their fantasies and so they shy away from engaging in them to the detriment of their arousal systems. Fantasies have an important role in alleviating inhibitions, exploring one's sexual psyche, and entering scenarios that you would be too shy to initiate in real life. Often woman are afraid to

acknowledge their fantasies for fear of judgment or embarrassment (Hite, 1976, Kelly, 2006, Berman & Berman, 2005, & Zopol & The Sinclair Institure, 2002). When you combine minimal self-touching and minimal sexual fantasy you get minimal knowledge about what to desire. Therefore this combination enables HSDD to the extent that we can't desire what we don't know exists.

Self Image and Spectatoring

There is a copious amount of pressure placed on body image in today's society. The majority of today's women feel compelled to be 'perfect' and anything less leaves them feeing bad about themselves. Because sexy is a state of mind, if you are thinking and feeling bad about yourself, the sexual desire will not follow. Discomfort with one's body leads to an inability to relax and a tendency to avoid intimacy (Masters, Johnson, & Kolodny, 1988). Schiller (1977) cites poor body images as the third most prevalent factor in a "destructive sex system." Therefore, low self esteem and poor body image often result in inhibited sexual desire. While we know this to be true, there is little empirical support in the literature. This section will examine some of the current research validating this connection.

Masters and Johnson had put forth an idea called *spectatoring*. This refers to scrutinizing, observing, and assessing oneself while engaged in sexual activity. They supposed that by concentrating your attention outward, as opposed to inward on pleasurable feelings, you increase performance pressure and consequently impede sexual functioning. Seal and Meston (2007) point out that Barlow's model, introduced in the

Anxiety section of this chapter, would support that spectatoring interrupts the cognitions associated with pleasure and focuses the mind toward the insecure performance.

There have been several studies that have uncovered inverse relationships between body image and sexual esteem, experience, satisfaction and desire. This phenomenon also seems to surface with body changes as well, particularly in middle adulthood. That is, as the body changes due to general aging, women report a marked decline in desire and sexual self-esteem (2007). Further, women who don't like their bodies or think they are overweight or sagging may not identify as a sexual person and thus feel no desire (Masters, Johnson, & Kolodny, 1988).

Seal and Meston (2007) furthered the empirical research on this topic with a study that was published in the Journal of Sexual Medicine. They concluded that there was in fact a correlation between body and sexuality. However, when a partner was not present the results were not as well supported. Otherwise stated, the women subjects were able to relax and reported more subjective arousal and comfort, in spite of having reported very poor body image when they were alone. Anger, Brown & Amundsen (2007) found a similar result in their research: they stated "the degree to which a woman was dissatisfied with her appearance also correlated with her degree of depression and sexual dysfunction."

Berman and Berman (2005) devoted a whole chapter in one of their books to emotional well being, self-esteem, and confidence as it relates to sexual satisfaction and desire. They echo the above suppositions that feeling comfortable naked is a key ingredient to a successful sexuality. Further, if you are under the covers, partially clothed, or always with the lights off the intimacy level will be deficient. Deficient

intimacy leads to lack of desire. Thus it comes full circle – unsatisfactory experiences and inability to relax lead to a lack of desire to engage the next time. Therefore when examining the causes of HSDD it is prudent to assess body image and esteem.

Anxiety and Performance Pressure

Another cause of sexual dysfunction that has received significant attention is anxiety and performance pressure (Masters, Johnson & Kolodny, 1988). In fact many current psychological treatments for HSDD hinge on reducing the anxiety associated with not wanting sex. There are a range of current studies that have found people with sexual dysfunction experience intensified levels of anxiety (Althof, Leiblum, Chevret-Measson, et al 2005.)

Barlow has done some significant work regarding anxiety and erectile dysfunction According to Seal and Meston (007) Barlow's model has been modified to address female sexual dysfunction also. While erectile dysfunction and hypoactive sexual desire do not share the same definitive qualities, they do share some similar maintenance behaviors and cognitive patterns. That is, once the patient has identified there is a faulty pattern, they engage in similar thought processes to avoid or overcome the problem. Therefore the following section will briefly examine his model. Hite has commented extensively on male sexuality, publishing in 1981 a pioneering study (the first since Kinsey in 1948) entitled "The Hite Report in Male Sexuality. It included over 4500 men who participated in her independently-financed, seven year research project. Hite's, thoughts on men and male psycho-sexuality were further refined in the book "Oedipus Rvisited" (2006), in which hite discussess the nature of male sexual development,

describing men's focus on coitus, and "penis size" as socially created, and asked whether sexual violence to women is an inherent part of male sexuality, or whether male sexuality in its diversity has yet to be fully understood.

Barlow had proposed a theory that contradicted Masters and Johnson (Nobre & Gouveia, 2000.) Instead of focusing on anxiety reduction solely, Barlow asserted a model that aimed to decrease cognitive interference. After examining cognitive-affect contributions to sexual function, he pointed to five features which comprise the primary differences between functional and dysfunctional individuals:

I. "Experimental induction of anxiety often facilitates sexual responding in individuals who are not already experiencing sexual difficulties."

II. "Subjective report of arousal is accurate or over-reported among functionals and under-reported among dysfunctionals."

III. "Distraction from erotic cues decreases arousal on functionals or either has no effect or slightly enhances arousal among dysfunctionals."

IV. "Performance demand facilitates responding among functional men and inhibits responding in dysfunctional men."

V. Dysfunctionals evidence greater negative affect pre and post-exposure to erotica."

Essentially, cognitive configurations that join the self with unlikely beliefs about sexual performance "form the core psychopatholgy of sexual dysfunction" (Nobre & Gouveia, 2000.)

One of the causes of hypoactive sexual desire may be anxiety surrounding sex in general, or anxiety about not "wanting it." Many women put an extraordinary amount of pressure on themselves to "want it." They engage in internal dialogue aimed at convincing the self that they desire their partner. This self-talk is prohibitive because the woman becomes so focused on 'wanting to want' sex that it becomes a performance-based activity and not an intimate and love filled one. Even if they are able to bring themselves to engage in sexuality activity – they are not addressing the HSDD. They are simply avoiding it temporarily. Hite (1976) notes that the idea of treating a woman with desire or orgasmic disorders "still leaves [them] with the impression that not having an orgasm during intercourse is "sick" and "abnormal" – a dysfunction". This underlying societal blame perpetuates the female's anxiety and sense of responsibility for the problem.

History of Sexual Abuse and Assault

A history of sexual abuse or a sexual assault may certainly be a primary or secondary cause of hypoactive sexual desire disorder (Masters, Johnson, & Kolodny, 1988, Kelly, 2006, Leiblum & Rosen, 1989, & Laine & Jones, 2007). When a woman's initial sexual experiences were violent, invasive, and unhealthy she may certainly have a hard time accessing her desire and activating her sex centers. Women experience fear of being defenseless, fear of losing control, mistrust in all intimate interactions, and a conditioned repugnance towards sexual activity in general (Leiblum & Rosen, 1989). When sex gets associated with abuse the result is often aversion or repulsion (Scott, 1993). Further, when a woman has been sexually assaulted she will often feel sex is now

an unbearable act; one for which she has NO desire (Kelly, 2006). Assault and child sexual abuse are different. The following will aim to offer clearer definition of each one.

There are many definitions of child sexual abuse (CSA). Because abuse is not always clear cut, women sometimes don't feel "entitled" to use the abuse to explain their HSDD. Instead they think that by explaining the HSDD through child abuse they are being weak (Matsakis, 2003). This is faulty and it is important to recognize that child sexual abuse is always considered a formidable cause of HSDD.

Alternatively some women do not identify as having been abused and are unable to connect their present dysfunction with past abuse (Leiblum & Rosen, 1989, Rellini & Meston, 2007). Because criteria vary, Holmes and Slap (1998), through a literature review, constructed a list of different criterion that attempt to distinguish between defining features of CSA.

Age differential: *unspecified, fixed, and graded*.

Whereby, *unspecified* refers to literature that simply implies sexual abuse occurred as a child. Within this framework there could be a 17 year old "child" who was assaulted by an 18 year old "adult.

Fixed age differential refers to a set number of years between the victim and the perpetrator; usually researchers employ a fixed difference of five years. Therefore, a five year old is considered to be victimized when a ten year old inappropriately touches their body.

Lastly, some professionals rely on a *graded* age differential to define a sexually abusive interaction. This is similar to the fixed feature except the age difference will vary with the age of the victim. For example, a victim under the age of 13 is only considered

to be abused if the offender is at least five years older; for a victim age 13-16, the perpetrator would have to be ten years older.

Additional features to consider when discussing and defining sexual abuse include:

- coercion, was there blatant coercive behavior on the perpetrator's behalf;
- reaction, did the victim instantly evaluate the event as negative;
- authority figure, was perpetrator a definitive authority figure;
- physical contact, this feature would exclude exhibitionism and sexual talk as abusive behavior;
- penetration, did the perpetrator actually penetrate the victim with either their genitalia, fingers, or other object.

As the above illustrates, there a lot of linguistic nuances present when determining child sexual abuse. What this means for women, is that they are often unclear as to what they should consider abuse and if that is a valid reason to feel inhibited desire. The answer is "yes." All of the above are abusive and they may very well explain low levels of desire. Hypoactive Sexual Desire Disorder is one of the most common side effects of sexual abuse or assault (Matsakis, 2003).

Rellini and Meston (2007) conducted a study to examine the effect of sexual abuse on sexual function and satisfaction. Their findings support the aforementioned assumption that definitions and perceptions of abuse largely influence subsequent functioning and satisfaction. Not surprisingly, women who experienced what they perceived as more severe abuse reported more anguish with their adult sexual life. This propels the theory that abuse is a cause of HSDD.

Sexual assault and rape can happen at any age unlike child sexual abuse which takes place before the age of eighteen. Similar to CSA, assault victims experience a multitude of negative feeling surrounding sexuality. The healing process is long and arduous and is often at the expense of a woman's desire, even if she is in a loving and safe relationship (Kelly, 2006, Scott, 1993 & Masters, Johnson, & Kolodny, 1988.)

Sexual assault has varying definitions but the overall feature is that it is nonconsensual sexual contact (Matsakis, 2003). Legal definitions of exactly what defines rape (vaginal, oral, and anal penetration), sexual battery, sexual misconduct, and other types of assaults vary between states. However, any forced sexual act is horrific and detrimental.

Sexual abuse and assault leave women with an abundant amount of negative feelings about themselves, sexuality, and men (Scott, 1993). As was discussed earlier, self love and confidence are important to sexual desire. The absence of this positive self image leads to inhibited or absent desire. Since sexual abuse leaves women feeling dirty, guilty, unlovable, anxious, and insecure, among other things (Scott, 1993) it is easy to see the connection between abuse and HSDD.

Aside from negative self appraisal, women who have a history of assault will often experience adverse feelings towards sex and men in general (Leiblum & Rosen, 1989). It is not uncommon for women to have invasive negative thoughts while in a "safe" sexual act. This automatic cognitive reaction to sexual activity or stimuli conditions the woman to avoid sexually charged situations altogether. Thus this avoidance, fear, and aversion clearly contribute to a sustained low desire.

As the previous pages highlighted sexual abuse and assault have profoundly negative effects on the victim. It takes a toll on their self esteem, trust, attitude towards sex, views of men, and ability to relax. All of these items are critical to healthy sexuality and when they are disrupted the end result is often a significant aversion to wanting to be around anything sexual. This aversion often translates to inhibited or absent desire.

CHAPTER 6

Psychological Impact of Hypoactive Sexual Desire Disorder

While sex takes two, feeling inadequate seems to be a lonely and singular act. A woman experiences psychological anguish when she consistently does not desire her partner or sexual activity in general – and worse, it is self perpetuating. Faulty, negative cognitions further exacerbate physical and mental deficits.

Sexual dysfunction takes a toll on more than just the sex in a relationship. There is a large psychological component tied to recurring unsuccessful attempts at intimacy. When the health of the psyche is compromised so are a woman's behaviors both in and out of the bedroom. The sense of failure, inadequacy, and defeat often leads a woman to withdraw from her partner and engage in bouts of self-blame and decreased self-confidence. There has been a large amount of research done on the importance of self esteem and self-efficacy and the role they play in success and accomplishment. And conversely, in their absences, the role they play in perceived failure and insufficiency. Interestingly, the idea that our self-perception defines our experiences is found across cultural and theoretical boundaries.

The following chapter will examine the psychological impact of Hypoactive Sexual Desire Disorder. First several personality and motivational theories will be introduced to illustrate the differences between an efficacious individual and one that is not. This discussion will also underscore the significant role our self-appraisal plays in the actual events in our lives. We will examine the ideas of a self-defeating cycle, the self fulfilling prophecy, quantum physics, sexual Taoism, and overall confidence and self worth and the role they play in maintaining a low level of desire.

Self-Esteem and Self-Efficacy

Albert Bandura discussed the concept of self-efficacy. He stated that people with high self-efficacy will approach new situations with confidence, they will set high goals for themselves, and they will persevere through hardship because they believe success is within their reach. Alternatively, people with low self-efficacy will anticipate failure, avoid challenges, quit when a task seems too hard, and are likely to succumb to a depressed state (Wood, Wood, & Boyd, 2008).

Hypoactive sexual desire disorder slowly erodes a woman's self-efficacy, Consistent with the above cited theory, a woman will then anticipate sexual failure or avoid sexual interactions altogether. The repeated sense of failure leads to a vicious psychological cycle of evasion and self blame (Althof, Leiblum, Cheverete-Measson, et al, 2005). Once a woman is caught in this psychic battle, it is very difficult and daunting to undo. The woman will then begin to attend exclusively to negative cues that are consistent with her sense of self worth and efficacy. This will lead to a faulty relationship with the external and internal environment in which she lives.

In the field of social psychology, there is a concept called "attributions." This field of works examines the way people explain their behaviors. There are two main types of attributions: dispositional and situational. Dispositional attribution refers to the idea that we will explain a behavior based on an internal cause such as a motive, a personal trait, or attitude. Situational attribution refers to a person explaining a behavior based on some external cue and not a personal or internal cause. Women with HSDD begin to rely only on dispositional attributions to explain their lack of desire. They internalize all of the blame and fundamentally come to believe that this is an

unchangeable, stable condition due entirely to their disposition and not to the busy day, the traffic, the laundry or the fight with their partner (situational). The error with this type of thinking is that you lose control over the ability to change the psychological circumstance.

This is opposite to the way most people use attribution theory. The majority of the population will use situational attributions to explain failure and dispositional attributions to explain success, thus casting themselves in the best light in each situation (Wood, Wood, & Boyd, 2008). However, women with HSDD use the opposite rationale and this serves to keep them stuck. By internalizing the failure and externalizing the success they are consistently forfeiting their locus of control.

The field of quantum physics is discussing a similar principle: the idea that our thoughts create our reality. If we think that we are sexually insufficient and there is no alternative definition to sex other than intercourse, then our reality will mirror our thought. We are what we think – literally. Deepak Chopra (1994) discusses this in the realm of intention and desire. He states that you must set your intention for something you desire as opposed to simply desiring it. He states that desire, in and of it self, is empty and it is the intention that will bring you closer to your goal. Women who have HSDD begin to feel hat they have no control and therefore they lose their intention.

Further, he goes on to state that the past is unchangeable and therefore dwelling on it is sure to lead to unwanted repetitive behaviors. He writes that the key to psychological freedom is to intend to be in the present and improve the future. This style of thinking is NOT shared by many women with HSDD. Instead, they are so fixated on their disappointment with the past experiences and their present disapproval of

themselves. This inability to look forward ensures that they remain in a psychologically stuck state.

Masuro Emoto (2004) echoes these suppositions in his work which explores the connection between science and consciousness. Whereby, he notes that sending yourself negative psychological messages will undoubtedly affect the cellular level of your body and thus affect your entire being. You must afford yourself psychological space to feel that there is an alternate route, or you will never find the path.

This idea of psychological health breeding sexual health is found across a multitude of teachings. Therefore it is logical that psychological unhealth breeds sexual dysfunction. Mantak Chia (1986) discusses psychological energy and sexual health in the realm of Taoist teaching. He supposes that if we can identify our negative energy or thoughts we can control the role they play in our sexuality. The more positively we regard ourselves, the more positively we will feel towards experiences and vice versa. If we are putting negative energy or thought into sexual experience, than we will encounter negative or avoidant patterns of intimacy. Women with HSDD are constantly battling the idea that they are no longer capable or worthy of sexual energy. The result is that their psyche controls the future sexual experiences. Further, Yudelove, in his book on Taoist Yoga and Sexual Energy (2005) emphasizes the importance of bringing the mind to a positive place in order to cultivate improved sexuality. The emphasis on a "can do" attitude permeates a multitude of sexual theories.

Ekman & Davidson (1994) write extensively on the relationships between positive moods and performance. They discuss an idea of *associative priming*, whereby positive thoughts are primed by positive moods and the result is positive performance.

They go on to state that a memory is formed with each experience and when the memory is tied to a positive mood state it is more likely to be recalled with fondness and a sense of efficacy. With women who are suffering from HSDD, their sexual memories become tied to emotions of failure, fear, inadequacy, and self-hate and thus the person will avoid future experiences. That is, anything that resembles a potential sexual interaction will cue negative feelings and memories. The psychological impact of not being able to perform or summon sexual feelings will lead to more of the same.

Self Worth

Although feminist books help women build their self-esteem, there are other works that also go in this direction. Carl Rogers has a body of work that examines self esteem and the role it plays on our ability to conquer tasks. He discusses the idea of unconditional positive regard and states that this is initially provided by one's caregivers and if implanted successfully in childhood a person can carry this sense of esteem through their lifetime. If not properly developed, one will have low self-esteem which leads to feeling inadequate and incapable. Even if someone has a good level of self-esteem, it may be broken down by repeated failure at a task or by enough negative feedback from a loved one. Such may be the case with HSDD. When a woman continuously feels nothing and is receiving messages of frustration and disapproval from her partner, she may experience a decrease in her sexual self-esteem. This decline in feeling capable leads to further avoidance (because we don't like what we are not good at) and this avoidance sustains HSDD.

Abraham Maslow also discussed the importance of having a sense of worth. He called this being "self actualized" and stated that once people's basic needs are met they can go on to become a self actualized person. He identified specific cognitive features associated with this. They include: perceiving reality accurately, being comfortable with life in general, accepting themselves and others, having a good sense of humor and tolerance, having relationships that are emotionally deep, ability to laugh at yourself, being independent. This idea of valuing yourself is important in the face of perceived failure because it serves as a protective factor from engaging in too much self blame, as is often the case with women suffering from HSDD. Having a sense of self-worth and actualization allows a woman to separate her isolated "failure" from the rest of her being. This enables her to approach a problem solving techniques with a more efficacious spirit, which ultimately generates a more desired outcome. The problem is that often because romantic relationships are so closely tied to sexuality, when the sexuality piece is missing a woman begins to doubt herself, her relationship, and her ability to be a "good" woman. The woman he portrays thus gets caught in a self-defeating cycle of psychological failure.

As one can see, female sexuality is multi-faceted and success and failure are largely produced within the brain. When the psychic frameworks are weak, self-loathing, insecure, or afraid the result is maintenance of the unwanted thoughts and behaviors. Women who feel good about themselves and are able to employ a positive thought process are more likely to approach HSDD with a sense of being able to conquer it. Therefore it is pertinent to assess for levels of self confidence and efficacy and help a woman restore her esteem in an effort to restore sexual functioning.

CHAPTER 7

Interpersonal Interference

Aside from the intra-psychic toll HSDD takes on a woman, there is a huge interpersonal price to pay as well. In fact, it is often the interpersonal distress that will compel a woman to seek treatment (Althof, Leiblum, Chevret-Measson, et al, 2005). The presence of HSDD becomes such an issue in the relationship and infiltrates non-sexual aspects of the partnership so profoundly that help must be sought.

Because of the intra-psychic struggle, a woman may then begin to alienate herself from her partner socially and forego sharing her feelings about daily life. Alternatively, she may avoid all forms of physical contact for fear of it leading to more sexually charged interactions. Over time, this persistent evasion erodes the relational foundation. The following section will explore different types of relationships and the subsequent interference of HSDD. It will examine the emotional toll HSDD takes, the partner's perceptions of HSDD, and the subsequent breakdown of communication.

Theories of Love and HSDD

It is important to not take sex as an isolated concept in a relationship because some unions from the start were less sexualized than others. With women's sexuality in particular it is integral to examine the relationship structure. Additionally, as is becoming clear, communication in and out of the bedroom will be a protective factor in coping with the presence of HSDD. Therefore, it is important to have a framework in which to categorize different relationships.

I like Sternberg's Triangular Theory of Love and Lee's Six Types of Love. Of course the third Hite report, Women and Love (1987), was the first study to focus on women and gender, asking women 'What is love?' It turned the tables on many long-held clichés about female psychology with over 3,500 women participating in its research it sought to differentiate, for example, whether a women felt and emotion of caring for her partner, or passion/lust/desire, or enjoyed being loved – and to identify which type of love had provided a better, long-term basis for a stable relationship or happiness.

On the other hand, Robert Sternberg identified three different mechanisms in a relationship: passion, intimacy, and commitment (Wood, Wood, Boyd, 2008). Whereby, intimacy is "those feelings that promote closeness, bondedness, and connectedness." Passion is those instincts in a relationship "that lead to romance, physical attraction, and sexual consummation." Lastly, commitment references "(1) a short-term aspect, the decision that one loves another person, and (2) a long-term aspect, a commitment to maintaining that love over time (2008)". His theory purports that a relationship can yield a combination of any three of these components, thus yielding seven different types of love. When examining the toll HSDD takes on relationship, it is crucial to recognize that not all relationships are created equal from the start. Identifying deficiencies as they relate to commitment, passion, and intimacy will enable a couple to better overcome HSDD – especially since HSDD effects all three components whether they are present at the time of the disorder or not. The seven love triangles are as follows:

1) Liking – this includes only the intimacy component. These relationships are characterized by warmth, bonding, friendship, and closeness but no passion or long-term commitment. Women with HSDD who have this type of relationship

often feel an immense amount of guilt because they want to be please their partner, especially since they have such a good friendship. Their inability to summon sexual feelings leads to self-blame.

2) Infatuated Love – this is love that is built solely on passion. There is no commitment or intimacy. Without these other two features, the passion is bound to be either short lived or shallow. Further, because there is little friendship or commitment, communication will likely be insufficient and this leads to sexual and other problems down the line, even if the relationship was built on passion.

3) Empty Love – this consists of the commitment feature only. There is no passion or intimacy but there is a willingness to stay together either because of religion, children, finances, convenience, etc. HSDD often may propel a couple into this empty love.

4) Romantic Love – this is a combination of passion and intimacy. These people are connected emotionally and physically but not necessarily committed to one another. If the lack of commitment leads to relational insecurity and low self-esteem then the sexual aspect and the intimate aspect will surely be compromised and potentially lead to HSDD.

5) Fatuous Love – this type of love has passion and commitment but no intimacy. Women in these relationships report being sexually aroused by their partner and committed to them, however they do not feel a platonic closeness. This love is not as likely to rear HSDD.

6) Companionate Love – this is comprised of intimacy and commitment. This type of love is often seen in women with HSDD. They love their partner, they

have a wonderful friendship with them, they are committed, but they can not summon any sort of sexual feelings.

7) Consummate Love – this is the most comprehensive and healthy triangle that contains all three components. This is the type of love-triangle couples should aspire to, according to Sternberg.

Since HSDD is affected by all three parts of the triangle, it is important to note what type of relationship a woman is in and then help her aim to find a more complete dynamic. Additionally, identifying a love type will provide insight into what was the initial sexual and emotional health of the relationship.

John Alan Lee (Masters, Johnson, & Kolodny, 1982) identified six principal types of intimate love that he categorized with Greek and Latin names. Similar to Sternberg, he suggested that most love is a combination of several of the categories. They are:

1) Eros –is a relationship founded on physical attraction – it is a profound sexual connection. This would be the equivalent to Sternberg's Infatuated triangle.

2) Ludus –is a relationship that is lighthearted and informal. These lovers are low on the commitment scale, but enjoy each other's company on a more friendly level. Sex is not about intimacy or dedication. This would be analogous to Sternberg's Liking triangle.

3) Storge – is categorized by caring and fondness that grows into love. Storge is a love that starts with friendship and blossoms into something more. This type of love is scarce on passion, but high on commitment.

4) Mania – this is a love that is wild, unpredictable, and volatile. The manic lover is crazy for the attention of their partner. This is an unstable love type that may have explosive but shallow sexual interactions.

5) Pragma – refers to a more balanced type of love. This may be a combination of Fatuous and Empty love as identified by Sternberg. This love may look good on paper, but may lack that intangible emotional feeling that is so integral to feeling love.

6) Agape – references a love that is stable, patient, and ubiquitous. This represents an ideal and may be analogous to Sternberg's consummate love. Masters and Johnson are quick to point out thought that this is more an idealistic notion than one rooted in reality.

It would be erroneous to discuss sex without love and relationships, especially where female sexuality is concerned (Hite, 1987). The aforementioned theories present the discussion of love and relationships from a cognitive perspective. There has been research on the biological and evolutionary component of sexual desire but it is beyond the scope of this paper. Especially since most research about HSDD supposes the brain to be the source of the issue. Thus, when there is relational dysfunction the sex centers in the brain will not fire and this results in a lack of desire. Therefore it is prudent to assess relational function (Hite, 1987) in conjunction with hypoactive desire.

Emotional Effects of HSDD

The emotional price of HSDD is profound. While it may begin as a disinterest in sex, it almost always permeates into the communication and friendship aspects of a relationship. Alternatively, it may be that HSDD is actually a result of poor communication and friendship but manifests as low or absent sex drive. Either way the emotional health of the relationship is in decline.

One of the defining features of a romantic relationship is that there is a sexual component, or there is supposed to be. One of the key concepts separating friendship from romantic partnership is the presence of sexual interactions. When this sexual piece is missing the relationship is thrown off balance. This imbalance leads to a host of negative emotions and confusion. However, there is a "chicken – egg" conundrum here, where it is unclear if emotional negativity brought on sexual indifference or vice versa (Althof, Leiblum, Chevret-Measson, et al, 2005). Regardless of which came first, they undoubtedly sustain one another.

Mantak Chia (1986) acknowledges that in order to have a good sexual relationship, people must be on the same physical, emotional, and spiritual level. He goes on to note that when problems about children, finances, life stress, etc. emerge, the sexual energy almost always declines. He writes: "during this period a man and woman seem far apart and alone." This concept of distance and loneliness is at the heart of the emotional problem.

Women desire sex more for emotional and intimate connectedness than for physical pleasure. Hite's (1976) findings suggest that "desire for sex with another person is usually based on feelings for another person and not on a purely mechanical need for

'release.'" Hite further propels this notion with her research findings, stating that "most women emphasized that the appetite for sex with another person became really intense only in relation to desire for a specific person." Therefore when the emotional component wanes the sexual feature does too.

Schiller (1977) discusses the idea of a marital dyad functioning in either a constructive or destructive system – the following are some of her ideas. An example of some of the factors present in a constructive system include: a caring loving relationship, affection, responsibility for ones sexual satisfaction, knowledge of the physiology of sexuality, confident in ones sexual identity and sex roles, open to experimentation and flexibility in a sexual system, etc. An example of some of the factors present in a destructive system include: fear of failure, power struggle, judgment, sex without love, sex without self responsibility, manipulation. When HSDD is present the system ends up in a destructive pattern. The free flowing intimacy and communication is absent and it becomes replaced with judgment, impatience, and poor perception of partner's self image.

Berman and Berman (2005) devote an entire chapter in one of their books to "Relationship Health: The Emotional Connection." They discuss the idea of personal connection to achieve sexual satisfaction and underscore the genuine importance of emotional connectedness and the subsequent problems that arise in its absence. McCarthy and McCarthy (2003) also pay a significant amount of attention to relational health and its importance to desire.

I am aiming to delineate how emotional intimacy affects sexuality, but how does sexuality affect emotional intimacy? Emotional intimacy means many things including

sharing aesthetics, spirituality, physical activity, non-sexual affection, social activity, intellectual ideas, friendship and the like. When the sexual piece of the relationship is threatened it often trickles down to the other forms of intimacy. When this happens, the couple starts to be deprived of the air that keeps the relationship breathing. There is a slow and steady withdrawal of each partner. This negative pattern will breed hostility and a constant sense of disconnectedness. Resentment, embarrassment, and rejection become the overarching feelings associated with the relationship. After a while women will often avoid any form of physical interaction for fear that it will be misread as a sexual signal – this effectively destroys the affectional intimacy component that is so important in a relationship. Hugs, hand-holding, cuddling, and kissing become extinct much to the detriment of the relationship and it is difficult to reclaim them. Often, after a certain amount of time has elapsed the communication will breakdown altogether and become hostile. The following pages will examine the communication failures that emerge as a result of HSDD.

Communication Breakdown

Hopefully by now the picture of HSDD and the couple is becoming clear: the longer the sexual issue goes unaddressed, the worse the problem becomes, and the harder it is to communicate about same. Sexuality in general is not a readily communicated subject. Historically, and culturally, women in particular have not been encouraged to vocalize their sexual desires, opinions, and thoughts as Chelser (1972) and Maines (1999) have pointed out. In my opinion, sex is often taken for granted in relationships or considered a "given," therefore warranting no discussion. This model may be

satisfactory when everything is functioning. However, when an inconsistency arises or a change in the pattern occurs people need to have the language to address it - sadly, most couples do not. What follows is usually a barrage of silence, snide remarks, impatience, irritability and bitterness. The communication simply shuts down – not just the communication about sex, but in many cases, communication about everything will deteriorate.

Women are not encouraged to communicate their sexual preferences and fantasies. In fact, most women rely on the man to set the sexual tone of the relationship. She will follow his "dance." Women rarely claim their own sexual desires for fear of hurting his feelings, lack of sexual knowledge, or because of embarrassment. Hite (1976) cautions women against this and offers a much more empowering sentiment: it is important to not "wait for the Right Man to be dependant on, but create your own good situation – which can include yourself as being the Princess Charming, who knows pleasurable things to do and who finds another person to do them with." It is pro-active statements like this that can offer women a way out of the generic societal role they have assumed.

If a woman is not getting what she wants in the bedroom and sex has become unsatisfying at a fundamental level and she doesn't know how to communicate this, she is bound to begin to avoid sexual interactions. Finding the words to say "I wish tonight you would touch my clitoris while licking my nipples" can be terribly intimidating. Even a more demure request such as "Can we start tonight with a gentle massage?" may be a challenge for some women. Further, some men may feel defensive by such a request or feel that their wife is acting uncharacteristically slutty and immoral. When you don't

have the means to communicate your needs, your desire for the "same old" may dissipate. This dissipation leads to avoidance and dissatisfaction, which eventually leads to a decrease in desire.

What further complicates the issue is that men and women, in general, communicate differently and for different reasons. Even when the relationship is functioning productively, men and women have a different set of communicative needs and motivations. Hite's (1987) research book, Women & Love, served to clearly illustrate this and offered the world and inside look into the different emotional and relational needs of men and women.

Research shows that women communicate because they need to feel understood, connected, and heard (Hite, 1987). Men will communicate because they are looking for a solution, they want humor, or they are sharing information. In the face of a relational fallout women will experiences feelings of hurt, sadness, or disappointment whereas men will experience anger (Cervenka, 2003, & Wood, Wood, & Boyd, 2008). Further, in this society males are reared to keep their feelings inside, not display too much sensitivity and not communicate their insecurities. The male expectation is that one should be strong, independent and capable. Women, on the other hand, are raised to be emotionally demonstrative, empathic, and verbal. They are expected to converse about their feelings, talk out their problems, and offer a sense of comfort and community. This dichotomous style of communication sets heterosexual relationships up for trouble (Hite, 1987), especially where sexuality and virility are in question, as this is both a sensitive and private topic for most individuals.

Since the male style of communication includes privacy and independence, approaching the issue of waning intimacy is simply inconsistent with what they know - especially when *their* desire is "just fine." Men do not communicate for a sense of community and therefore feel that if a woman doesn't have any sexual desire it is her problem to "fix." Because the male model of communication is solution-oriented, a discussion for feelings-sake just doesn't compute (Tannen, 1990). The male may then become aggravated or impatient by a woman's need to discuss and share her feelings about the issue. The woman will then experience this aggravation as a withdrawal from her partner and feel alone and misunderstood (Hite, 1987). These negative feelings directly maintain the hypoactive sexual desire. Remember, women enjoy sex for the sense of connection and intimacy (Cervenka, 2003 & Nijland, Davis, Laan, et al., 2006) so when those emotions don't precipitate the act, they further lose interest.

The communication piece often ends up in a vicious cycle of silence, resentment, anger, and withdrawal. As you will see in the following treatment section of this paper, communication training, among many other things, is always an integral part of the treatment of Hypoactive Sexual Desire Disorder.

CHAPTER 8

The Two "Ps" in Treatment: Psychological and Pharmacological

The previous pages aimed to illuminate the multi-faceted concept of hypoactive sexual desire in pre-menopausal females. It is evident that there is not one etiology of HSDD and so logically, there is not one direct treatment (Althof, Dean, Derogotis, et al., 2005). We have explored the human sexual response cycle, definitions and diagnostic criteria of HSDD, the complex female anatomy, the potential causes, and of course the intrapsychic and interpersonal toll HSDD takes on a woman. So now what?

After painting a picture of this disorder and identifying its contributing factors, what do you do? There is no one comprehensive treatment. And much to the dismay of the pharmaceutical-loving western world, there is no pill to pop which magically incites lust in a woman who has otherwise lost it. There is however a multitude of psychological treatment that has proven to be quite successful. There is also an array of pharmacotherapy on the horizon that may offer some respite as well. The following pages will examine sex therapy techniques, couples therapy models, and individual psychotherapy. This will be followed by a discussion on pharmacological treatments.

Couples Counseling and Sex Therapy:

Psychological treatment is one of the most preferred methods of working with people who have HSDD (Basson, Brotto, Laan, et al., 2005). Some of the most important issues to be addressed in couples counseling include, the sexual component via sex therapy and psycho-education, bibliotherapy, the communication element, and the overall relational structure.

Cognitive Behavior Therapy (CBT) has received a lot of attention in the treatment of HSDD because it helps combat and rework false or fear-based sexual cognitions. Women and couples are instructed to do a lot of homework that involves changes in literal behaviors. According to Basson et al (2005), "CBT has resulted in 75% of women significantly improving with 65% remaining improved at 1-year follow-up."

Sex therapy is a large piece of this cognitive-behavioral component and often addresses the disturbances and distractions that women grapple with while in a sexual moment. Safety, timing, and privacy are critical to the success of treatment. Basson, et al (2005) note that sensate focus, which is similar to systematic desensitization, often found in therapies that treat anxiety, is shown to have about a 50% success rate "following treatment." Women have specific fears that are gender-based that deal with making sex a 'no-go' area, and it is important to acknowledge this (Hite, 1976, Chesler, 1972 & Seaman, 1972).

Couple sex therapy, when conceptualizing HSDD, aims to "emphasize the one-two combination of personal responsibility, and being an intimate team" (McCarthy, 2002.) Sex Therapy begins with taking a history of both partners. The information gathered by the therapist helps them gain a sense of each ones' sexual IQ, experiences, values, childhood familiarity, masturbatory habits, communication, and overall comfort. This is followed by what McCarthy (2002) calls a Feedback Session, which has three main foci: 1) institute a new understanding of HSDD, and promote hope for change as a team; 2) delineate a treatment plan; and 3) assign the first set of interventions. Thus the process begins.

The sex therapy session takes place weekly with an average of three homework assignments in between meetings. Assignments may include reading, psycho-educational videotapes, and behavioral exercises. In the course of therapy, four overall themes are addressed: 1) educating the couple and shifting faulty cognitions; 2) reducing sexual and performance anxiety; 3) training the couple to communicate better; and 4) sexual modifications.

The cognitive concepts introduced in sex therapy are designed to help partners adjust maladaptive and incorrect beliefs regarding sex. As was discussed in the causal section of this paper, HSDD is caused and sustained, in large part, by anxious thought processes. These schemas are what lead to the external distress in couples – the self blame, the partner's feelings of rejections, the mutual inadequacy, etc. Therefore the therapist's aim is to correct the malignant cognitions. This part of the therapy also serves to psycho-educate. The therapist assumes a didactic role. He or she will disseminate information about sexual physiology and anatomy, effects of age and illness, and other facts related to fully understanding HSDD (McCarthy, 2002.)

The next component addressed in the sex therapy session is the behavioral one. Conjoint therapy has become what Bodie, Beeman, & Monga (2003) state as the unequivocally accepted technique. Behavioral concepts assert that positively reinforced actions will be repeated, and vice versa. Further, the presence or absence of these behaviors is guided by the anxiety we feel to initially perform them. Therefore, one of the principle behavioral goals of therapy is to minimize or eradicate sexual pressure and anxiety. Sensate focus, although limited in its approach for women, is the most widely

used behavioral sex therapy technique. The following section will outline this therapeutic practice.

Sensate focus is introduced to simultaneously eliminate the pressure and reinforce the sexual behavior. Sensate focus is an agenda of non-genital, non-demanding, pleasing actions between partners. Intercourse is avoided during the early phases of this technique, while relaxation and communication is promoted. The goals are to endorse physical closeness and bodily familiarity without the pressure of intercourse. By eliminating the outcome event, the woman has the opportunity to focus on the erotic stimulus exclusively. This promotes a reinforcement of the current behaviors, minus the self *and* partner imposed pressure to achieve desire and intercourse. Additionally it supports the "one-two combination of personal responsibility, and being an intimate team" idea which McCarthy (2002.) underscores as the core of conceptualizing treatment for HSDD.

Helen Singer Kaplan (1987) discusses the different phases of sensate focus as they apply to addressing "frigidity" in women. Frigidity was an earlier term meant to indicate a sexually unresponsive or disinterested woman. It is no longer in use however as it connotes negativity and blame. Hite (1976) correctly observed that pathologizing women's sexuality also connotes shame and blame. Dr. Hite was interested in reworking definitions to better accommodate the female psyche and has been successful at raising awareness in the sexological community about same. Classifications aside, sensate focus is broken down into four phases: sensate focus I - pleasuring, sensate focus II – genital pleasuring, non-demand coitus, coitus. Lets take a closer look at what each phase looks like.

Sensate Focus I – Pleasuring- The purpose of this phase is not to be sexual but to institute consciousness of touch sensations by noting curves, textures, temperatures, tempos etc., while being touched or doing the touching (Masters, Johnson, Kolodny, 1988). The couple is told to have two sessions where they have intimate and deliberate touching that does not include breasts or genitals. By placing the genitals and breasts off-limits the sexual connotation and pressure is immediately eliminated; there is no expectation to please or be pleased in a sexual sense. "Failure is practically impossible under these circumstances."

The couple is instructed to take turns first laying face down and having their backs, head, feet, inner thighs, legs, arms, ears, etc. stroked, tickled, and caressed. They may then turn over and do the same sort of touching to the front side of the body, all the while avoiding genitals and breasts. They are instructed to pay attention to what tactile sensations were particularly pleasing and which ones were uncomfortable. While dialogue is discouraged during this exercise, they should be able to communicate if something is particularly awkward or unpleasant.

They will then attend session and have a debriefing on their experience. This conversation should be thorough and authentic, which simultaneously increases communication and both self and partner awareness. They should also discuss any dreams or fantasies that may have arisen during the course of the exercise. For a woman with HSDD, this may be a powerful discussion affording her insight into some sexual stimuli. Further, because she is not obliged to go through with intercourse, oral sex, or digital penetration, she is freed up to relax into the situation without regard for her low desire.

Sensate Focus II – Genital Pleasuring- After successful completion of sensate focus I, the couple may move on to sensate focus II. Sensate Focus II is very similar to phase I in its turn-taking and emphasis on tactile sensation, but it incorporates the genitals and breasts. Coupes are still instructed to refrain from orgasm, as this is not the goal of the exercise – they are aiming for a state of arousal not climax. They are also encouraged to postpone their desire to head straight for the genitals and breasts. Rather, they should caress the body and slowly begin to touch the more sexually charged areas. The touching should take a teasing-like tempo, not a determined and focused one. Touches should alternate from thigh to breast to vulva to ear and so forth. There should be an easy exchange of strokes between all of the body parts and it should have a playful undertone. Masters and Johnson discussed what they considered an ideal position for female clitoral stimulation during sensate focus. It involves the woman sitting with her back to a man's chest/stomach and in between his legs, such that he may reach around and stroke her clitoral structure without making immediate eye contact. While this is good for completion of the exercise, the findings of The Hite Report (1976) remind us that no one position is ideal for all women.

Masters and Johnson also said that at this stage "hand-riding" would be a helpful and appropriate form of non-verbal communication. It involves places your hand over your partner's hand as he/she caresses you. When something feels particularly satisfying you may apply extra pressure to signify pleasure. Alternatively you can guide their hands to more exact points of arousal and you can help them find the right tempo for their strokes. This is both enlightening and non-threatening. Enlightening because it is

educational for each party but non-threatening because the absence of dialogue removes pressure, perceived bossiness or criticism, and self-consciousness.

The next portion of this phase includes mutual touching. This has a two-fold purpose. Firstly, real life sexual interactions do not often include "turn-taking," and secondly it increases the sensual contributions of the interaction. Masters and Johnson note that this is a helpful step for women that are plagued by the spectatoring phenomenon. At this juncture, they should be encouraged to focus on their partner's body parts and response instead of monitoring their own.

Again, couples are brought into session and asked to share their feelings about this experience. A positive response will usually include a woman reporting that she is rediscovering her sex centers. Common responses include: "I got wet." "I was really into it." "I found myself fantasizing and wanting more." A negative response may include feelings of anxiousness, pressure, or self-consciousness about odors, lubrications, or appearance (Kaplan, 1987). Treatment should then include a forthright discussion about said issues, which will improve communication and understanding in the long run. It is critical to treatment that a non-hostile and trusting environment is created. Any signs of tension, criticism, or blame will ignite the anxiety that is so central in women with HSDD. If a couple is able to successfully move through this phase they will proceed to non-demand coitus.

It should be noted that as the weeks pass and a couple moves through these exercises, they are experiencing sexually intimate successes – something that has been absent for some time. Specifically, by "prescribing" homework that is fail proof, women (and the couple they are a part of) begin to rebuild their sexual self-esteem. As was

discussed earlier, one doesn't want to do what one is not good at. Therefore if a woman can start to feel competent about these tasks, she will experience a reduction in anxiety and pressure, thus leading to an increased desire to respond to or initiate sexual interactions – she will stop resisting, consciously or subconsciously, sexual stimuli.

Non-demand Coitus – The next step in sensate focus involves prescribing the woman some control over the sexual situation. Women with HSDD usually assume passive and helpless roles during sex, because they just are disinterested and it becomes obligatory. The first two stages of sensate focus aim to eliminate some of those faulty schemas, but the next step aims to give the woman a newfound lead in the sexual dance. The couple is told to embrace one another with gentle erotic strokes until the man has an adequate erection and the woman is slightly lubricated. The couple is then instructed to have the woman mount the man in what is called "female superior-non thrusting." She will gently insert his penis into her vagina and sit with it inside of her. Of note, the Hite Report (1976) uncovered that this is a very pleasant position for women, offering them more control and ability to adjust their movements. The woman may then engage in Kegel exercises with his penis inserted so that they can both enjoy the sensation of penetration without motion. This pubococcygeal contraction also serves to heighten her awareness of vaginal sensation, without the pressure of thrusting motions that are so common in western penetration sexual scenarios. She will then lift up on his penis and sit to the side of it, and go back to playful stroking, and then mount him again just placing the tip of his penis into her and, in teasing tempo, begin to experiment with different speeds, angles, and pressure. The partner is simply lending his penis to the woman. The goal is not to have an orgasm, but if the female does reach climax, this is not seen as a

therapeutic violation. The male on the other hand, is discouraged from using this exercise as a means to ejaculate.

This is a team effort of sorts and thus bolsters a sense of unification and joint-problem solving. In-therapy discussions always follow the behavioral homework and pleasures, fears, blockages, and enlightenment must always be addressed. This is a time for the couple to regroup and connect cognitively in a non-threatening milieu. This is the one-two approach of couples therapy discussed earlier: the behavioral-cognitive blend of treatment.

Coitus to Orgasm – When and if the aforementioned exercises lead to comfort, open-dialogue and a heightened sexual awareness for the woman, the couple is instructed to attempt coitus to orgasm. At this point in therapy it is hoped that communication has been improved, the behavioral component has been re-worked and the couple's sexual understanding has reached a more mutual place. Further, expectations of a vaginal orgasm exclusively will have dissipated and "a more "direct" gentle clitoral massage" (Hite as cited in Larson, 2008) will be incorporated into the routine to produce orgasm. Hite (1976) cautions though, that if undue expectation is put on reaching orgasm through coitus, there could be negative results. Thus, intercourse is hopefully not as daunting and overwhelming for the woman with HSDD – but rather a more flexible and approachable activity. At this point one would most likely expect to see the principle symptoms of HSDD diminish.

The previous pages outlined one of the most widely used sex therapy techniques ever introduced. We looked at how it may be applied to the woman with HSDD. Because

sexuality is multidimensional, it is prudent that treatment address communication between the couple as well.

Communication

As aforementioned, communication is one of the principle things to break down in the relationship when HSDD is present. Therefore, communication training is another key component found in couples counseling and sex therapy. While sensate focus inadvertently aims to improve a couple's sexual communication, outright training is helpful also (Barbach, 1997). Creating a safe environment and providing the script for couples to better express themselves is important. As with the cognitive exercises, communication training enables the couple to replace faulty assumptions with accurate facts (Bodie, Beeman, & Monga, 2003). It also gives them a new framework from which they may operate in the future.

Many people think communication is about talking, and listening is about being quiet. However, non-verbal communication is a powerful tool also. And active listening is a very effective strategy that involves much more than just being silent.

Non-verbal communication, also known as body language and facial expressions, is almost always as important as the words that are spoken. In fact, research on lying shows that people attend more closely to a person's body language when trying to ascertain the truth, than to what is actually coming out of there mouth. We speak volumes in our motions. When the sex is compromised, couples often withdraw from other physical interactions and their body language begins to convey an "off-limits" message. Sometimes, the woman will "take one for the home team" and try and engage

in intercourse to placate her partner – but almost always her body is rigid and tense and her non-verbal message is "hurry up, finish, and get off of me." A partner is aware of this physical tension, even if they choose not to acknowledge it.

Alternatively, nonverbal communication is a wonderful tool to express pleasure and to redirect a sexual interaction. People who present in couples therapy are having a communication break down on several levels. Many women feel uncomfortable directly requesting something sexual (Hite, 1976, 1987). However, a moan at the right moment, or pressure on a hand when it is in the "right" spot can indicate massive amounts of helpful information. Also, a touch on the face, or a stroke of the head, can indicate messages of sweetness, tenderness, and connectedness without explicit statements which for some can be awkward or laborious.

Part of communication training in couples therapy serves to make the participants aware of the non-verbal cues they send to one another. Because body language is less conscious and contrived than our verbal messages, women are often unaware of the impact and breadth of their nonverbal dialogue both for better and worse. Helping couples maximize the positive use of nonverbal communication and minimize the detrimental use is an integral part of the communication training.

"I" messages are a communication tool that is used throughout couples therapy, assertiveness training, and negotiation/persuasion training. This is simply the practice of starting messages with the word "I" instead of "You." When the relationship is threatened by sexual instability, resentment often rears its head. This almost always leads to blaming and arguing. By speaking from the "I" standpoint, one takes the blame out of the message they are trying to convey. Consider the following two examples:

"You really irritate me when you just undress and pull my pants off and go right for intercourse. You think that makes me want to have sex with you?"

"I would love it if we could engage in a little more foreplay. I feel a little rushed sometimes and would love to try slowing it down a bit."

These are the exact same messages, but with entirely different tones.

Jack Annon, used the acronym PLISSIT to describe a model that he proposed to help information exchange between people. Whereby P= permission, LI = limited information, SS = specific suggestions, and IT = intensive therapy. This highlights that simple reassurance, education, and anxiety reduction are often sufficient enough to adequately diminish the sexual roadblock.

There are new communication-training techniques emerging constantly. The point that I want to underscore is that regardless of which one you employ to address the HSDD, it is pertinent that at least one is utilized. A couple without a dialogue for their problems falls into a downward spiral of silence, faulty assumptions and sexual failures (Barbach, 2007). In addition to increasing the communication between the couple, a therapist must also broaden the couple's definitions of sexual experiences. The following section will explore alternative or broadened meanings of sex.

Alternative Scripts

It is helpful to give the couple some sexual script modifications. It has been recorded that sexual dysfunction is most sexually debilitating when the affected pair have "limited repertoires" (Feldman, Goldstein, Hatzichristou, et al., 1994.) In the same vain that we consider people with a large support network to be better equipped for crisis, or folks with more money to have greater access to industry, we should regard couples with

more sexual scripts to be better resilient to a sexual dysfunction. Part of therapy aims to help the couple acquire more scripts, which in turn provides them with more coping mechanisms and outlets to overcome HSDD (McCarthy & McCarthy, 2003). For instance, a lot of couples have negligible amounts of foreplay or non-intercourse stimulation. They head straight for the intercourse, which is unsuccessful. Because they don't have more scripts they will end up repeating the failing sexual routine. Facilitating alternate practices allows the couple to explore other solutions to sexual road blocks.

Examples of alternate routines may include audiovisual material which will help them model new sexual behaviors and fuel arousal (Bodie, Beeman, & Monga, 2003.) Also sexual paraphernalia such as feathers, hand cuffs, masks, vibrators, food, etc. may open a world of erotica for the couple (Zopol, 2002). For some couples role play might be useful. The function of the clinician is to encourage the couple to try new things and discover alternative ways to connect, stimulate, and satisfy one another. In doing this, a new dimension of pleasure is added to their sex and the pressure for typical intercourse is eradicated.

Counseling and sex therapy are often very successful in helping women and partners overcome or better manage HSDD. However, it is sometimes useful for a woman to seek individual care, especially if she is dealing with past abuse, self-loathing, or a genuine unwillingness to address sexual issues in the presence of her partner.

Individual Psychotherapy

Hypoactive Sexual Desire Disorder certainly affects the couple and needs to ultimately be addressed with couples counseling and sex therapy. However, there is a very personal component to HSDD. For some women experiencing HSDD, individual

counseling is a necessary adjunct to couples counseling and sex therapy. As was discussed in the 'Causes" and "Psychological Interference" section of this paper, there are some individual issues that a women may be dealing with which contribute to HSDD. These may best be addressed in individual therapy. Some examples include: sexual messages from childhood, sexual abuse, body image and spectatoring, self-esteem and self-worth, and lack of self or sexual knowledge that they are too embarrassed to address with their partner in the room.

Sexual desire is not necessarily inherent in everyone. Different people are raised with different sexual messages (Hite, 1976). Some people are brought up thinking sex is natural and healthy. Others are brought up thinking sex should be associated with shame and guilt. The internal messages you hold about sex will affect your long-term sexuality. Working with an individual therapist to uncover how your sexual messages may be sustaining your HSDD is powerful.

Additionally, when a woman has problems with desire as a result of sexual abuse or assault, she will be suffering from a host of plaguing issues – many of which do not pertain to the romantic dyad. Therefore individual counseling to address potential post traumatic stress disorder and flashbacks, vaginismus, and invasive thoughts is a must. These are psychological roadblocks that will interfere with desire, but that are not necessarily appropriate for a couples setting.

Body image is one of the largest predictors of sexual desire, whereby women with a poor body image do not show interest in sex. Further, when engaged in a sexual act, they attend more to what they think they look like, than to sexual cues. This cognitive mind-trick is an issue to be explored in individual treatment. If a woman is already

feeling self-conscious, having a discussion in front of her partner about her self-consciousness will be counter-productive on all accounts.

Feelings of self-esteem and self-worth are also a personal issue. Individual cognitive-behavioral therapy that involves thought-stopping, journaling, and thought-challenging are all practical and helpful tools to assist in bolstering esteem. Improving esteem will also be a peripheral point of interest in couples therapy, but the bulk of the work needs to be done by the individual sessions.

Then there is the general embarrassment that most women feel by their lack of knowledge or simply discussing sexual issues, particularly if they were raised with negative sexual messages or in a Madonna/Whore milieu. Individual treatment provides a safe and non-threatening environment for people to ask personal questions and work through insecurities. Further, they are able to focus on individual issues that they feel may be contributing to HSDD, such as high stress, parenting, and job factors that are not directly part of the romantic dyad.

A helpful technique to help women overcome the thought-fog around HSDD is Rational-Emotional Therapy (RET). This was a treatment style developed by Dr. Albert Ellis. This model aims to help people transcend irrational beliefs and unrealistic expectations that sustain the sexual problem. The RET goal for a woman with HSDD would be to help her see that while there is uneasiness and objectionable feelings associated with sexual situations, this does not make her a bad person, less of a woman, or incurable. This is a wonderful technique for breaking the self-defeating cycle of self blame that a woman with HSDD so often engages in.

After the woman has successfully addressed the self-esteem piece and other pending issues such as abuse, then individual treatment must focus on helping her access her sexual self. Treatment should take on a coach-like role of encouraging her to explore sexual images, messages, fantasies, and establish a functional sexual identity.

LoPiccolo recommended that a therapist make suggestions for the patient to keep a desire checklist for recognizing circumstances that may ignite desire, taking "fantasy-breaks" to go over sexual scripts, increasing contact with erotica such as books, videos, and magazines (Leiblum & Rosen, 1989).He is not the only researchers who has acknowledged the importance surrounding yourself with more erotically themed items if you are to increase your desire. After all, if you want to learn a new language, you buy some books, maybe eat the food of the country for fun, and you start practicing. Increasing sexuality is in fact learning a new language – the language of desire.

Another alternative feature that may be introduced in individual treatment is the practice of Eastern sexual strategies. If patients are open to exploring ovarian strength training and Taoist sexual principles, this can be a helpful adjunct towards the end of their treatment. Chia & Chia (1986) have outlined an entire program that addresses harvesting sexual energy within the female. While this deviates from conventional therapy, it is worthwhile to recommend if the woman appears open to same.

Additionally, Dr. Lonnie Barbach (1997) developed a sexual enrichment program that is quite comprehensive. It is a 12 week program that consists of exercises aimed at helping a woman discover or rediscover her sexual passion and desire. It includes behavioral components, cognitive features, and a communication training section. While it is aimed at ultimately helping the couple, this can best be employed in an individual

setting for the woman who has very poor self-knowledge and or confidence. This is designed to give her a language and a framework in which she may begin to address her sexuality.

Bibliotherapy as a general recommendation in individual treatment is wonderful. There is no one formula for creating a satisfying sex life and increasing female desire. When it comes to sex, each person is uniquely different and as competent as a therapist is, they can not *give* the answer to the patient. However, there are so many wonderful and creative books out there that offer a host of suggestions and sexual food-for-thought. When a woman is simultaneously trying to work through personal issues and develop her desire, it can be overwhelming. Suggesting a light and creative book may be just the personal homework they need. Books like this give women the permission they need to uncover their sexual self and also gives them new ideas.

Individual therapy is not necessary for every woman with HSDD. However, it can be very helpful depending on the precipitating factors or the ancillary cognitions contributing to the maintenance of the dysfunction. There are a multitude of individual techniques that can be employed from the conventional, to the alternative, to the very adventuresome, as were delineated in the preceding pages. The important thing is that treatment is tailored to the individual needs of the woman. A good therapist will be able to adjust the recommendations, pace, and tone of sessions depending on the level of insight and adjustment a woman wants.

Therapy, both joint and individual is a necessary and powerful tool to address hypoactive sexual desire. However, as technology and medicine move forward so too

does the pharmaceutical industry. The following pages will address pharmacotherapy for Hypoactive Sexual Desire Disorder.

Pharmacotherapy and HSDD

The field of male sexual dysfunction, focused on the penis, has enjoyed a massive amount of pharmacotherapy research and treatment over the past several decades. The word Viagra seems as common in our society as aspirin and some insurance plans will even cover a man's prescription for same. Unfortunately, the field of medicine and female sexual function is lagging behind – by decades. In a meta-review of pharmaceutical research for female sexual dysfunction, Nijland, Davis, Laan et al (2006) were able to find a meager 25 published studies that over the course of 25 years. This is slowly beginning to shift though and the start of the twenty-first century has brought an increased amount of funding and research towards the field (Shames, Monroe, Davis, et al. 2006). In a country that adores anything it can swallow in a pill, this is well-received news. However, the road is still long and winding and inconclusive. The following pages will examine current trends pharmaceutical treatments for Hypoactive Sexual Desire Disorder.

Hormones, and their role in female sexual function, are at the heart of the pharmacological research being conducted presently. Not female hormones, though – male hormones. Estrogen and Progesterone are the primary female hormones and Testosterone and Androgen are the primary male hormones, however each gender has all four in their system (Kelly, 2006). It is the levels of each one that vary by gender.

Studies are revealing that interference with androgen, testosterone (Anger, Brown, & Amundsen, 2007) and estrogen production may lead to sexual dysfunction (Berman & Berman, 2001) including HSDD (Basson, Brotto, Laan, et al 2005).

Research is showing contrasting empirical evidence on this however. It seems studies are unable to pin down concrete correlative data to support testosterone levels and desire in pre-menopausal women (Anger, Brown, & Amundsen, 2007). Therefore it seems pre-mature to urge doctors to use this treatment and more prudent to caution them against it.

To further complicate the situation, most of the research examining hormone production and its role in female sexual function is looking at post-menopausal women who are experiencing a marked hormonal shift. Research that does not address a post-menopausal is not vast, and population seems to then center on women who have had an oophorectomy (removal of an ovary) or a like procedure that markedly interferes with hormone production.

In fact early guidelines for clinical trials of medicine to treat female sexual dysfunction mandated that the women meet one of the following four criteria: naturally menopausal, surgically menopausal, women on menopausal symptom therapy, or women on hormonal contraception (Shames, Monroe, Davis, et al., 2006). The Division of Reproduction and Urologic Products actually required a marked hormonal imbalance in order to do clinical research. It should be noted that one of the main reasons for this was because there is no one set of guidelines for female sexual dysfunction and therefore they needed some sort of uniformity within the trial populations. Further, the FDA required that women included in clinical trials must meet criteria for sexually related personal-

distress, although there is no uniform questionnaire to determine same (Nijland, Davis, Laan, et al., 2006). This paper is concerned with seemingly healthy pre-menopausal women, a population which is significantly understudied.

Many of the following conclusions are based on populations that have had their hormonal balance altered for a specific medical reason. That does not mean, however, that the findings may not transfer to a more general population. It certainly merits a discussion examining the possibilities.

Simon et al. (2005) conducted a study on women who suffered from HSDD. The population consisted of over 500 women who were surgically induced into menopause. They then gave a half of the group twice-weekly testosterone via a transdermal patch. As compared with the placebo group, the testosterone group showed a marked increase in "satisfying sexual activity." Simone et al., (2005) went on to conclude that "the testosterone patch is efficacious for the treatment of women with HSDD." Even though this group had a specific predisposed variable (surgical menopause) the findings suggest expanding studies to examine this as a form of treatment in women who show no biomedical predisposition to hormone imbalance but are clearly suffering from HSDD.

A study that was presented at the 14th Annual Meeting of the North American Menopause Society, and sponsored by Proctor and Gamble in 2003, had evidenced similar findings: testosterone patches administered twice a week transdermally provided a marked increase in sexual satisfaction in women.

Other approved methods of testosterone administration for HSDD include oral estrogen/androgen therapy, which is available in two different doses. There is a testosterone cream that has shown positive results in small population studies and a new

testosterone gel that has also had positive results in small scale trials. In Australia and the United Kingdom testosterone is often "administered in the form of a crysatalline subcutaneous implant" (Papalia & Burger, 2006).

Sildenafil (a form of Viagra) has not yet been approved for women, but according to Berman & Berman (2005) it is undergoing advanced clinical trials for women. Sildenafil and Tadalfil (Cialis) advance blood flow and smooth muscle relaxation. Women who do not have a hormone imbalance but DO have low libido may be good contenders for this form of treatment. However, since increased blood flow to the genitalia is not the key ingredient to female sexuality this is not going to be a comprehensive solution. Research conducted by Pfizer, the makers of Viagra, found that women who had previously been on Selective Seratonin Reuptake Inhibitors (SSRIs) used to treat depression and had since lost their libido had a positive response to Viagra as a means of increasing desire and satisfaction.

L-argenine is an amino acid often used by athletes to promote blood flow to muscles. This same amino acid, found in an over-the-coutner cream, is shown to increase blood flow directly to the smooth muscles in female genitals igniting sexual arousal. The studies are still informal and inconclusive. However, the unofficial research is indicating some promising results. However, it should be noted, that most women's sexual difficulties are more psychological tan biological and there is no 'magic bullet.

Arginmax is a dietary over-the-counter supplement purporting to have very positive effects on female libido, although it is always important to ask which pharmaceutical companies may have sponsored this research. This supplement is

comprised of L-arginine, ginko biloboa, and damiana. Arginmax is starting to appear in the clinical literature as having a positive effect on female desire and sexual response, specifically two small-scale studies were conducted in 2001 and 2006 and result showed a marked improvement in female sexual functioning (Polan, M.L. & Trant, 2001 & Ito, P., Polan, M.L., Whipple, B. et al., 2006)

The above findings are promising, but there is still a lot of research that needs to take place in order to assess the safety and long term side-effects of both hormone therapy and Sildenafil/Tadalfil, and supplements such as L-argenine. This is a field of treatment in its infancy. Therefore continued research is needed.

The previous pages aimed to highlight the current modes of treatment for HSDD. Again, due to the multidimensional aspect of female sexuality, treatment remains layered and somewhat inconclusive.

A combination of couples therapy and sex therapy seems to be one of the most effective modes of treatment. Individual therapy, when appropriate can have successful outcomes as well.

The field of pharmacotherapy and HSDD leaves a lot to be desired. Little is known about healthy pre-menopausal women experiencing low or no desire and the consequent pharmaceutical options. This is clearly a field that is gaining momentum and in the coming years is sure to receive more attention.

Future research should focus on the effects of hormone therapy on a normal pre-menopausal population of women experiencing hypoactive sexual desire disorder. Papalia & Burger (2006) note that there are some such studies in progress, but we are at the very beginning of examining this particular population. Further, longitudinal studies

on effects of testosterone treatments need to be conducted (Shames, Monroe, & Soule, 2007).

From a psychological standpoint, it would behoove professionals to have one uniformly agreed upon assessment to measure HSDD. This is also a needed addition to the screening process of clinical trials for medications, especially since there is no internationally approved screening instrument for HSDD (Althof, Dean, Derogotis, et al., 2005, Graziottin, 2007 & Heiman, Guess, Connell, et al., 2004).

CHAPTER 9

Conclusion

Hypoactive Sexual Desire Disorder is the most commonly reported sexual dysfunction among females. The examination of female sexuality is in its infancy and therefore much of the research and models are male-based. This is slowly shifting however, and this paper presented some of the more female-centric models being proposed. The beginning section of this paper introduced a through discussion on the most prominent models of both past and present. This was done in an effort to afford the reader the larger picture of the female sexual response from "start to finish."

In light of the fact that HSDD is just starting to be studied with vigor, it is no surprise that definitions and diagnoses remain slightly muddied. A large section of this paper was devoted to clarifying the different definitive criteria of Hypoactive Sexual Desire Disorder. Hopefully, there will be a more concrete universal definition to surface in the near future.

The definitions are flimsy and identify no one true etiology. What the research revealed was that while male sexuality seems to be more straightforward and linear, women's sexuality seems more rounded and multidimensional. There is no one start-stop point for women. This makes distinguishing a cause rather complicated. It is prudent to examine the women in her entire socio-cultural context when trying to help her examine the root of her HSDD. These items included relational satisfaction, self image, self knowledge, body image, anxiety, and sexual abuse.

The research presented herein revealed that HSDD takes a toll on more than just a woman's sex life. The intrapsychic impact is profound and often leaves a women feeling

ashamed, inadequate, embarrassed and frustrated. These emotions frequently lead to a self-defeating cycle of failure and avoidance.

When the woman begins to avoid and retreat from sex it effects the romantic dyad in which she is a part. The emotional stability of the relationship is tested and the communication often collapses entirely. This paper aims to illustrate what a relationship "looks" like in the face of HSDD and how to best overcome it.

Since identifying one primary cause is often impossible, treatment is almost always multimodal. It is usually necessary to seek couples counseling and sex therapy and, when appropriate, individual therapy as an ancillary treatment. Therapy must employ a wide range of techniques to properly address all issues and simultaneously strengthen the relationship and offer safety and sexual knowledge to the woman. Pharmacotherapy is on the forefront of research, but it has revealed little conclusive evidence thus far.

Future directions for treatment and research need to start with a more standardized approach to assessments, definition, and diagnosis. Further, they need to examine populations other than post-menopausal women. At that point professionals will be better able to tailor treatment options.

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Appendix A

All Orgasms are NOT Created Equal

Are you still in search of the all elusive earth-shattering orgasm? We read about them, women in movies and on T.V. are having them – so why isn't the average woman relishing in this sexual spot-light? The answer is: All orgasms are NOT created equal.

With men, we rely on the process of ejaculation to let us know the orgasm has arrived. Women however, do not have such a definitive indicator. This leads us to the question: What defines an orgasm for women and if we don't have our version of ejaculation and mind-blowing convulsions, then are we climaxing?

First lets talk briefly about what makes up the female orgasm - it is a rhythmic and involuntary contraction of the vaginal muscles often accompanied by an increase in lubrication of the inner vaginal walls; the entire body may convulse in muscular spasms. It is the peak of sexual excitement and usually marked by feelings of extreme pleasure. Immediately after an orgasm, a woman's genital area is extremely sensitive to the touch. This is known as the resolution phase – it almost hurts if someone continues to play with us in these post orgasmic moments.

There are two pathways to the female orgasm: the clitoral or vaginal (or a combo). The majority of women fall into the clitoral category; to experience an orgasm, pressure and movement must be applied to the clitoris. A handful of women will be able to achieve orgasm thru vaginal penetration alone, and for many of us it will be a combination of both, also called a blended orgasm.

However, regardless of your orgasmic pathway, the intensity, duration, and enjoyment of **each** orgasm will vary. In fact for some of us, the orgasmic experience will never be more than a mere wobble of the body, while for others it may be a convulsive and tremendous moment.

Believe it or not, some women don't even know that they have had an orgasm – because their orgasmic expectations were so different from the reality.

There is no formula to ensure orgasmic consistency. There is only practice and paying attention to your body and your climax-cues (see box below for list of cues).

Also try some of the following applications to bolster the chances of having or recognizing a climax:

- Minimize outside distractions that may cause you to lose focus – for more on this see the blindfold exercise
- Masturbating while alone is a great way to explore your paths to orgasm without the diversion and responsibility of a partner
- Do your daily Kegel exercises

Climax-Cues
-Rise in body temperature
-Increased heart rate
-A warm tingling sensation in genital area
-Pressure in genital region
-A feeling that muscles are about to spasm
-A build-up and pinnacle of overall pleasure

If you are trying to become more aware of your orgasmic patterns, start keeping a log for yourself. Do this for one month and see if you are able to discover positions, times of day, routes of stimulation, etc. that help contribute to your orgasmic success.

WEEK 1

Amount of orgasms from masturbating by yourself this week____
Clitoral Vaginal Blended

Did you use a vibrator?
YES NO

Amount of orgasms from your partner masturbating for you this week____
Clitoral Vaginal Blended

Amount of orgasms from intercourse this week_____

Did you attempt to have intercourse while either you or your partner simultaneously stimulate your clitoris?
YES NO
**if not, this may be something to try in week two.*

What was the time of day that you were able to most easily orgasm?

Morning Noon Late Afternoon Night Didn't Matter

What were your thoughts/fantasies that allowed you to reach arousal and climax most easily?

_____
_____
_____
_____

Other things you noticed during this week of paying extra attention to your orgasms

_____
_____
_____
_____
_____

Week 2

Amount of orgasms from masturbating by yourself this week____
Clitoral Vaginal Blended

Did you use a vibrator?
YES NO
**If you are not using a vibrator, this may be something to try in week 3*

Amount of orgasms from your partner masturbating for you this week____
Clitoral Vaginal Blended

Amount of orgasms from intercourse this week_____

Did you attempt to have intercourse and have either you or your partner simultaneously stimulate your clitoris?
YES NO

Did this extra stimulation help?
YES NO

If not, why? What didn't work for you?

_____

What was the time of day that you were able to most easily orgasm?

Morning Noon Late Afternoon Night Didn't Matter

What were your thoughts/fantasies that allowed you to reach arousal and climax most easily?

_____
_____
_____
_____

Other things you noticed during this week of paying extra attention to your orgasms

_____
_____
_____
_____
_____

What are your personal goals for Week 3?

_____
_____
_____
_____
_____

Week 3

Amount of orgasms from masturbating by yourself this week____

Clitoral Vaginal Blended

Did you use a vibrator?

YES NO

Did you find it easier to climax with the help of a vibrator?

YES NO

If you haven't used one yet, what is stopping you? Where are you stuck?

_____
_____
_____

Amount of orgasms from your partner masturbating for you this week____

Clitoral Vaginal Blended

Amount of orgasms from intercourse this week_____

Did you attempt to have intercourse and have either you or your partner simultaneously stimulate your clitoris?

YES NO

Are you communicating to your partner the physical, verbal, emotional cues that stimulate you?

YES NO

This is an important feature in Week 3. Gently guide their hand to where you like to be touched. Give a soft moan to let them know they are in the right spot. Praise them with words like "yes" or "that's good." OPEN THE LINES OF ORGASMIC COMMMUNICATION!

What was the time of day that you were able to most easily orgasm?

Morning Noon Late Afternoon Night Didn't Matter

What were your thoughts/fantasies that allowed you to reach arousal and climax most easily this week? Are you noticing your fantasies changing or evolving?

Other things you noticed during this week of paying extra attention to your orgasms

How did it feel to take a deliberate step to communicate your needs to your partner? Was it helpful? What emotions did you experience – fear, embarrassment, pride, relief, satisfaction…..?

Which if any of the personal goals that you set for yourself at the beginning of this week were you able to meet? Which ones, if any, were not met and why?

Add to your personal goal list for Week 4. What else do you want to accomplish?

_____

_____

Week 4

Amount of orgasms from masturbating by yourself this week____

Clitoral Vaginal Blended

Amount of orgasms from your partner masturbating for you this week____

Clitoral Vaginal Blended

Amount of orgasms from intercourse this week_____

Did you attempt to have intercourse and have either you or your partner simultaneously stimulate your clitoris?

YES NO

Are you communicating to your partner the physical, verbal, emotional cues that stimulate you?

YES NO

This is an important feature for life. Good sexual communication equals good sex. Gently guide their hand to where you like to be touched. Give a soft moan to let them know they are in the right spot. Praise them with words like "yes" or "that's good." OPEN THE LINES OF ORGASMIC COMMMUNICATION!

What was the time of day that you were able to most easily orgasm?

Morning Noon Late Afternoon Night Didn't Matter

What were your thoughts/fantasies that allowed you to reach arousal and climax most easily this week? Are you noticing your fantasies changing or evolving? Are there any patterns?

_____

_____

_____

_____

Have you notices patterns about time of day, type of stimulation, fantasies, etc. What are they? These patterns are important because they are the key to your Inner Isis. Our patterns reveal our orgasmic path. Note your patterns in this section

_____

_____

Have you and your partner begun to communicate more openly and effectively about what your orgasmic needs are?

What surprised you most about yourself this past month?

What surprised you most about your partner this past month?

APPENDIX B

Discover and Uncover Your Inner Isis – NOW!

Objective: To identify what you would like to do and have done to you in an intimate way.

When I am talking with women who are having desire issues I always ask for their wish list.
"What would make you happy?"
"What turns you on?"
"What do you want done to you? When? How? Where? With Whom?

I am always shocked at the genuine unknowing that many women experience. A lot of us simply don't what we like because we were either never given permission to discover our pleasures, we were following someone's lead, or we were scared.

Isis was the goddess of love, sex, and fertility. Discovering your Inner Isis is about finding the answers to the above questions and more.

Step 1:
Take a mirror and look at yourself. It is imperative to know your anatomy if you want to know how to navigate same.

Step 2:
Masturbate, Masturbate, Masturbate!!!! If we don't know how to please ourselves and what we like to think about then no one else can. There is no other way to uncover these lovely truths than to start rubbing, touching, tickling, caressing, inserting, et cetera.

Step 3:
Pay close attention to what you are fantasizing about while touching yourself. This is the key to your Inner Isis. Where do you go in your head to find your fantasy?

Step 4:
Write down some of the things you liked. See the attached sheet, to help you with this.

Step 5:
Practice telling your partner. You will be surprised at how non-threatened most people are to have a little guidance and direction.

Step 6:
Continue to masturbate. Maybe even introduce a piece of a fantasy to your partner.

Step 7:
Pay attention to what cues in your daily life trigger a sexual or intimate thought. Pay attention to what fabric or surface may feel extra nice on your skin.
Stay aware of feeling that little sense of sexiness – be it a brunch or in bed. There are many opportunities in the day to acknowledge to ourselves we are sexual. Perhaps the mimosa on your tongue tickled in just the right way. Or the silk handkerchief felt extra soft as you tucked it in your purse. These little revelations don't make you dirty or too preoccupied with sex. They are the little clues to what you like in intimate moments.

So carry on with your day and feel this new sense of awareness - a sense of determination to allow yourself to notice your own arousal patterns. ENJOY!

Discovering and Uncovering Your Inner Isis - Log

What was your sexy trigger or sensual cue?	What you fantasized about… Or what action did you take?	How it made you feel + / -
Monday		
Tuesday		
Wednesday		
Thursday		
Friday		
Saturday		
Sunday		

APPENDIX C

Putting on a Blindfold May Help you Take your Blinders Off

Since many women tend to have a hard time focusing on the sexual moment, either because they are too self-conscious or too overwhelmed with outside thoughts, the following is an exercise in detaching from the world and getting in the sexual NOW. The exercise is simple – you blindfold yourself Now some of you may think: "Oh this is not for me, I am not into that kinky stuff, thanks anyway." But before you turn a blind eye to a blindfold, allow me to elaborate….

Applying a blindfold is sort of like a sensory deprivation that may better allow you to go inside and mentally arrive at the "place" you need to be to get to where you are going, if you know what I mean.

Our lives (and sometimes our bedrooms) are so cluttered that it is difficult to fully disconnect from everything and simply focus. This inability to be 100% present robs us of the full enjoyment that we could be experiencing.

Applying a blindfold not only adds spice because it is new and exciting, but it is quite functional. **It literally enables us to block out the visual distractions and focus on the physical sensations**. By applying a blindfold, you *can't* notice the dirty clothing that needs washing, the carpet that needs vacuuming, or any other daily disruption awaiting your line of vision. By temporarily suspending your sense of vision you will simultaneously heighten the remaining four.

Additionally, blindfolding enables us to access our fantasies more readily. It is awfully hard to pretend we are in our sexual paradise when we open our eyes and see family portraits and Macy's bedspreads (unless of course that is your paradise). A blindfold transports you to a world far away; the world for which you have lusted, albeit temporarily. This isn't a time machine folks – just a sexy suggestion.

Another benefit to the blindfold is its ability to allow you to be with whomever you want in the moment. Our fantasies do not always include our partners. I repeat OUR FANTASIES DO NOT ALWAYS HAVE TO INCLUDE OUR PARTNERS. However, as anyone who has tried will tell you, imagining Person "XXX" while Person "A" is the one lying on top of you is a challenge for even the most creative of minds. Pop on a blindfold and voila you are free to momentarily enjoy your imaginary lover.

So take a break from your standard routine and treat yourself to a simply **blinding** experience!

BLINDFOLD Reflection Log – To take your efforts to the next level and ensure that you didn't just go through the motions, take a moment to mentally reflect on your

experience. This will help you on your journey to discovering and uncovering your Inner Isis. Ask yourself the following questions:

What did I like most about the blindfold exercise?

_____
_____
_____
_____
_____

What did I like least about the blindfold exercise?

_____
_____
_____
_____
_____

What surprised me most about myself and my thoughts while I was blindfolded?

_____
_____
_____
_____
_____

How would I want to do it differently next time?

_____
_____
_____
_____
_____

What do I think my partner enjoyed (or didn't enjoy) most about this experience?

_____
_____
_____
_____
_____

Additional Arousal Notes:

_____
_____
_____

APPENDIX D

Women's Sexuality Survey

The following survey is geared towards obtaining information relating to female sexual desire patterns and behaviors. Your identity is anonymous, so please answer all questions as honestly as possible.

Age: _____

Race/Ethnicity: _____

Religious Background_____

Current Religious Practice_____

Relationship Status:
Single In a Relationship Married Divorced Separated

If in a relationship, how long have you been in it? _____

Do you have children? Yes No

If yes, do they still live at home? Yes No

Sexual Orientation:
Heterosexual Lesbian Bi-Sexual

At what age did you first masturbate? _____

At what age did you lose your virginity? _____If still a virgin check here ☐

The following section of the survey is related to frequency of sexual activity. Please answer as accurately and honestly as possible. Remember this is an anonymous survey.

1. On average, how many times a month do you have intercourse?
_____

2. Would you like intercourse…
More Less Satisfied As Is

3. On average, how many times a month do you receive oral sex?

4. Would you like to receive oral sex…
More Less Satisfied As Is

5. On average, how many times a month do you give oral sex?

6. Would you like to give oral sex...
More Less Satisfied As Is

7. On average, how many times a month to you engage in "heavy petting" or "outer-course"?

8. Would you like to engage in outer-course…
More Less Satisfied As Is

9. On average, how many times a month do you masturbate?

10. Would you like to engage in masturbation…
More Less Satisfied As Is

11. Are you able to have an orgasm when you masturbate?

Always Often Sometimes Rarely Never

12. Do you have orgasms with your partner either from oral sex, manual stimulation or intercourse?

Always Often Sometimes Rarely Never

13. If you have never reached an orgasm either alone or with a partner, please check this box

The following section of this survey will ask questions regarding your overall relational satisfaction and communication. If you are not currently in a relationship, please think of the last relationship you were in and answer accordingly. Please answer as accurately and honestly as possible.

14. If you are currently in a relationship how would you rate your overall relational satisfaction (If not in currently in a relationship, please think of your most recent partner and answer accordingly)

Very satisfying Satisfying Somewhat Satisfying Neutral Unsatisfying

15. How would you rate your <u>emotional</u> satisfaction in your relationship?

Very satisfying Satisfying Somewhat Satisfying Neutral Unsatisfying

16. How would you rate your over <u>sexual</u> satisfaction in the relationship?

Very satisfying Satisfying Somewhat Satisfying Neutral Unsatisfying

17. On average, how would you rate your overall level of communication?

Very Open Open Somewhat Open Closed Very Closed

18. On average, how would you rate your level of communication about sexual topics?

Very Open Open Somewhat Open Closed Very Closed

19. Do you feel comfortable telling your partner you want to try something new sexually?

Always Often Sometimes Rarely Never

20. Do you feel comfortable telling your partner that you're not in the mood?

Always Often Sometimes Rarely Never

21. When you're angry with your partner do you notice your desire decreases?

Always Often Sometimes Rarely Never

22. Do you feel sex is more like a chore than a pleasant activity that you look forward to?

Always Often Sometimes Rarely Never

23. Do you feel it is your responsibility to keep your partner sexually satisfied, even if you are not in the mood?

Always Often Sometimes Rarely Never

The following section of this survey is concerned with obtaining information about your sexual fantasies and thoughts.

24. I fantasize about sexually themed material during the course of the day

Always Often Sometimes Rarely Never

25. I fantasize about my partner during masturbation (if you don't masturbate, leave blank)

Always Often Sometimes Rarely Never

26. I have lesbian fantasies even though I identify as a heterosexual

Always Often Sometimes Rarely Never

27. I have fantasies I wish I could share with my partner but feel too embarrassed

Always Often Sometimes Rarely Never

28. Do you experience guilt about your fantasies?

Always Often Sometimes Rarely Never

29. Do you use pornography to help you get aroused?

Always Often Sometimes Rarely Never

30. If yes, alone, or with a partner, or both?

31. What other material do you rely on to get aroused?
(Examples, books, television, magazines, phone sex)

The following section of this survey is concerned with your sexual desire and self image.

32. How much of your desire for sex do you think is mental?

Entirely Very Somewhat Not Very Not at all

33. How much of your desire for sex do you think is physical?

Entirely Very Somewhat Not Very Not at all

34. Does the way you feel about your body affect your desire to have sex with your partner?

Always Often Sometimes Rarely Never

35. Are there positions you won't do because you think you look unattractive in them?

Always Often Sometimes Rarely Never

36. If you could "fix" the body part you like least, do you think you would have more desire to have sex?

Yes Maybe I Don't Know No

37. Do you have trouble focusing on staying in an intimate moment because you are too concerned with what you may look like to the other person?

Always Often Sometimes Rarely Never

38. What part of your sexual self do you wish you could improve?