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Sexual Desire/Interest Disorder

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Sexual desire/interest disorder is absence of or a decrease in sexual interest, desire, sexual thoughts, and fantasies and absence of responsive desire.

In sexual desire/interest disorder, motivations to become sexually aroused are scarce or absent. The decrease is greater than what might be expected based on a woman's age and the relationship duration.

Causes often involve primarily psychologic factors (eg, depression, anxiety, stress, relationship problems) and/or unrewarding experiences (eg, due to lack of sexual skills or poor communication of needs). Use of certain drugs, such as SSRIs (particularly), some anticonvulsants, and β-blockers, can reduce sexual desire, as can drinking excessive amounts of alcohol. Fluctuations and changes in hormone levels (eg, at menopause, during pregnancy, with the menstrual cycle) can affect sexual desire. For example, atrophic vaginitis and hyperprolactinemia may contribute.

Women with sexual desire/interest disorder tend to be anxious, to have a low self-image, and to have mood lability even if they do not have a clinical mood disorder.

Diagnosis is clinical (see Overview of Female Sexual Function and Dysfunction : Diagnosis).

Treatment

- Education
- Psychologic therapies
- Hormonal therapy

If factors that limit trust, respect, attraction, and emotional intimacy between partners are the cause, the couple should be counseled that emotional intimacy is a normal requirement for female sexual response and needs to be enhanced with or without professional help. Education about sufficient and appropriate stimuli may help; women may need to remind their partner of their need for nonphysical, physical nongenital, and nonpenetrative genital stimulation. Recommendations for more intensely erotic stimuli and fantasies may help eliminate distractions; practical suggestions to improve privacy and a sense of security can help when fear of unwanted outcomes (eg, discovery, pregnancy, sexually transmitted diseases) inhibits arousability.

For patient-specific psychologic factors, psychologic therapies (eg, cognitive-behavioral therapy) may be required, although simple awareness of the importance of psychologic factors may be sufficient for women to change patterns of thinking and behavior. Mindfulness-based cognitive therapy (MBCT—see Treatment), typically used in small groups of women, can improve arousal, orgasm, and subsequent desire and motivation.

Hormonal causes require targeted treatment—eg, topical estrogen for atrophic vaginitis or bromocriptine for hyperprolactinemia.

Systemic estrogen therapy

Systemic estrogen therapy (see Menopause : Hormone Therapy) initiated at menopause or within the next few years may improve mood and help maintain skin and genital sexual sensitivity and vaginal lubrication. These benefits may enhance sexual desire and arousal. Transdermal preparations of estrogen are usually preferred after menopause, but no studies identify which preparations available in the US are the most beneficial sexually. Progestins or progesterone is also given to women who have not had a hysterectomy.

Testosterone therapy

Benefits and risks of postmenopausal testosterone supplementation continue to be studied. Early studies in sexually healthy postmenopausal women who had some sexually satisfying experiences before treatment—most of whom were taking estrogen—showed modest efficacy. Thus, when no interpersonal, contextual, and intrapersonal factors were evident, some experienced clinicians have considered supplementation (eg, with methyltestosterone 1.5 mg po once/day or transdermal testosterone 300 mcg daily; transdermal preparations formulated for men are used). However, recent studies in sexually healthy postmenopausal women who were not depressed and who did not have relationship problems —about half of whom were taking estrogen—show no benefit with testosterone.

Taking testosterone might benefit some women who are taking estrogen and who have premature ovarian failure due to other conditions (eg, adrenal or pituitary dysfunction, chemotherapy, idiopathic). Taking testosterone might also benefit postmenopausal women who are taking estrogen therapy, who can no longer be aroused by previously effective stimuli and contexts, and who, as a result, have unsatisfactory sexual experiences. However, these groups have not been studied, so no recommendations can be given.

Too little is known about the long-term safety and efficacy of testosterone therapy to recommend it. However, if it is prescribed, full explanation of conflicting efficacy data and lack of long-term safety data, as well as periodic follow-up is essential. Periodically, the free testosterone level should be calculated or the bioavailable testosterone level should be measured (see Male Hypogonadism : Diagnosis of primary and secondary hypogonadism); if either is above the normal range for premenopausal women, the testosterone dose is decreased. Women should also be checked for hirsutism. Mammography should be done to check for breast changes because the evidence concerning testosterone's effect on the risk of breast cancer is conflicting. Tests should also be done to check for hyperlipidemia and impaired glucose tolerance.