8.113: Hyperactive Sexual Desire Disorder (302.71)

**DSM-IV-TR criteria**

- Persistently or recurrently deficient (or absent) sexual fantasies and desire for sexual activity. The judgment of deficiency or absence is made by the clinician, taking into account factors that affect sexual functioning, such as age and context of the person’s life.
- The disturbance causes marked distress or interpersonal difficulty.
- The sexual dysfunction is not better accounted for by another Axis I disorder (except another Sexual Dysfunction) and is not due exclusively to the direct physiological effects of a substance (e.g., a drug of abuse, a medication) or a general medical condition.
- Specify type:
  - Lifelong Type
  - Acquired Type
- Specify type:
  - Generalized Type
  - Situational Type
- Specify:
  - Due to Psychological Factors
  - Due to Combined Factors

**Associated Features**

- Hypoactive Sexual Desire Disorder affects women’s sexual desires, and contributes too many sexual dysfunctions.
HSDD is a common reason for women’s sexual dissatisfaction. HSDD causes a lack in sexual desire, and usually leads to relationship problems, involving lack of communication, distrust, anger, and lack of a connection. Women will experience sexual aversion, sexual apathy, and sexual desire. The person will usually not initiate sex, and will be unresponsive to another person’s initiations. In extreme cases of HSDD some patients may have never felt sexual desire, and if they did at one time, no longer have an interest, could be due to some traumatic event, such as incest, sexual abuse, or rape. However, if sexual trauma is absent it could be due to rigid religious training. Another possibility is that the initial attempts at sexual intercourse resulted in pain or sexual failure. Rarely, HSDD in both males and females may result from insufficient levels of the male sex hormone, testosterone.

- Low sexual interest is frequently associated with problems of sexual arousal or with orgasm difficulties. The deficiency in sexual desire may be the primary dysfunction or may be the consequence of emotional distress induced by disturbances in excitement or orgasm. General medical conditions may have a nonspecific effect on sexual desire due to weakness, pain, problems with body image, or concerns about survival. Depressive disorders are often present with low sexual desire, and the onset of depression may precede, co-occur with, or be the consequence of the deficient sexual desire. Individuals with Hypoactive Sexual Desire Disorder may have difficulties developing stable sexual relationships and may have marital dissatisfaction and disruption.

- Acquired HSDD- is acquired, situational HSDD in the adult is commonly associated with the boredom in the relationship with the sexual partner. Depression, the use of psychoactive or antihypertensive medication, and hormonal deficiencies may contribute to the problem. HSDD may also result from impairment of sexual function, particularly erectile dysfunction in the male, or vaginismus in the female. Vaginismus is defined as a conditioned voluntary contraction or spasm of the lower vaginal muscles resulting from an unconscious desire to prevent vaginal penetration. An incompatibility in sexual interest between the sexual partners may result in relative HSDD in the less sexually active member. This usually occurs in the presence of a sexually demanding partner.

- Painful Intercourse- (dyspareunia) is more common in women than in men, but may be a deterrent to genital sexual activities in both sexes. The causes are usually physical in nature and related to an infection of the prostate gland, urethra, or testes. Occasionally, an allergic reaction to a spermicide preparation or condom may interfere with sexual intercourse. Painful erections may be a consequence of Peyronie’s disease, which is characterized by fibrotic changes in the shaft of the penis that prevent attainment of a normal erection. In the female, dyspareunia may be caused by vaginismus or local urogenital trauma or inflammatory conditions such as hymenal tears, labial lacerations, urethral bruising, or inflammatory conditions of the labial or vaginal glands.

- Priapism- the occurrence of any persistent erection of more than four hours duration occurring in the absence of sexual stimulation. It is not associated with sexual excitement and erection does not subside after ejaculation. Priapism can occur at any age, by is more common between the ages of five to ten years and between ages twenty to fifty. In children, priapism is commonly associated with leukemia and sickle cell disease, or occurs following trauma. The most common cause in adults is the intrapenile injection of agents to correct erectile dysfunction.

- Prolactinoma- is a rare but important case of HSDD, it is a functioning prolactin-secreting tumor of the pituitary gland. Men who have this condition typically state that they can achieve an erection, but they have no interest in sexual relations with their partner. In females, prolactinomas are associated with galactorrhea (lactation in the absence of pregnancy), amenorrhea, systems of estrogen deficiency, and dyspareunia.

- Delayed maturation- is a potential cause of HSDD. It is present in boys if there is not testicular enlargement by age thirteen and a half or if there are more than five years between the initial and complete growth of the genitalia. In girls, delayed sexual maturation is characterized by a lack of breast enlargement by age thirteen or by a period greater than five years between the beginning of breast growth and the onset of menstruation. Delayed puberty may be the result of familial constructional disorders, genetic defects, such as turner’s syndrome in females and Klinefelter’s syndrome in males, central nervous system disorders such as pituitary conditions that interfere with the secretions of gonadotropic hormones, and chronic illness such as diabetes mellitus, chronic renal failure, and cystic fibrosis.

- Sexual Anhedonia-s is a rare variant of HSDD seen in males, in which the patient experiences erection and ejaculation but no pleasure from orgasm. The cause is attributed to penile anesthesia, due to psychological or emotional factors in a hysterical obsessive person. Psychiatric referral is indicated unless there is evidence of spinal cord injuries or peripheral neuropathy. Loss of tactile sensation of the penis is unlikely to be organic in cause unless there is associated anesthetic areas in the vicinity of the anus or scrotum.
Child vs. Adult presentation

- Hypoactive Sexual Desire Disorder is not common in children. The typical age of onset for Lifelong forms of Hypoactive Sexual Desire Disorder is puberty. More frequently though, the disorder develops in adulthood, after a period of adequate sexual interest, in association with psychological distress, stressful life events, or interpersonal difficulties.

Gender and cultural differences in presentation

- Across cultures, there is a higher prevalence of HSSD among men from the Middle East (21.6%) and South East Asia (28.0%) compared to European, North American, and South American men.
- The prevalence of low sexual desire in American and Swedish women ranges from 27% to 34% of the population. HSDD is reported by 43% of women from the Middle East and Southeast Asia.

Epidemiology

- Sexual desire decreases with age, relationship duration, and children. Nearly half of all women will have some sexual dysfunction during their life, and HSDD accounts for a large portion of those dysfunctions. Approximately 33% of women in the United States and Canada reported having little sexual desire. This number represents the number of women who periodically have little sexual desire. Only 7.9% of women reported that they frequently lack sexual desire.
- Because of a lack of normative age- or gender- related data on frequency or degree of sexual desire, the diagnosis must rely on clinical judgment based on the individual’s characteristics, the interpersonal determinants, the life context, and the cultural setting.
- Low desire occurs in approximately 15% of men aged 19 to 59. In men, operationalized low sexual desire as reduced thoughts, fantasies, and sexual dreams. Reduced sexual behavior with a partner, and reduced sexual behavior through masturbation. Men in the 50 to 59 age category were three times as likely to experience low desire as men in the 18 to 29 age category.

Etiology

In some cases Hypoactive Sexual Desire Disorder is considered lifelong, or beginning in adolescence. Most cases of HSDD can be linked to a point in life when libido decreased. Social problems, like marital problems or depression, may cause HSDD. Anorexia nervosa and Bulimia nervosa can also be a determining factor for HSDD. Hormonal deficiencies such as low estrogen lead to vaginal dryness and can promote HSDD. Physical ailments like endometriosis and pelvic inflammatory disease can cause the disorder too (West et al., 2008). This disorder can also be due to a general medical condition which causes pain (dyspareunia) or discomfort during intercourse.

Empirically supported treatments

- Sex therapy is very common for people with this disorder. Typically, the therapist tries to find a psychological or biological cause of the HSDD. It is very common for both partners to join in therapy, but women generally accept sex therapy more readily. Therapy treatment generally focuses more on relationship and communication issues, improved communication (verbal and nonverbal), working on non-sexual intimacy, or education about sexuality may
all be possible parts of treatment. Counseling/Sex therapy can open each partner up to the other’s point of view, and is often seen as the best chance to make improvements in sexual desire.

• Psychotherapy may involve exploration of interpersonal issues, including anger, trust, exploration of an affair, and feelings of attractiveness. Treatment might also encourage men to use fantasies, erotic stimuli, and include forms of sexual activities besides intercourse.

• Among the pharmacological treatments for HSSD, bupropion is a norepinephrine and dopamine agonist with an efficacy rate of approximately 86% in nondepressed men.

• Testosterone replacement has been the primary hormonal treatment and is administered as an injection, a patch, or as a gel. Testosterone treatment in women is recommended against, due to increased risk of cardiovascular disease and/or breast cancer. If testosterone treatment is considered in men with low desire, close consultation with an endocrinologist is essential because of possible negative side effects on prostate size and gynecomastia (males).

• The synthetic hormone, tibolone, which has estrogenic, androgenic, and progestogenic effects while not stimulating the uterus lining is licensed for the treatment of menopausal symptoms in Europe. Tibolone was found to significantly increase sexual desire, the frequency of sexual fantasies, and sexual arousability relative to control (woman).

Prognosis

The prognosis for HSDD depends primarily on the underlying cause or causes. In certain medical conditions, the prognosis for development, or recovery of sexual interest, is good.