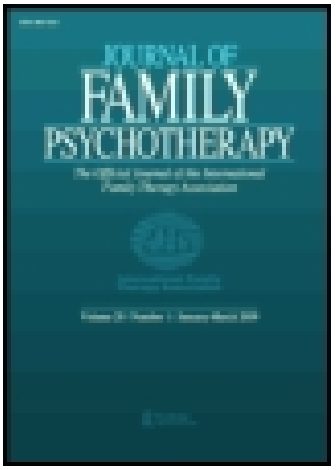

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The Treatment of Hypoactive Sexual Desire Disorder

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The Treatment of Hypoactive Sexual Desire Disorder

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In this article, the authors provide a definition and discuss the diagnostic criteria for hypoactive sexual desire disorder (HSDD). The article provides a discussion of the systemic etiological factors contributing to HSDD across several areas: individual psychological, individual biological, couple/dyadic factors, family-of-origin factors, and sociocultural factors. The authors also present an integrated treatment approach for this presenting problem based on the intersystems model. A case example is provided.

KEYWORDS hypoactive sexual desire disorder, couples, sex therapy, intersystems approach, integrative

Hypoactive sexual desire disorder (HSDD) is one of the most common presenting problems in the practice of sex and couple therapy; approximately 20% of men and 33% of women are affected by low or absent sexual desire (Laumann, Palik, & Rosen, 1999). The incidence is higher in the clinical population; over 50% of couples in treatment complain of insufficient sexual desire within their relationship (Segraves & Segraves, 1991).

While HSDD is prevalent, it is also among the most complex and difficult sexual problems to treat because it can be caused any number of biopsychosocial factors. For instance, the source of HSDD is often a combination of factors such as the individual's feelings and beliefs about sexual intimacy, relationship issues, and, in some cases, family-of-origin difficulties and traumas. Hormone imbalances and other physical factors might also be

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contributory. Further, HSDD can occur in conjunction with other sexual dysfunctions in either partner (Weeks & Gambescia, 2002). For example, a woman who experiences pain with intercourse may gradually lose her desire for sex or a man may become disinterested in his partner with orgasm problems. Treatment, therefore, cannot follow a short protocol based model but must be comprehensive, flexible, and tailored to each couple.

DEFINITION

In order to appropriately diagnose HSDD, there are three criteria that must be met according to the *Diagnostic and Statistical Manual of Mental Disorders* text revision (*DSM-IV-TR*; American Psychiatric Association, 2000). First, there is a lack of sexual fantasy and desire to engage in sexual activity. This absence of fantasy and desire must produce marked personal or interpersonal distress. Sometimes the distress is more pronounced in the individual who would like to feel desire but cannot experience it. In other cases, the distress affects both partners, particularly if there is a marked discrepancy in sexual appetite resulting in frustration, disappointment, and so forth. Finally, HSDD cannot be met by another Axis I disorder or another sexual dysfunction, be a byproduct of a general medical condition, or the result of substance abuse.

HSDD can be a lifelong condition in which absence of sexual desire is a typical state for the person. Alternately, when an individual has experienced a change in his or her sexual appetite, the term acquired is used; desire has been present, normally for a period of several years, but there has been a noticeable decline in over time. The change can be gradual or precipitous (American Psychiatric Association, 2000).

An individual with generalized lack of desire does not have a sexual appetite under any circumstance regardless of the partner or situation. Typically, this individual does not engage in sexual fantasy or any type of self-pleasuring. The situational type, on the other hand, is marked by selective desire, in certain situations or with specific partners (American Psychiatric Association, 2000). For example, the person might feel desire when alone but not with a spouse, or one might feel desire toward an affair partner but not with one's established partner.

A SYSTEMIC APPROACH

The purpose of this article is to present a comprehensive method of treating HSDD. We have called our model intersystemic because it deals with the interfacing of three general areas: (a) each partner's biological and psychosocial

dynamics, (b) the couple's relationship, and (c) factors learned within the families of origin and expressed in the present. Since HSDD symptoms are usually embedded within the couple's relationship dynamics, the sexual symptom is not treated in isolation (Weeks, 1994, 2004; Weeks & Gambescia, 2002). Instead, all components of the system are considered in assessment and treatment.

The Individual

The individual partners contribute unique ingredients to the couple's overall sexual functioning. These include biological factors such as hormonal status, age, and physical health. For instance, normative changes of aging can affect the homeostasis of the hormonal system and adversely impact sexual desire. In one case, a happily married woman feared she had fallen out of love for her husband of 25 years because she experienced a marked decline in sexual desire after menopause. The partners were concerned and worried about her lack of desire and the meaning she ascribed to this change in their relationship.

Psychological strengths, limitations, values, attitudes, psychopathology, and so forth are also included in this category. For example, an individual with low self-esteem can seem indifferent about enjoying the pleasures of sexual intimacy. Often, the partner in this situation worries that the lack of interest is a reflection of diminished sexual attraction or interest in the relationship. Another emotion that can inhibit sexual desire is anxiety; apprehension and worry can impede sexual pleasure (Katz & Jardine, 1999).

Interactional

Numerous relational factors have an effect on the sexual climate of a relationship. Some of these factors include discrepancies in sexual appetites or attraction, levels of resentment, discord, disagreements about power and control, and the lack of communication. We have often seen a partner express resentment indirectly through avoidance and disinterest in sex. Sometimes, lack of desire is the only form of establishing power in a relationship that is unbalanced. In other instances of partner specific HSDD, the individual can ostensibly seem disinterested in relational sex but enjoys frequent solo sexual activity.

Intergenerational

Each partner is strongly influenced by familial religious beliefs, culture, attitudes, values, and expectations toward sex. For example, early exposure to a highly repressive familial environment can distort adult perceptions of

normal sexual feelings and behaviors. Often, sexual ignorance, secrecy, mythology, and trauma are learned within the family of origin and through early social experiences. As adults, individuals will often reexamine acquired beliefs about sex. Also, as times change, the couple will reinterpret their sexual behavior through other lenses (Weeks, 2004). This lens may include the partner's own developmental changes as well as environmental/societal influences that can dampen or enhance early education about sexual intimacy.

PROBLEMS WITH NONSYSTEMIC APPROACHES

A major problem in the treatment of HSDD has been the fragmentation of therapy into distinct categories dealing with marital, sexual, and family issues separately. This difficulty stems from the fact that sex, marital, and family therapy are often seen as distinct and separate entities (Weeks, 2004). Additionally, some treatment models focus on the symptom bearer and overlook the contribution of each partner in the development, maintenance, and treatment of the sexual difficulty. Therapies grounded by an individualistic/behavioral perspective are inadequate because they are not systemic. Sexual problems affect the couple, the partners contribute to the problem in a number of ways, and the couple is the focal point of treatment.

Another obstacle in the treatment of sexual dysfunctions is the bifurcation of medical versus psychological therapies. Currently, pharmacological treatment of sexual problems has become so popular that, regardless of etiology, some individuals seek medicines over psychotherapy for sexual problems. Frequently, the individual hypothesizes that the cause of HSDD is physical and therefore obtains treatment from a medical practitioner without including the partner in the decision-making process. Various hormonal, psychotropic, and off-label (not approved for the intended use) treatments may be attempted to increase sexual desire. The individual may become pessimistic about correcting the problem if the remedies do not work as expected. Often, the relational components of the problem were never assessed in the first place, thus treatment might not be successful. Conversely, many psychotherapists are not comfortable seeking medical consultations when necessary; thus, important biological information is missed. Since HSDD is often a result of combined etiologies, the systemic therapist must consider several etiologies and be flexible in selecting treatment modalities. The reader is referred to an interesting chapter by Ashton (2007) for a comprehensive discussion of the new sexual pharmacology.

Some of the current approaches to HSDD propose new diagnostic criteria and differentiate indices of desire between genders (Basson, 2007; Maurice, 2007). We agree that men and women often experience desire differently and that the woman's sexual appetite is strongly influenced by

her relationships and contextual factors. One of the most controversial ideas to come out of this newer body of literature is the presupposition that women in long-term relationships do not experience spontaneous sexual desire (Basson, 2000, 2001a, 2001b). This assumption has been challenged in an excellent and highly sophisticated conceptual critique (Both & Everaerd, 2002). Further, Basson (2000, 2001a, 2001b, 2007) proposed that women engage in sex for many nonerotic reasons, such as the wish for emotional closeness and that desire and arousal often emerge from the nonerotic motivations. Our clinical experience suggests that many women in long-term relationships remain quite interested in sex and become frustrated to the point of considering divorce when their partners lose desire.

The systemic approach addresses the totality of factors that engender and maintain sexual symptoms. This approach has been fully described in our text, *Hypoactive Sexual Desire* (Weeks & Gambsecia, 2002). Reviews of other psychological and physiological treatment modalities and their effectiveness can be found in Ullery, Millner, and Willingham (2002) and Heiman (2002).

CLINICAL ASSESSMENT

Preliminary Assessment

Treating HSDD involves a comprehensive assessment that begins with the first telephone contact. The therapist notes which partner ostensibly has the problem, the duration, and what the couple hopes to gain from treatment. Is the symptomatic partner taking the initiative for treatment or placating the significant other? In the next few sessions, the therapist begins to generate hypotheses regarding the causes of the problem. Initial impressions and reactions are gathered about the individual partners and their relationship including recent significant changes in each partner's life. Early in treatment, the therapist begins to establish treatment goals by exploring and identifying the couple's expectations of treatment.

Focused Appraisal

Next, the therapist directs the assessment to the sexual relationship by asking focused questions in the session and also suggesting that the couple think about them at home as part of a deeper exploration:

1. How often do you have sex?
2. How often do you feel like having sex?
3. Do you believe your desire level is too low?
4. When did you first notice you losing desire for sex? What was happening at that time?

5. Did you lose desire rapidly or slowly?
6. What was your level of sexual desire earlier in your relationship?
7. Any changes in your health? What medications are you taking now?
8. On a scale of 1 to 10 how much desire do you feel in general? Prior to sex? During sex?
9. How often do you think about sex or fantasize about romantic scenarios?

Individual Partners

The clinical assessment also includes individual sessions to determine level of desire, extent of sexual thoughts and fantasies, solo sexual activity and related fantasies, desired forms of erotic stimulation, ease in articulating erotic desires, and fantasies that make the individual comfortable or uncomfortable. Individual sessions provide a forum for discussing secrets that can later be shared, unusual sexual preoccupations, or if there is an extramarital affair. The therapist also considers aspects of the HSDD that will require medical evaluation.

The Couple

Throughout the duration of the assessment process the therapist evaluates the couple's emotional contracts, styles of communication, level of discord, conflict resolution style, and ways of defining problems. Each partner's capacity for intimacy is another focal point of an ongoing dyadic assessment. Thus, sexual and nonsexual relational parameters are evaluated.

The Intergenerational System

Intergenerational factors are assessed through the use of a genogram, which examines different aspects of familial functioning (DeMaria, Weeks, & Hof, 1999). Also, the clinician evaluates for incest, parentification, triangulation, and other dysfunctional patterns of familial relating that impact intimacy and sexuality. As stated, sexual misinformation generated within the family of origin can negatively influence intellectual and emotional understanding of sexuality and interfere with the enjoyment of sexual intimacy in adult relationships.

Cognitive Considerations

Our theory is that the presence of negative cognitions (about the self, sexual intimacy, partner, etc.) will directly affect sexual desire. We also believe that the individual who is able to experience sexual desire is actually having sexual thoughts while the individual who lacks desire has an absence of sexual thoughts or has a number of negative sexual thoughts. From the

onset of treatment, negative sexual cognitions are observed regarding the self, the partner, the relationship, the family of origin, and so forth. This aspect of the assessment helps to determine which of the thoughts can be changed through cognitive therapy techniques and to further gauge other problems in the relationship that must be addressed through couple therapy. We return to this issue in the treatment section.

Empirical Tools

The assessment procedures mentioned above are all clinical in nature. The clinician or researcher who wishes to conduct an evaluation that includes psychometric devices may also use new instruments that have been empirically validated for female clients. For general sexual dysfunction, the clinician could use the Female Sexual Function Index (FSFD; Meston, 2003; Wiegel, Meston, & Rosen, 2005). A new inventory that has been developed to assess HSDD is the Sexual Interest and Desire Inventory-Female (SIFI-F; Sills et al., 2005; Clayton et al., 2007). An instrument that has been shown to have validity and reliability has not been developed for men.

Favorable Conditions for Treatment

We expect that other individual and relational issues will surface during treatment because HSDD does not occur in a vacuum. Most concerns are treatable although their position of importance may vary during the duration of treatment. Often, the clinician must balance the pressure to treat the HSDD against the obvious problems that must be addressed first. It is always important to elucidate the relationship between the HSDD and the other concerns in order to promote compliance. We consider the following conditions to be favorable for treatment:

- Partners have positive sex beliefs and want to experience desire again
- Both partners are relatively free from psychiatric problems that can impede treatment
- There is an inability to break the cycle of negative sexual cognitions and obsessive thoughts that interfere with building sexual desire
- If a partner has withheld historical information about physical, sexual, or emotional abuse or sexual addiction and is willing to share and work on this information
- Negative sexual attitudes based on religious beliefs, internalized negative sex messages from the family of origin, and the resulting sexual guilt
- Stress from situational life stressors that affect one partner such as severe work stress or death of a loved one
- Unrealistic expectations the normal physiological changes of aging and the willingness to accept accurate information

- Treatable relational difficulties in negotiating issues of power, control, inclusion, and autonomy
- The couple's sexual script has not been successfully negotiated or the partners may have different preferences or misinformation
- Treatable discord in other areas of the relationship, such as ineffective communication, unresolved anger, and unmet expectations
- When HSDD can be related to other sexual difficulties in either partner such as erectile dysfunction, inhibited female orgasm, or vaginismus
- The presence of response anxiety (discussed later in this article)

Contraindications for Couple Therapy

The systemic treatment for HSDD is not appropriate when

- The HSDD partner does not wish for or care about sexual desire or has sexual aversion
- If the problem is viewed as solely belonging to the partner who lacks desire and the other partner is unwilling to participate in the therapy
- A great deal of untreatable discord or the inability to work together cooperatively
- When one or both partners are not committed to their relationship
- A lack of commitment to treatment such as during an affair or active addiction in one or both parties
- Presence of a significant psychopathology in either partner

One couple presented for treatment of the husband's gradual lack of desire for his wife and avoidance of sexual relations over the past year. He complained that she was too thin and that she was overinvolved with their children. She was concerned that he was acting depressed and that his behavior had changed recently. He left the home for unexplained reasons and became secretive in his use of the cell phone and computer. The wife eventually discovered evidence of an extramarital affair. The focal point of treatment rapidly changed to address the crisis.[1]

ETIOLOGY

The systemic framework is used to assess the risk factors for HSDD arising from three major areas: the individual partners, families of origin (intergenerational), and the couple's relationship (interactional).

[1] See Weeks and Gambescia (2003) for treatment of infidelity.

Individual Risk Factors

Psychological risk factors in the individual partners can be expressed within the context of sexual intimacy, thus giving rise to the development of HSDD. These involve anxiety, depression, negative cognitive distortions, inaccurate beliefs about sex, poor body image, a tendency to fuse sex and affection, career overload, and related sexual problems. In such cases, the therapist may be tempted to turn the focus of treatment to the partner with the lack of desire, but it is imperative that a relational stance is maintained (Weeks & Gambescia, 2002).

Fears in one or both partners could place a couple at risk for the development of HSDD since emotional and physical intimacies are closely related. Working on sexual desire may be hampered by one partner's fear of intimacy, anger, rejection and abandonment, exposure, feelings, or dependency. As noted previously, psychiatric factors such as anxiety, depression, obsessive-compulsive disorder, and sexual orientation conflicts can contribute to the development of HSDD. Further, physical factors, sexual abuse and emotional trauma can inhibit desire. It is important for the therapist to assess in all of these areas.

Intergenerational Risk Factors

Many of the aforementioned risk factors, such as antisexual beliefs, are learned within the social and familial contexts of each partner. It is essential that the therapist explore intergenerational legacies and other environmental messages and regarding sexual intimacy. In one example, the couple presented for treatment of the woman's lifelong HSDD. She was raised in an extremely religious household and learned that sex was for procreation and not personal enjoyment. Although she recognized that her beliefs did not make sense, she found it difficult to observe her own body, engage in erotic thoughts or solo sex, and enjoy sexual intimacy with her husband. Treatment required a flexible format of individual and conjoint sessions, psychoeducation, bibliography, correcting mythological cognitions, and ultimately acceptance of her right to enjoy all of the intimate benefits of marriage.

Interactional Risk Factors

Interactional risk factors might overshadow the course of treatment as research indicates that the extent to which each partner is satisfied with their marriage is related to one's sexual satisfaction (Morokoff & Gilliland, 1993). Specifically, problems related to dyadic adjustment and HSDD often coexist. For example, women with HSDD tend to report greater degrees of marital distress and less relational cohesion (Trudel, Ravart, & Matte, 1993). For women, sexual satisfaction is related to factors such as the manner in

which sex was initiated, level of arousal, and the behaviors present in that interaction. Other relational risk factors include contemptuous feelings, criticism, defensiveness, power struggles, and toxic communication (Gottman, 1994). The etiological factors mentioned previously are presented in a highly compressed form. Readers interested in doing a thorough assessment should consult our text on this subject (Weeks & Gambescia, 2002).

Medical Aspects

Most therapists treating HSDD are not physicians yet they must assess for physical conditions that could cause or contribute to the lack of desire. Often, a medical consultation is a necessary part of treatment. The therapist must be comfortable interfacing with medical care providers, collecting medical information, and working collaboratively with psychiatrists, urologists, and gynecologists. Also, the therapist must be familiar with the role of testosterone in sexual desire and the medical conditions that could create deficiencies of this and other hormones. Additionally, chronic medical conditions, normative physiological changes, and iatrogenic effects of medications can contribute to HSDD (see Crenshaw & Goldberg, 1996; Maurice, 2007; Weeks & Gambescia, 2002).

BASIC TREATMENT STRATEGIES

Addressing Pessimism and Skepticism

In most cases, our couples have struggled with HSDD for months or years before seeking treatment. Often, they have attempted to change the problem on their own, have failed, and then resigned themselves to a passionless relationship. Consequently, they enter treatment with a sense of pessimism and skepticism because they cannot imagine how talking about a sexual problem could possibly alleviate it. Lack of sexual desire is a complex phenomenon and difficult for a person to change. The couple's failed attempts should be normalized by explaining that pessimism is a natural response to a difficult situation. Support them for their efforts to correct the problem even if these strategies have failed.

Maintaining a Systemic Focus

HSDD couples often view the symptomatic partner as the one with the problem. They must be educated to think systemically. This involves helping them to recognize that HSDD is a relational problem. One systemic technique is the therapeutic reframe in which the therapist helps to conceptualize the HSDD in a different way (Weeks & Treat, 2001). The therapist reframes the HSDD by asking focused questions that become more and more directed in

order to help the couple appreciate how relational problems contribute to the lack of desire. The therapist emphasizes that the couple struggles together and will need to work together to resolve the problem. For a more detailed discussion of reframing the reader is directed to our text (Weeks & Gambescia, 2002).

Responsibility for Sexual Intimacy

Many of our clients feel powerless with respect to owning and controlling their sexual feelings. They believe that sexual gratification is something that happens to them. Throughout the process of therapy, couples gradually learn that sexual desire and satisfaction are created, fostered, practiced, and nurtured by the self and the partner (Gambescia & Weeks, 2006). Sensate focus exercises (Weeks & Gambescia, 2002) and other cognitive behavioral assignments promote responsibility for sensual and sexual enjoyment. Ultimately, our couples recognize that they have control over their feelings, behavior, and sexual satisfaction.

Setting Priorities

The systemic treatment of HSDD should not be generic or predetermined. Usually, the therapist commences by focusing on the presenting problem. During the course treatment, however, other individual or relational issues might take precedence. These often include anxiety, anger, sexual ignorance, or lack of communication. The therapist prioritizes the order in which each issue is treated. Some problems may overlap or be addressed concurrently. Moreover, it is important for the couple to understand that the format must be flexible and that modifications do not indicate failure. In one instance, individual issues in the husband contributed to his lifelong HSDD. During treatment, he revealed that as a child he had been sexually abused; this a fact surprised his wife of 20 years. The couple needed time to discuss and understand this aspect of his childhood experience and the impact of early trauma on adult sexual functioning. Then, the focus of treatment returned to the HSDD as the couple gained a better understanding of the genesis of the problem.

Establishing Treatment Goals

The fundamental goal of treatment is to restore sexual desire to the intimate relationship; however, other objectives can be accomplished in the process. A lack of sexual desire can be tied to other elements of the couple's relationship, specifically those that diminish the sexual experience such as anger, resentment, or poor communication. Thus, treatment of HSDD addresses relationship problems, thereby improving overall

relationship satisfaction. Moreover, effectively working together to solve their sexual problem will foster greater improvements in the overall emotional relationship.

Implementing Goals

Since the treatment of HSDD also addresses the relational problems, it is essential that the therapist is qualified and knowledgeable about couples and sex therapy techniques and knows the circumstances under which the techniques will be most effective. Furthermore, we suggest that couples must be active members in their treatment; thus, they should be aware of why a strategy is being used and what the outcome is expected to be. This collaborative effort will increase compliance.

Correcting Unrealistic Expectations

Couples enter a relationship with expectations of themselves, each other, and what it means to be in a loving relationship. The expectations are often unstated and partners are left feeling disappointed upon the realization that hopes and dreams will not come to fruition. Some ideas are unrealistic from the start, such as believing that if your partner loved you, she or he would know automatically what you want. In cases where expectations are not met, one partner may misattribute this to their partner not caring about them enough and, as a result, withhold sex or desire. The therapist should help the couple to develop realistic perceptions of themselves, what each can offer, and a reasonable perception of love and all that it involves.

Lowering Response Anxiety

In our clients, the low desire partner continuously monitors and worries about the lack of sexual desire rather than enjoying sexual activity. A person experiences response anxiety when they believe they should enjoy more desire for their partner than they currently feel. The focal point of sexual intimacy turns into anxiety rather than pleasure. As response anxiety increases, the likelihood of desire decreases, thereby increasing anxiety, and so on.

One critical component to the treatment of HSDD is lowering the response anxiety and we use several techniques. First, the therapist educates the couple by explaining the concept. Cognitive strategies such as thought-stopping and thought substitution are also useful (A. T. Beck, 1976; J. Beck, 1995). Another method is to confront irrational ideas that foster response anxiety, such as the equation of sex and intercourse. In this case, the definition of sex is broadened to include behaviors, such as noncoital sexual touching, that are less likely to cause response anxiety. The therapist

familiar with systemic approaches can use paradoxical intervention, a technique in which a symptom is intentionally prescribed in order for the client to recognize that they have control over the symptom (Weeks & L'Abate, 1982).

Addressing Affect

Another focus of treatment is the emotional processes that occur within the session. As such, the couple will learn to communicate about feelings rather than staying fixed on content. The therapist will need to attend to the level of affect expressed by each partner. For instance, the lower desire partner may appear to have a lack of motivation for sex, have a lack of affect, and seem withdrawn, especially in the sexual area. Conversely, the higher desire partner is often more emotional, frustrated, and pessimistic. In these instances, the therapist should help the partners attend to and discuss their style of expressing emotion. Also, they are helped to inquire rather than ascribe motives for each other's feelings. This process helps the couple become more aware of themselves, their patterns of interactions, and the emotional barriers to feeling desire. This work is ongoing.

Cognitive Work

Cognitive therapy is indispensable in the treatment of HSDD. Negative cognitions about sexual intimacy, the self, and the partner directly contribute to the lack of desire by preventing the emergence of enjoyable sexual thoughts and fantasies. This cognitive mental mechanism is powerful; it has strong behavioral consequences. Further, couples develop interlocking sets of irrational beliefs that perpetuate sexual problems; these beliefs need to be explored, interrupted, and changed conjointly. A man with HSDD might think, "I'm just not interested in sex." His partner might also think, "He isn't interested in sex, so why initiate anything." These two interlocking thoughts help to perpetuate sexual avoidance.

The partners are helped to identify interlocking irrational sexual beliefs and to replace them with more positive, factual cognitions. Also, they are encouraged to engage in erotic thoughts and fantasies to promote prosexual cognitions and feelings. Each partner learns to monitor his or her thoughts or behaviors in order to determine when the nonproductive thought has started again. It is stopped (thought stopping) and consciously replaced (thought substitution) with an enjoyable idea. As such, the individual is mentally rehearsing or replaying a positive sexual encounter. This process creates a state of positive anticipation for the next experience. Eventually, erotic thoughts become more natural and automatic (A. T. Beck, 1976; J. Beck, 1995; Weeks & Hof, 1987, 1994).

Communication

Another aspect of treatment involves helping the couple to discuss their sexual needs, wishes, preferences, and concerns. Since most of our clients find it difficult to talk about sex, the therapist might start by fostering communication about less threatening topics and gradually move into sexual intimacy. Other areas of effective communication include: using "I" statements, validating each other, reflective listening, and learning to edit what one says (Weeks & Treat, 2001). In addition, Gottman (1994) recommends that a 5:1 ratio of positive to negative exchanges promotes relational satisfaction.

Psychoeducation

The therapist wants to correct as much misinformation as possible about sexual desire, the lack of desire, and sexuality in general. The revision of some misconceptions may take time and repeated discussions, whereas others seem to evaporate the moment the conversation is over. Some mythological beliefs are not revealed until they are uncovered through an individual discussion with the therapist. Bibliotherapy reinforces the psychoeducational process by providing accurate information about sexual structure and functioning. Also, we recommend readings that normalize aspects of sexual intimacy such as fantasy and solo sexual activity (Barbach, 1982; Comfort, 1994; Friday, 1998a, 1998b; Zilbergeld, 1992).

Systemic Homework

The therapist treating HSDD must play a directive role in session and beyond the therapy hour through the prudent use of assignments to be performed at home. Homework assignments address individual, relational, and intergenerational issues associated with the lack of sexual desire. For instance, homework for the individual partner(s) includes prescriptions regarding physical exercise, guided imagery, gradual exposure to sexual material, directed masturbation, and exposure to fantasy through bibliotherapy or selected visual materials (Bright, 2000; Martin, 1997). Homework for the couple includes sensate focus, communicating sensual and sexual wishes and needs, and conflict resolution exercises (Weeks & Gambescia, 2002). The couple is also directed to explore intergenerational messages regarding sexual intimacy, pleasure, and entitlement to sexual satisfaction. Additionally, the continued use of homework assignments will promote compliance and prevent relapse of the sexual symptoms, particularly with desire phase disorders (McCarthy, 1999).

Treating Other Sexual Dysfunctions

It is not unusual for an individual to have more than one sexual problem; thus, it is possible that HSDD might be related to another sexual difficulty such as physical discomfort during sex, erectile dysfunction, or trouble with orgasm. Sometimes, the higher desire partner also has sexual difficulties that can make intercourse less desirable, such as erectile dysfunction, thereby increasing the possibility of HSDD. The role of the therapist is to educate the couple in how other sexual dysfunctions in either partner might contribute to the development and maintenance of HSDD. Further, the couple is encouraged to make a commitment to working on all elements of the dysfunction not just the HSDD.

A couple, married for 30 years, sought treatment for the man's disinterest in sex for the past few years. The therapist learned that he had experienced erectile dysfunction (ED) for several years but the couple managed to have noncoital sex on a regular basis. Assessment revealed that he engaged in masturbation and fantasy when alone, although his erections were not robust. The wife was unaware that he had any sexual desire for her and she blamed herself for the couple's lack of sex. Each time she brought up the sexual issue for discussion, he would retreat. Finally, she insisted on treatment. The husband explained that the ED made penetration difficult or impossible and that he felt emasculated and embarrassed by his lack of performance. For him, it was easier to avoid sex altogether rather than anticipate a failure. Through psychoeducation, cognitive therapy, and behavioral homework, the couple gradually resumed sexual intimacy. In addition, they attended a urological consultation and an oral medication was prescribed to promote more adequate erections.

ADVANCED TECHNIQUES

Promoting Sexual Intimacy

The topic of sexual intimacy is a central focus of systemic treatment of HSDD. The couple shares their ideas about what it means to be intimate, identifies discrepancies in their definitions, and work toward a common meaning (Weeks & Treat, 2001). Next, the therapist helps the couple to understand that intimacy and sex are not distinct entities. This concept is reinforced during the treatment as intimacy within their sexual relationship is encouraged. Additionally, the therapist works with the couple to expand their definition of sexuality to include other intimate sexual and nonerotic behaviors. Increasingly, the couple becomes aware of the ways in which they create obstacle to intimacy and how these barriers can inhibit sexual desire.

Working with Fears of Intimacy

Fears of intimacy and closeness, whether conscious or unconscious, are often exhibited through one's behavior. It is important to address this issue since, for many, the fear intimacy compromises sexual desire. The therapist assumes that the fear of intimacy may be an unconscious motivator in cases of HSDD; thus, this position should be shared with the couple. Then the therapist helps the partners identify their fears through the use of a genogram that focuses on elements of one's upbringing that have an effect on intimate behavior (DeMaria et al., 1999). Also, the therapist educates the couple about the many reasons why individuals might fear intimacy so that they understand the concepts and will be willing to discuss the related issues as they apply to them.

In HSDD cases, a few factors related to underlying fears of intimacy are seen more frequently. For example, the fear of losing control is sometimes manifested in relationships through a power imbalance that is so severe that one partner is perceived as a parent and the other as a child. This issue has the potential to make sex feel nearly incestuous (Weeks & Gambescia, 2002). The fear of losing oneself is another common presentation. It relates to HSDD in that desire is one aspect of the relationship that is in their control. The fear that their partner's ultimate goal is to control them is unconsciously reduced through the inhibition of sexual desire for the partner.

There are several guidelines for treating intimacy fears. First, it is important to identify the fear. Next, the therapist uses cognitive therapy to help neutralize the negative thoughts associated with the fear and then replace them with appropriate and adaptive cognitions. The therapist and clients then work to disrupt the pattern of avoidance that results from the fear. It is important for each partner to validate the fearful partner's emotions without agreeing with them, as agreeing would lead to continued avoidance of the feared stimuli and, consequently, the behavior.

When the therapist is confident that the couple can directly tackle the fear, the suggestion should be made that the fear is threatening to the present relationship and serves little or no purpose. It is essential that the therapist and couple explore the ways in which each person in the relationship contributes to the problem rather than placing the blame solely on the person with the fear. The underlying fears of intimacy are usually deeply entrenched and require extended work ranging from cognitive therapy to intergenerational work.

Working with Conflict and Anger

Many of our HSDD couples have experienced anger and frustration over a protracted period of time. For some, the anger has become chronically

suppressed or circumvented, making it very difficult to feel desire toward one's partner. Eventually, the couple avoids all emotional contact in order to avoid the unpleasant feelings. Additionally, sexual feelings become suppressed and fused with the noxious emotions of anger, frustration, disappointment, helplessness, and so forth. The couple must be helped to understand that anger, if expressed, need not destroy the partner or the relationship. A variety of techniques can be implemented to promote appropriate expression of anger (Weeks & Gambescia, 2002).

In one case, the wife, in her mid 30s, suffered from situational HSDD and avoidance of sex for a year after the birth of their first child. Her husband was frustrated and angry about her apparent lack of attention to him and the ailing sexual relationship. His anger was uncensored, which caused her to withdraw from him. The more he raged, the more unreceptive she became. By the time they presented for treatment, they were prepared for divorce. The therapist used immediate techniques to regulate affect of both partners. As the woman began to discuss her feelings of frustration, blame, sadness, and so forth, her husband was able to respond more empathically. He accepted her feelings; thus, she became interested in getting closer to him and so on. The therapeutic outcome was positive after 6 months.

Medical Therapies

A variety of prosexual remedies is currently available to enhance the sexual appetite. Most of these preparations are nutritional supplements and remain unregulated by the Food and Drug Administration (FDA). Some prescription medications are used off-label for prosexual purposes. For example, Bupropion SR (sustained release), an antidepressant, has been found to enhance desire in nondepressed women (Ashton, 2007; Seagraves et al., 2001; Seagraves, Clayton, Croft, Wolf, & Warnock, 2004).

The iatrogenic effects of many commonly used prescription medications can be another factor in HSDD (Ballon, 1999; Rosen, Lane, & Menza, 1999). Treatment strategies for overcoming the sexual side effects of medications include waiting to see if the symptoms remit, lowering the dose, substituting another antidepressant, adding a supplementary medicine to act as an antidote, or discontinuation for brief periods (Verhulst & Reynolds, 2009). Bupropion SR is used to counteract HSDD caused by another group of commonly used antidepressants called selective serotonin reuptake inhibitors (SSRIs).

Testosterone is recognized as an important component of the sexual appetite in men and women as it promotes sexual desire, curiosity, fantasy, interest, and behavior (Crenshaw & Goldberg, 1996; Rako, 1996). Testosterone deficiency in men can be treated with an assortment of products and with varying results; however, testosterone deficiency in women remains untreated pharmacologically. Moreover, the relationship between testosterone

and sexual desire in women is complicated. Davis, Davison, Donath, and Bell (2005) found that HSDD in women cannot be diagnosed through assessing the level of circulating sex hormones such as testosterone. Specifically, some women with low testosterone levels do not experience desire problems and most women with HSDD have normal testosterone levels.

The medical and psychological treatments can work in combination as proposed in the Intersystems model (Weeks & Gambescia, 2000, 2002). However, we do not believe that medications will override the effects of adverse relationship factors in HSDD but may prove useful where certain medical and drug side effects are present. A drug may eventually be developed that serves as a basic "energizer" of sexual desire thus making it easier to experience desire when the suppressive individual, relational, and family-of-origin factors are worked through therapeutically.

RELAPSE PREVENTION

The therapist should help the couple to understand that sexual desire is maintained through active sensual and sexual contact with one another. Thus, the therapist assists the couple in relapse prevention by including strategies in the repertoire which involve sensual touching and caressing. These strategies are discussed in detail in our chapter on sensate focus (Weeks & Gambescia, 2009). The therapist must be mindful that relapse is to be expected, especially since conflicts and anger not related to sexuality can emerge during the sensate focus exercises. One of the signs that a couple is relapsing is their non-completion of the homework assignments. Therefore, the couple is reminded to plan a schedule including sexual dates to spend with one another.

Paradoxical strategies can also prevent relapses (Weeks & Gambescia, 2002; Weeks & L'Abate, 1982). One strategy is to ask the couple to identify and predict the ways that they might sabotage their progress in therapy. Therapists can also ask the couple to predict the factors that might provoke the recurrence of inhibited desire. Asking the couple to think about these factors will increase the likelihood that these problems will not arise.

CONCLUSION

Treating HSDD can be complex, as it involves many factors related to the individual partners, intergenerational influences, and the couple's relationship. The intersystem approach can guide the therapist to decode and address many problem areas in couples presenting with this complex dilemma. The therapy is characterized by of a number of apparent contradictions. First, although the symptoms are ostensibly expressed by one partner, HSDD is a relational problem. Next, HSDD is not simply a sexual problem;

often, the lack of desire is a reflection of other problems in the relationship. Also, the HSDD partner may appear unemotional, yet, the sexual symptom is often a way of indirectly expressing strong emotions related to the partner. The partner with HSDD might appear disinterested in sex. In effect, this individual wants to feel desire for their partner, yet this desire cannot be forced or it will further diminish the sexual appetite. The therapist must be equipped with a variety of techniques that are used judiciously; patience and flexibility are critical. Moreover, the therapeutic strategies must be shared with the partners in order to ensure their cooperation. As the intersystemic issues are addressed, often concurrently, sexual desire will gradually return to the relationship.

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