The Presentation of Hypoactive Sexual Desire Disorder in Premenopausal Women

Nancy N. Maserejian, ScD,* Jan L. Shifren, MD,† Sharon J. Parish, MD,‡ Glenn D. Braunstein, MD,§ Eric P. Gerstenberger, MS,* and Raymond C. Rosen, PhD*

*New England Research Institutes, Inc., Watertown, MA, USA; †Vincent OB/GYN Service, Massachusetts General Hospital, Boston, MA, USA; ‡Department of Medicine, Albert Einstein College of Medicine, Montefiore Medical Center, Bronx, NY, USA; §Department of Medicine, Cedars-Sinai Medical Center, Los Angeles, CA, USA

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ABSTRACT

Introduction. Little is known about the clinical presentation of hypoactive sexual desire disorder (HSDD) in premenopausal women or their perceptions of sexual problems.

Aim. Describe characteristics of premenopausal women with clinically diagnosed acquired, generalized HSDD, and investigate factors perceived to contribute to desire problems.

Methods. Cross-sectional analysis of baseline data from premenopausal women with clinically diagnosed and confirmed HSDD enrolled during the first year of the HSDD Registry for Women (N = 400).

Main Outcome Measures. Relationship, demographic, and clinical characteristics were assessed by clinician's medical history review and self-administered questionnaire. Sexual desire function was measured by the validated Female Sexual Function Index (FSFI).

Results. Over 85% of women cited multiple factors that contributed to ongoing decreased desire (mean 2.9 ± 2.3 factors, range 0–12). Most commonly cited contributing factors were "stress or fatigue" (60.0%), "dissatisfaction with my physical appearance" (40.8%), and other sexual difficulties (e.g., inability to reach orgasm) (33.5%). Exploratory analyses of the FSFI score confirmed that self-image ($P = 0.002$) and other sexual problems ($P < 0.001$) were significantly associated with decreased desire. Almost all (96%) participants were currently in a partner relationship. Antidepressant medication was currently used by 18.0% of women, hormonal contraceptives by 28.5%, and hormonal medications (for noncontraceptive reasons) by 7.3%. Physical functioning was consistent with general population norms (SF-36 mean ± standard deviation, 53.3 ± 7.6 vs. norm of 50 ± 10), while overall mental functioning was slightly lower (SF-36, 44.7 ± 10.6).

Conclusions. Within this sample of premenopausal women with clinically diagnosed HSDD, decreased sexual desire was associated with multiple factors, including poor self-image and stress or fatigue. Clinicians presented with premenopausal women expressing sexual desire problems should assess patients' perceptions of their condition to develop a comprehensive, patient-oriented management plan. Therapy may need to address issues with low self-esteem and mood and offer practical coping mechanisms for stress and fatigue. **Maserejian NN, Shifren JL, Parish SJ, Braunstein GD, Gerstenberger EP, and Rosen RC. The presentation of hypoactive sexual desire disorder in premenopausal women. J Sex Med 2010;7:3439–3448.**

Key Words. Hypoactive Sexual Desire Disorder; Female; Sexual Dysfunction; Premenopausal

Introduction

Hypoactive sexual desire disorder (HSDD) may be a common form of female sexual dysfunction in the United States, with recent population prevalence estimates of 7–12% based on the symptoms of decreased sexual desire and associated distress [1–3]. According to Diagnostic and Statistical Manual of Mental Disorders-IV (DSM-IV), HSDD is a deficiency or absence of sexual fantasies and desire for sexual activity, which causes marked distress or interpersonal difficulty

and cannot be better accounted for by another nonsexual Axis I disorder or result solely from the direct physiological effects of a substance or medical condition [4]. Distressing decreased sexual desire has been associated with depression and anxiety, as well as a substantial impairment in health-related quality of life [2,5].

Female sexual dysfunction, including HSDD, remains a clinically underappreciated and relatively neglected area of research, particularly among premenopausal women. This is especially troublesome considering that, while decreased sexual desire is more common among postmenopausal or older women, premenopausal or younger women are more likely to report being bothered or distressed by the problem [1,3,6,7]. Furthermore, epidemiological studies of sexual desire have relied solely on self-reports of desire and distress, rather than a clinician's use of standard diagnostic criteria. Thus, the clinician faced with a premenopausal patient newly diagnosed with HSDD has limited evidence-based knowledge to help understand the possible psychophysiology of the diagnosis and, therefore, the most appropriate behavioral, psychological, or pharmacological treatment.

Our objective was to provide clinicians with information on the range of clinical and personal characteristics that are likely to be encountered in premenopausal women presenting with clinically diagnosed HSDD, and to explore factors that are perceived by patients to contribute to their lack of desire. We note that for DSM-V, it has been recommended that the diagnostic criteria be modified to specify contributing causes (e.g., partner, relationship, individual vulnerability, cultural/religious, medical) [8]. Thus, our data on the relevance of possible contributing factors would also benefit the process of future modifications to the diagnostic criteria. We use early findings from the HSDD Registry for Women to profile the presentation of HSDD as it occurs in the "real world" clinical setting in premenopausal women.

Materials and Methods

Source Population: The HSDD Registry for Women

The HSDD Registry for Women is a prospective observational registry study of women with clinically diagnosed generalized acquired HSDD. Enrollment of 1,500 women (approximately 1,000 premenopausal, 500 postmenopausal) at approximately 40 clinical sites throughout the United States is planned over a 26-month period from 2008 to 2010. Women will be followed for up to 4 years with in-person clinic visits and remote computer-assisted self-interviews. To be eligible, women must be 18 years or older and must have received a diagnosis of HSDD by a qualified clinician within 3 months of enrollment (baseline). All participants provided written informed consent, and the study was approved by the Institutional Review Boards of all participating sites. Recruitment occurred through various channels, ranging from routine visits in clinical settings to public announcements about the study. Additional details on the design and methods have been previously published [9].

Analytic Sample

As of June 15, 2009, a total of 400 premenopausal women were enrolled from 18 clinical sites (eight obstetrics/gynecology, seven sexual medicine, one reproductive endocrinology and infertility, one urology, and one dedicated women's health research unit). Participants were recruited from new or existing patients (54.0%) or from advertisements/postings or referrals specifically for the study (46.0%). These 400 premenopausal women comprise the sample used in this analysis. Preliminary analyses showed that method of recruitment was not associated with sexual desire level, distress over lack of desire, or self-assessed HSDD severity in this sample; thus, recruitment source was not considered further in this analysis.

Menopausal status was determined by the participant's answers to questions on menstrual bleeding, age, bilateral oophorectomy, hysterectomy, endometrial ablation, menopausal symptoms, and medication use. In primary analyses, women were classified as premenopausal if they met one of these criteria: (i) menstrual bleeding in the past 12 months (n = 361, 90%); (ii) aged ≤55 years and no menstrual bleeding in the past 12 months for reasons of pregnancy/breastfeeding, medication, or birth control (n = 15, 3.8%); (iii) aged ≤55 years, no menstrual bleeding in the past 12 months for reasons of hysterectomy or endometrial ablation, no menopausal symptoms, and no medication/supplement use for menopausal symptoms (n = 24, 6%) [10–12]. In secondary analyses, we used a cut-point of aged ≤51 years (median age for menopause in the United States) for women who did not report menstrual bleeding in the past 12 months (falling into criteria ii and iii above). This modification resulted in exclusion of five women (1.3% of the primary analytic sample), all of whom had previously fulfilled criteria iii. Results were similar to the primary analyses and therefore are not presented.