MAYO CLINIC

REVIEW

The International Society for the Study of Women's Sexual Health Process of Care for Management of Hypoactive Sexual Desire Disorder in Women

Anita H. Clayton, MD; Irwin Goldstein, MD; Noel N. Kim, PhD; Stanley E. Althof, PhD; Stephanie S. Faubion, MD; Brooke M. Faught, WHNP-BC; Sharon J. Parish, MD; James A. Simon, MD; Linda Vignozzi, MD; Kristin Christiansen, MD; Susan R. Davis, MBBS, PhD; Murray A. Freedman, MD; Sheryl A. Kingsberg, PhD; Paraskevi-Sofia Kirana, PhD; Lisa Larkin, MD; Marita McCabe, PhD; and Richard Sadovsky, MD

Abstract

The International Society for the Study of Women's Sexual Health process of care (POC) for management of hypoactive sexual desire disorder (HSDD) algorithm was developed to provide evidence-based guidelines for diagnosis and treatment of HSDD in women by health care professionals. Affecting 10% of adult females, HSDD is associated with negative emotional and psychological states and medical conditions including depression. The algorithm was developed using a modified Delphi method to reach consensus among the 17 international panelists representing multiple disciplines. The POC starts with the health care professional asking about sexual concerns, focusing on issues related to low sexual desire/interest. Diagnosis includes distinguishing between generalized acquired HSDD and other forms of low sexual interest. Biopsychosocial assessment of potentially modifiable factors facilitates initiation of treatment with education, modification of potentially modifiable factors, and, if needed, additional therapeutic intervention: sex therapy, central nervous system agents, and hormonal therapy, guided in part by menopausal status. Sex therapy includes behavior therapy, cognitive behavior therapy, and mindfulness. The only central nervous system agent currently approved by the US Food and Drug Administration (FDA) for HSDD is flibanserin in premenopausal women; use of flibanserin in postmenopausal women with HSDD is supported by data but is not FDA approved. Hormonal therapy includes off-label use of testosterone in postmenopausal women with HSDD, which is supported by data but not FDA approved. The POC incorporates monitoring the progress of therapy. In conclusion, the International Society for the Study of Women's Sexual Health POC for the management of women with HSDD provides a rational, evidence-based guideline for health care professionals to manage patients with appropriate assessments and individualized treatments.

 ■ Mayo Clin Proc. 2017;■■(■):1-21

The International Society for the Study of Women's Sexual Health (ISSWSH) process of care (POC) for hypoactive sexual desire disorder (HSDD) in women provides a consensus management guideline for the diagnosis and treatment of HSDD, the most common sexual dysfunction in women (Figure 1). Given recent research and increasing public awareness about HSDD, greater numbers of women are anticipated to seek treatment for HSDD from a health care professional (HCP). This POC model consists of an evidence-based approach to identification, diagnosis, and treatment, emphasizing biopsychosocial assessment and education. It highlights opportunities to address modifiable

From the Department of Psychiatry and Neurobehavioral Sciences and Department of Obstetrics and Gynecology, University of Virginia, Charlottesville,

Affiliations continued at the end of this article.

ARTICLE HIGHLIGHTS

- Hypoactive sexual desire disorder (HSDD), the most common sexual dysfunction in women, has been associated with negative emotional and psychological states, as well as medical conditions including depression; therefore, a guideline for management of HSDD has been developed for health care professionals by the International Society for the Study of Women's Sexual Health.
- This guideline starts with questions to ask regarding sexual health concerns and moves on to diagnosis of generalized acquired HSDD. Treatment begins with education, modification of potentially modifiable factors, and, if needed, additional therapeutic interventions.
- The choice of therapeutic intervention is most often dependent on patient (and partner) preferences and goals.

factors, includes patient needs and preferences in the decision-making process, and defines situations for specialized referral. The model incorporates the following essential principles: (1) identification of subtypes of HSDD, (eg, generalized vs situational and acquired vs lifelong), with emphasis on associated concomitant medical and psychological factors, (2) importance of patient and partner education during all phases of management, (3) goal-oriented focus with patient and partner needs and preferences guiding recommendations for treatment, and (4) clear guidance for follow-up and consideration for referral.

METHODS

This HSDD POC was developed under the auspices of the ISSWSH with input from an international multidisciplinary panel. After a planning conference call, panelists were asked to individually conduct an evidence-based literature review. The panel of 17 researchers and clinicians, ISSWSH members and nonmembers, convened for 2 days to review and discuss management strategies for HSDD using a modified Delphi method.[1-3] This iterative process involved presentations summarizing the current literature, debate and discussion of divergent opinions concerning HSDD assessment and management, and consensus development of a clinical guideline for the HCP. There was no industry participation in any part of the process.

BACKGROUND

Definition of HSDD

Women who are persistently and recurrently not interested in sexual activity who report the absence of sexual fantasies and who are bothered by their lack of sexual interest are said to be experiencing distressing low sexual desire.[4] Because there is substantial experimental and clinical evidence for this classification,[4-8] we will adopt the widely utilized diagnostic label of HSDD to describe women who are distressed by their clinically low levels of sexual desire and utilize the definition developed by the ISSWSH nomenclature committee.[9] This definition states:

HSDD manifests as *any* of the following for a minimum of 6 months:

- Lack of motivation for sexual activity as manifested by:
  - Decreased or absent spontaneous desire (sexual thoughts or fantasies); or
  - Decreased or absent responsive desire to erotic cues and stimulation or inability to maintain desire or interest through sexual activity;
- Loss of desire to initiate or participate in sexual activity, including behavioral responses such as avoidance of situations that could lead to sexual activity, that is not secondary to sexual pain disorders;
- And is combined with clinically significant personal distress that includes frustration, grief, guilt, incompetence, loss, sadness, sorrow, or worry.

Hypoactive sexual desire disorder may be lifelong or acquired and generalized or situational. This definition should be understood in a biopsychosocial context and therefore can be applied to both somatic and psychiatric diagnostic schema.[9]

Clinical Significance and Epidemiology

Hypoactive sexual desire disorder is associated with negative emotional and psychological states, as well as medical conditions including depression.[10-12] Women with HSDD may experience decreased quality of life including impaired body image, self-confidence, and self-worth and feel less connected to their partners.[10] Women with HSDD also have increased health care costs and health burden.[13,14]

Mayo Clin Proc. ■ XXX 2017;■■(■):1-21 ■ https://doi.org/10.1016/j.mayocp.2017.11.002
www.mayoclinicproceedings.org