Human Sexual Desire Disorder: Do We Have a Problem?

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Abstract

Hypoactive Sexual Desire Disorder (HSDD), loss of sexual desire for sexual activity, is one of the most common sexual dysfunctions of men and women in the United States. This article presents an overview of this specific sexual dysfunction including incidence, possible causes, treatment options, and the role of the health educator in addressing this topic. The importance of the role of the health educator in prevention and health promotion efforts is explored, such as functioning as part of a multidisciplinary response team, addressing communication in relationships, and accessing professional resources to address HSDD, are described in concert with this dysfunction. Because satisfactory sexual functioning is an important aspect of most peoples' lives and often a barometer of their relationship, the response to HSDD should be through a comprehensive, multidisciplinary approach and a health promotion perspective.

Introduction

One of the most frequently stated reasons for people to seek sexual counseling in the U.S. is to address the problem of hypoactive sexual desire disorder (HSDD) (Kaplan, 1985; Laumann, Paik, & Rosen, 1999; Weeks & Gambescia, 2002). Sexuality is a complex process of interactions of the neurological, vascular, and endocrine systems and is strongly influenced by value and belief systems. The topic has always been viewed as controversial in the health education discipline. Age old questions as to whether it is appropriate to teach this topic, what topics should be taught, who should teach it, and when it should be taught, are still being asked. People often are uncomfortable discussing the topic of sexuality, primarily because there is not ongoing dialogue in the home and school. While progress has been made in comprehensive sexuality education programming in the schools, there is still a great deal of apprehension in regards to addressing the topic of sexual dysfunctions throughout the lifespan.

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As a complex disorder, sexual dysfunctions may be indicators of more significant underlying organic disease processes. Likewise, a lack of appropriate education about sexual dysfunctions may lead to sexual anxiety and guilt, which can create apprehension or delay treatment of a specific sexual problem, such as HSDD. Due largely to the lack of public education on sexual health, the myths surrounding sexuality, the lack of tools to accurately assess HSDD, and the lack of rigorous studies of the disorder, HSDD is considered the most difficult sexual disorder to operationally define, evaluate, and treat (Meuleman & Lankveld, 2005). This article presents a brief overview of HSDD, including incidence, possible causes, and treatment options, and explores the role of the health educator in addressing this topic.

Defining the Problem

Because sexual desire includes emotions, thoughts, and fantasies that activate sexual appetite, it is difficult to develop a universal definition as to what is a lack of desire versus an acceptable desire. It appears there is a great deal of variation in sexual desire within and between individuals, and partners are rarely in sync when sexual desire is experienced (Weeks & Gambescia, 2002). The 2000 edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV-TR) (American Psychiatric Association, 2000) delineates three criteria for the diagnosis of HSDD: 1) deficiency or absence of sexual fantasies and desire for sexual activity; 2) the disorder produces marked personal or interpersonal distress; and 3) the condition must not be a result of another disorder (except another sexual dysfunction) or medications or substance abuse. Therefore, when there is a deficiency or absence of sexual fantasies and desire for sexual activity, as determined by the clinician, and it results in distress for the person or a relationship, HSDD may have occurred. Medical causes or use of certain drugs must be excluded before the diagnosis of HSDD can be made. HSDD can be categorized as lifelong, from puberty forward, or acquired, when a person felt sexual desire in the past, but lost, or had a notable decline in, desire. It may also manifest as situational - there are selective situations in which desire is reduced - or global - a person does not feel desire in any circumstances (Weeks & Gambescia, 2002).

The literature indicates general agreement that disorders of low sexual desire are probably the most common sexual dysfunction and complaint brought to sex therapists (Kaplan, 1985; Laumann et al., 1999; Weeks & Gambescia, 2002). In a U.S. study of over 1,600 women and 1,200 men, Laumann et

al. (1999) found prevalence of low sexual desire to be about 33% of women and 15% of men. Segraves and Segraves (1991) estimated that 40% to 50% of couples seeing a clinician in sexual practice complain of insufficient sexual desire in one or both partners.

In addition, the problem appears to be present worldwide. Agmo, Turi, Ellingsen, and Kasperson (2004) summarized studies that report prevalence of the condition in other countries to range from 11% to 37% among women and 3% to 25% among men. The First Latin American Erectile Dysfunction Consensus meeting reported difficulties in desire to be common among men and women in Latin America (Reporters, 2003). Laumann et al. (2005) used The Global Study of Sexual Attitudes and Behaviors to investigate health status, as well as attitudes, beliefs, behaviors, and satisfaction regarding sex and relationships among middle-aged and older adults in 29 countries. Researchers observed many effects that were significant only in certain regions of the world, yet their results clearly indicated that dysfunctions of low sexual desire are prevalent in both men and women throughout the world.

Though researchers continue to study HSDD, lack of methodological rigor in studies of sexual dysfunction is considered a barrier to fully understanding the disorder. Simons and Carey (2001) reviewed 52 studies conducted between 1990 and 2000 that provided data regarding the prevalence of sexual dysfunction; however, they caution that methodological concerns limit the confidence that can be placed in the findings.

Historical Perspective

Despite the obvious current importance placed on sexual performance, as evidenced by the popularity of drugs to treat impotence, low sexual desire has not always been viewed as a problem that needed to be resolved. Agmo et al. (2004) explored the cultural and societal influences on the slow emergence of HSDD as a recognized disorder. They postulated that, for centuries, sex was only legitimate when performed for procreation. If reproduction is the only acceptable purpose of sex, then desire is not particularly important; only when sex becomes recreational does desire emerge as an important consideration. In addition, if sex outside of procreation is considered a sin, as it was and is within some belief systems, then low or absent sexual desire could be considered a virtue. In fact, hyperactive sexual desire has been punished throughout the centuries – sometimes as a religious infraction and other times as a legal infraction There was a time when the penalty for sexual assault was castration. Within such a value system, there is little drive to recognize low sexual desire as a condition that needs to be treated or resolved – on the contrary, it would be revered. Agmo et al. (2004) contend that the recent shift in attitude toward acknowledgement of HSDD, and thus the interest in treating it as a legitimate disorder, is indicative of a shift in cultural norms and attitudes toward and acceptance of sexuality.

Deficiencies in sex drive, according to Kaplan (1985), were not acknowledged until around 1980, and prior to this date were included under diagnoses of impotence and frigidity. Kaplan initially labeled physiologically generated low desire as hypoactive sexual desire and psychologically caused low desire as inhibited sexual desire. The syndrome name did not appear in the mainstream literature until the term inhibited sexual desire (ISD) became an official diagnosis in the Diagnostic and Statistical Manual III (DSM-III) (American Psychiatric Association, 1980) and was described as a "persistent and pervasive inhibition of sexual desire" (p. 278). In 1987, the DSM-III-R (American Psychiatric Association, 1987) included the term hypoactive sexual desire disorder to describe a person's low sexual desire, thus this term has been relatively consistently applied to the disorder, since that time.

Etiology of HSDD

Various methods have been used to classify HSDD. Weeks and Gambescia (2002) categorized etiology risk factors of HSDD as Psychological, Interactional, and Intergenerational. Psychological risk factors include anxiety, lifestyle changes, negative feelings about self and partner, sexual ignorance and mythology, poor body image, a lack of affection and sex, career overload, stress and anxiety, poor communication in the relationship, and partner sexual problems (Corona et al., 2004;Trudel et al., 2001; Walsh & Berman, 2004; Weeks & Gambescia, 2002) . Interactional risk factors might include the partner factor in which people try to fix a problem themselves resulting in a slow and gradual decrease in intimacy. Common fears of intimacy include fear of anger, fear of performance, fear of struggles over power and control, and fear of rejection and abandonment (Weeks & Gambescia, 2002). Renshaw (2001) notes that both anger and guilt in a relationship markedly decrease sexual desire. These issues can become particularly problematic when combined with poor communication skills between partners (Corona et al., 2005; Renshaw, 2001). Intergenerational risks may include sexual secrecy, sexual ignorance, sexual trauma, depression, anxiety, and acceptance; these can all interfere with sexual desire (Weeks & Gambescia, 2002).

Biological or physical causes can also lead to reduced sexual desire. Ullery, Millner, and Willingham (2002) suggested investigating the following physical aspects: central nervous system, neurotransmitters, medications, hormones, and chronic illness. Diseases or conditions that may be associated with reduced sex drive include stroke, hypertension, chronic renal dialysis, heart disease, chronic pain, endometriosis, hormonal or metabolic abnormalities, various forms of cancer, AIDS, alcoholism, and clinical depression (Corona et al., 2004; Henry & McNab, 2003; Renshaw, 2001; Walsh & Berman, 2004; Warnock, 2002). Often, the medications used to address these physical problems are implicated in lack of sexual desire. Though many have been identified as causing sexual dysfunction, the drugs most commonly cited are antihypertensives,

antidepressants, anticonvulsives, neuroleptics and sedatives, and antipsychotics (Reporters, 2003).

The factors that influence sexual desire have been found to differ between women and men. In general, low sexual desire is more common in women than in men, though it is considered significant in both sexes; aging is associated with loss of sexual desire in both men and women, though for different reasons (Agmo et al., 2004; Laumann et al., 1999; Mueleman & Lankveld, 2005). According to Regan and Bercheid (1996), male sexual desire appears more constant and genitally focused, whereas women appear to be more variable in their levels of sexual desire and influenced, to a greater degree, by social and interpersonal factors.

Women are often more likely to experience reduced sexual desire on the basis of motivational and relational factors; their sexual response frequently arises from relationship factors and intimacy needs rather than biological needs (Hurlbert, 1993; Warnock, 2002). For women, sexual desire may be a response, stemming from psychological-based rewards and values, such as the desire for closeness and tenderness, or trust and comfort in relationships (Regan and Bercheid, 1996; Warnock, 2002). Premenopausal women with HSDD usually have psychogenic (stress and depression) causes, while older women have organic causes such as estrogen or testosterone insufficiency, which can increase psychogenic causes (Weeks & Gambescia, 2002). A lack of estrogen in postmenopausal women may also contribute to reduced vaginal lubrication making intercourse uncomfortable or painful, thus reducing interest in sexual behavior (Henry & McNab, 2003).

For men, loss of sexual desire is often linked to sexual performance and sexual dysfunction, such as erectile dysfunction, premature ejaculation, and anorgasmia (Corona et al., 2004; Renshaw, 2001). Many studies of HSDD in men have explored its relationship with hormone levels and chronic disease, though some acknowledge the likely presence of psychological causes as well. It is generally agreed that HSDD is one of the most difficult sexual disorders to treat in men, and that HSDD is often misdiagnosed as erectile dysfunction; therefore, it is not always treated appropriately (Carson, 2002; Meulemann & Lankveld, 2005). In addition, the impact of chronic disease, and the associated medications, on sexual desire may preclude the satisfactory treatment of HSDD.

It is clear that HSDD is a complex disorder, one for which a clear and distinct etiology has not yet been determined. As a result of the various causes cited, people with HSDD lose the ability to show affection and ultimately reduce or eliminate sexual activity. The literature reports a strong association between sexual dysfunction and impaired quality of life (Carson, 2002; Laumann et al., 1999); thus, it is important that the problem be addressed.

Assessment and Treatment

The complexity of the issue of HSDD, the lack of tested theory, the sensitivity of and lack of discourse about the topic, the intricate physiological and psychological factors, and the lack of a universal diagnostic tool make HSDD particularly difficult to assess and treat. Warnock (2002) suggests that providers must assess the complex interplay of biological, psychosocial, interpersonal, cultural, and environmental factors that may contribute to HSDD. Most authors recommend multidimensional assessment, including a comprehensive medical evaluation: a psychosexual and physical evaluation to differentiate between organic and psychosocial causes, a sex history, a medical exam, a self-report questionnaire, an evaluation of relationships, treatment strategies involving behavioral and/or psychological strategies, and sex therapy specific for the dysfunction (Beck, 1995; Walsh & Berman, 2004; Warnock, 2002). A medical evaluation of hormonal deficiencies in concert with psychological risk factors also is a common approach.Currently, there is no single instrument with which to assess HSDD, though recently, instruments have been developed that offer the possibility of standardized assessment. The Hurlbert Index of Sexual Desire (Hulbert, 1993) is a 25-item self report scale that has been demonstrated to have good validity and internal consistency. The Sexual Desire Inventory, developed by Spector, Carey, and Steinberg (1996), is a 14-item scale to assess sexual desire as an experiential construct separate from overt behavior. Initial research revealed adequate internal consistency and discriminant validity to warrant further scale development (Beck, 1995). Meston (2003) reported the Female Sexual Function Index (FSFI) to be a reliable and valid measure of sexual functioning for women with HSDD. The emergence of new instruments, as well as further research using existing instruments to assess HSDD, suggests that there is increasing interest in and need for standardization of the evaluation of sexual desire.

After a thorough medical evaluation of physical and psychological factors and assessment to confirm the diagnosis of HSDD, treatment of HSDD, like most other sexual dysfunctions, may involve various alternatives. In the past, research into medical approaches has dominated the literature in the treatment of HSDD (Ullery et al., 2002). If an underlying biological cause is identified, treatment to correct or control progression of the medical condition is appropriate. Drug therapies are often utilized in such cases. For example, patients might be prescribed drugs to alter brain chemicals, control symptoms of menopause, alleviate depression, or balance hormones. Conversely, should medications be suspected of contributing to sexual dysfunction, the drug should be discontinued or an alternative medication prescribed. However, while medical solutions may correct for physical or biological anomalies, other contributing factors must be considered for complete resolution of symptoms (Ullery et al., 2002; Walsh & Berman, 2004)

If the cause is determined to be primarily psychological in nature, a multidimensional therapeutic approach is generally recommended. Many of the non-medical treatments for HSDD have not been extensively researched, and most studies have been grounded in clinical observations and

case studies rather than rigorous empirical design (Ullrey et al., 2002; Trudel et al., 2001). Beck (1995) reviewed controlled studies that involved psychological treatments, and found that most focused on traditional sex therapy, based on the Masters and Johnson (1966) program. This approach may include sex education, nongenital and genital pleasuring, communication training, and interventions to reduce performance anxiety. Both partners are usually involved in the treatment process, which involves addressing any psychological issues that may be involved before moving on to the physical aspects of sexual intercourse.

Weeks and Gambescia (2002) noted most clients present a lack of desire but want to feel desire. Often, HSDD may be the result of deliberate withholding or selective disinterest, and abstinence from sex may be seen as normal behavior (Renshaw, 2001). In such cases, HSDD cannot be cured unless the maladaptive behavior responsible for the sexual impairment is corrected (Kaplan, 1985). On the other hand, HSDD can lead to, or be the result of, anxiety and anger, and may result in the end of a relationship. Obviously, treatment must be individualized to address the many biological, psychological, and psychosocial factors that may be inhibiting sexual desire in an individual and a relationship.

The difficulty in resolving HSDD was addressed by Kaplan (1985) when she stated "Sex therapy is not a simple task. It is a complex amalgam of individual and couple therapy, of behavioral and psychodynamic therapy, and of systems analysis. Hypoactive Sexual Desire is an important symptom indicating that the system is malfunctioning" (p.75). Weeks and Gambescia (2002) stated "the treatment of this disorder is remarkably challenging, complex, and lengthy compared to other sexual dysfunctions" (p.1). Renshaw (2001) reflected on both sides of the treatment issue in stating that, on the one hand, brief therapy for some has been effective in reversing HSDD, and on the other hand, "it is not possible to shake sexual desire from someone like pennies from a piggy bank—each can only change the self" (p.13).Because many men and women consider sexual activity as a barometer of their relationship (Renshaw 2001), resolving HSDD may be a major factor in the overall success of a relationship.

The Role of the Health Educator

HSDD, or loss of sexual desire for sexual activity, is one of the most common sexual dysfunctions of men and women in the U.S. As with most of the common, lifestyle-related illnesses experienced today, many sexuality problems can be avoided, mitigated, or treated through education and clinical interventions. Many of the treatments noted in the previous section require special clinical training or medical licensure; however, health educators have and will continue to encounter clients with HSDD. Most recently, researchers and practitioners have broadened their concept of causality and are more apt to recommend a combination of medical and psychotherapeutic approaches. Though not based on outcome studies, some observational reports indicate that integrated, multi-elemental treatment programs may hold promise for HSDD. This has opened more possibilities for treatment and expanded the field to include a broader scope of health practitioners, including health educators, that may be able to help those suffering with HSDD.

Clients often will not reveal sexual problems unless explicitly invited; health educators must always be alert to both verbal and non-verbal feedback from clients to allow them to most effectively respond to all potential needs. If HSDD is suspected, health educators can discuss the etiology of the condition and recommend a response strategy specific to the circumstances and needs of the individual. Health educators should first consider referral and consultation with a physician to determine if there are any biological impacts on sexual functioning. This can be particularly pertinent for a person with pre-existing medical conditions including menopause, depression or anxiety, or some chronic illnesses (Ullery et al., 2002). Carson (2002) noted this may be particularly important for men, as in the U.S., men make approximately 150 million fewer physician visits than women, especially when the topic pertains to sexual dysfunctions. Explanations as to what would take place in visiting a sex therapist including accessibility, location, fees, and possible examinations should be part of instruction on HSDD. In addition, often HSDD is associated with other sexual dysfunctions; therefore, comfort in accessing qualified sex therapists is of paramount importance in addressing these sexual health issues. It is important to inform clients that medical solutions may correct physical problems, but other contributing factors must still be addressed for a more complete amelioration of symptoms.

After addressing any physiological bases for HSDD, the client should be encouraged to pursue appropriate psychotherapeutic approaches. Among the factors cited as contributing to HSDD that would be within the province of the health educator to effectively address are: lack of public education on sexual health, myths regarding sexuality, and insufficient sexological knowledge of health-care providers (Meuleman & Lankveld, 2005); as well as self-esteem, body image, quality of interpersonal relationships with a partner, and anxiety or stress (Reporters, 2003). It is important for health educators to recognize that their role will be as one member of an integrative treatment team approach; methods and techniques should match their training and level of competence, and should be guided by the specific needs of the individual, relative to the underlying causes of the disorder.

While health educators may not be licensed therapists or counselors, they are well prepared to address a number of the underlying contributors to HSDD as a member of a multidisciplinary HSDD response team. Using the National Health Educator Competencies as a framework, a number of ways can be identified in which the health educator can support the function of a multidisciplinary patient care team, as well as assist individual clients to address HSDD (Section III, 2006) (see Table 1). In addition, there are some strategies that can be delivered by health educators to address specific factors contributing to HSDD, particularly relating to the

Table 1

The Role of the Health Educator in HSDD Response

Competency area	Health educator actions for HSDD clients
Area I: Assess Individual and Community Needs for Health Education	• Identify valid client reference sources of information (print, on-line, etc.) (see Figure 1) • Identify available resources and providers • Clarify and advocate for the role of the Health Educator as valid member of a multidisciplinary (MD) client response team • Assist in establishing provider networks • As member of MD team, identify appropriate health education needs of individual clients
Area II: Plan Health Education Strategies, Interventions, and Programs	• Using current research, identify appropriate health education interventions • Clarify for MD team how health education can be effectively integrated into the treatment plan • As member of MD team, design health education strategies specific to identified needs of individual clients
Area III: Implement Health Education Strategies, Interventions, and Programs	• As member of MD team, conduct individually tailored health education programs (e.g. sexuality education, relationship communication skills, conflict management, stress management, body image, etc.)
Area IV: Conduct Evaluation and Research Related to Health Education	• Design/concuct/analyze process, impact, and outcome evaluations for all health education strategies, consistent with client objectives as developed by the MD team • Prepare and submit on-going evaluation results to MD team and appropriate administrators
Area V: Administer Health Education Strategies, Interventions, and Programs	• Assist in developing effective feedback mechanisms for MD team communication • Promote cooperation among all MD team members
Area VI: Serve as a Health Education Resource Person	• Serve as MD team resource person for valid information regarding HSDD • Develop and maintain valid resource information systems for clients and providers • Provide team-building training for providers • Develop and provide health care provider training in MD response to HSDD
Area VII: Communicate and Advocate for Health and Health Education	• Continually advocate for inclusion of the health educator in MD team response to HSDD • Continually advocate for comprehensive sexuality education throughout the lifespan

Note. Based on Section III: The CUP Model (2006). In *A Competency-Based Framework for Health Educators*. Washington, DC: American Association for Health Education, National Commission for Health Education Credentialing, Society for Public Health Education.

psychosocial arena – these can be viewed both from the perspective of patient education as well as methods of primary prevention.

Mental health and stress are thought to influence sexual function (Laumann et al., 2005; Reporters, 2003; Trudel et al., 2001). Classes or individual sessions in stress management can assist the client in dealing with specific individual sources

- American Academy of Clinical Sexologists. 1929 18th Street NW, Suite 1166, Washington, DC 20009. (202) 462-2122. www.aacpsy.org/
- American Association for Marriage and Family Therapy. 112 South Alfred Street, Alexandria, VA 22314-3061. (703) 838-9808. www.aamft.org/index_nm.asp
- American Association of Sex Educators, Counselors & Therapists. American Association of Sexuality Educators Counselors & Therapists (AASECT). All rights reserved. AASECT P.O.Box 1960, Ashland, VA 23005-1960. (804) 752-0026. www.aasect.org/
- American Psychiatric Association. 1000 Wilson Boulevard, Suite 1825, Arlington, Va. 22209-3901. (703) 907-7300. www.psych.org/
- Community Health Care. *CHC Medical Library and Patient Education: Sexual Dysfunction.* Available at http://www.chclibrary.org/micromed/00065030.html
- Weeks, G. R., & Gambescia, N., (2002). *Hypoactive sexual desire: Integrating sex and couple therapy*. New York: WW. Norton Co. Inc.

Figure 1. Sources of information and treatment of sexual dysfunctions.

of stress, either life stress in general, or stress related to relationships and the presence of HSDD. Offering classes in body-image, self-esteem, and positive self-talk can help clients deal with these issues, found to be associated with HSDD, particularly in women (Reporters, 2003; Trudel et al., 2001). Many sources cite interpersonal, or relationship, issues as contributing to HSDD (e.g. Corona et al., 2005; Laumann et al., 2005; Reporters, 2003; Trudel et al., 2001). A common topic in sexuality education is relationships; most health educators, particularly sexuality educators, are well-prepared to offer sessions in this area. Based on the literature, among the topics that would be particularly relevant for HSDD patients are: interpersonal communications; communicating sexual needs/desires with a partner; conflict resolution; promoting intimacy; and behavior modification/cognitive restructuring. The importance of communication in relationships (McNab, 1997) to reduce anger and guilt in concert with organic causes of HSSD should be emphasized, with the objective of helping individuals understand unresolved anger and conflict as a predominant cause of HSDD. Because conflict is going to occur in relationships and is often related to HSDD (Kaplan, 1985), health educators can address this topic by describing how to resolve anger and conflict issues and how to address HSDD from a primary, secondary and tertiary level. There are numerous resources for designing and implementing effective sexuality education strategies for strengthening relationships. For example, McNab and Henry (2005) describe role playing exercises health educators can use that allow individuals to describe specific sexual dysfunctions, to address them with a partner, and how to locate and discuss the dysfunction with a sex therapist.

Consistent with the philosophical foundation of health education would be to take a prevention or health promotion approach to HSDD. Meuleman and Lankveld (2005) called for improved public education, health care provider education, and education regarding the myths of sexuality; these are all health promotion/prevention-focused strategies. Because satisfactory sexual functioning is an important aspect of most people's lives, sexuality and, specifically, sexual dysfunctions, are topics that should be part of a comprehensive health promotion program throughout the life span (Henry & McNab, 2003). Unfortunately, sexual dysfunctions are often seen as taboo subjects; however, if not addressed, they can negatively affect quality of life. Health educators can educate individuals on what HSDD and other sexual dysfunctions are, how to address the topic, and where individuals and partners can go to access and receive additional information and treatment. Instruction should include physical, emotional, and interpersonal factors that may affect sexual desire, sexual activity, and one's overall sexual health. Because many men and women consider sexual relations a barometer of their relationship (Renshaw, 2001), discussions pertaining to what sex means to each partner and what message sexual avoidance conveys to a partner can be addressed in classroom and community discussions, from a health promotion perspective. Coverage of other sexual dysfunctions should also be included, in conjunction with HSDD, so that individuals understand that most people, at some time in their lifetime, will experience some type of sexual dysfunction, but that these dysfunctions can be addressed and, in most cases, resolved in a positive manner.

A key part of the health educator's efforts should include activities relevant to overcoming fears in discussing and seeking help and providing the means to access competent certified sex therapists (McNab & Henry, 2005). Learning how to access professional resources that address sexual dysfunctions, including HSDD, such as the American Association of Sex Educators, Counselors, and Therapists is an important part of promoting positive sexuality throughout the lifespan. Figure 1 provides a listing of such resources.

Summary

It is clear from the overwhelming popularity of drugs to alleviate erectile dysfunction that there is a high level of interest in maintaining active, positive sexual relationships.

Having healthy sexual relationships is an important factor in many people's qua l ity of life. Unfortunately, approximately one-fifth of men and one-third of women in the U.S. experience HSDD, a condition that may contribute to reduced quality of relationships, and, subsequently, reduced quality of life. Because HSDD is viewed as a complex disorder, generally possessing both physiological and psychological aspects, a multifaceted, multidisciplinary approach to treatment is recommended. Treatment should begin by medical personnel first ruling out medical or drug reasons for the disorder. After determining and initiating treatment for any underlying medical conditions, the HSDD patient should be referred to appropriate psychotherapeutic and behavioral therapists and educators, including psychologists, counselors, and health educators.

Uncompromised sexual desire requires a delicate balance between various biological and psychological systems. Consistent with the philosophical foundation of the profession of health education and health promotion, an appropriate response to the problem of HSDD would be to avidly advocate for and consistently deliver sexuality education programs that comprehensively address the broad range of topics that support sexual health across the lifespan, including aspects of dysfunction. Health educators can contribute to the resolution of HSDD in their clients through their expertise, further education, specialized training, referral, consultation, and on-going participation in research.

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TIME CAPSULE

Where will you be in 40 years?
Where will ESG be in 40 years?
This is your chance to share a bit of history with future Gammans.

Eta Sigma Gamma chapters are encouraged to submit artifacts to be placed in a time capsule. The capsule will be opened in 2047, on the 80th anniversary of Eta Sigma Gamma.

Send your chapter's artifacts to:
Eta Sigma Gamma, Alpha Alpha Chapter
Attention: Time Capsule
Southern Illinois University
307 Pulliam Hall
Carbondale, IL 62901

Deadline to submit artifacts: December 8, 2006