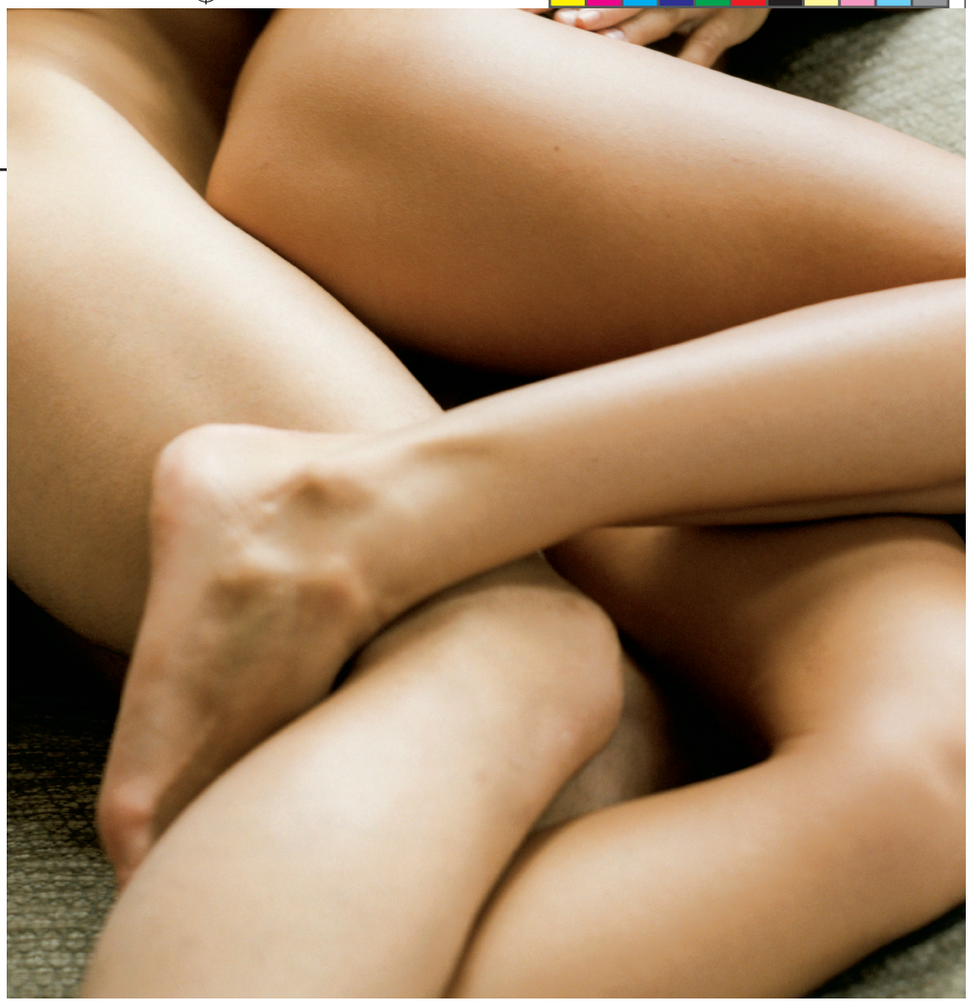
Low libido



Natural aphrodisiacs are an attractive option for many experiencing flagging libido — but do they work? **John Kron** examines the available evidence.

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Low libido is a lack of interest in sex that causes distress or interpersonal difficulty. A substantial number of men and women exhibit low libido, according to Australian[1,2] and overseas[3] surveys.

The 2001–2002 Australian Study in Health and Relationships found that 24.9 per cent of men and 54.8 per cent of women out of 19,307 respondents aged 16–59 years expressed a lack of interest in sex for one month or more during the previous 12 months.[1] An earlier 1999–2000 Australian survey of 1784 respondents aged 18–59 years found that 8.7 per cent of men and 17.7 per cent of women reported a lack of interest in sex for a period of several months or more during the previous 12 months.[2]

The cause of low libido in the majority of cases is multifactorial, involving an interplay of psychological, social and physical factors, according to Dr Sue Reddish, medical centre director at The Jean Hailes Foundation in Melbourne. These factors include:

- interpersonal issues, such as reduced physical attractiveness of the patient or partner, boring sexual routines and marital-adjustment problems[4]
- medical conditions, such as depression, diabetes, hypertension and hypothyroidism[4]
- use of medications, such as SSRIs, some antihypertensives, the oral contraceptive pill and corticosteroids[4]
- hormonal changes, particularly in testosterone and oestrogen levels[4]
- desire discrepancy, where the differing desire levels of partners may affect the relationship. This may arise from different personalities or sexual styles of each member, or a poor relationship. It is usually treated with relationship and sexual counselling.

Low libido due to unknown causes is termed hypoactive sexual desire disorder. The *DSM–IV* defines this as a persistent or recurrent absence or deficiency of sexual fantasies and desire for sexual activity that is not caused by a mental-health or medical condition or drug.[5]

Management involves first treating any known underlying medical or other causes, and providing treatments that directly enhance the patient's libido. This article focuses on treatments that directly enhance libido in otherwise healthy individuals; underlying medical causes of low libido (e.g. diabetes and depression) are beyond its scope.

Herbal and nutritional medicine

Some commonly prescribed herbs for low libido — including horny goat weed (*Epimedium sagittatum*), tribulus

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SUMMARY

- Low libido, defined as a lack of interest in sex that causes distress or interpersonal difficulty, is a common problem. It is usually due to a combination of psychological and physical factors, but in a minority of cases the causes are unknown
- Management involves treating known underlying causes. Conventional treatment involves hormone therapy, medications such as Viagra and psychological and relaxation techniques
- Complementary therapies patients may try include herbal and nutritional supplements, traditional Chinese medicine, homeopathy, yoga, sex therapy and psychological treatment
- Hormone therapy has highest level of evidence for efficacy, followed by sex therapy and herbal medicines. Other treatments have little or no supporting evidence

(*Tribulus terrestis*), saw palmetto (*Serenoa repens, Sabal serrulata*), maca (*Lepidium meyenii)*, shatavari (*Asparagus racemosus*), holy basil (*Ocimum sanctum*) and shilajit (Asphaltum; mineral pitch) — do not have studies investigating efficacy.

However, several review articles have found a small number of studies provide supporting evidence for the efficacy of the following herbs and nutritional preparations[6,7] — see also 'Libidinal herbarium' table, above.

Ginkgo biloba achieved increased libido in a 1998 uncontrolled study of 63 men and women exhibiting sexual dysfunction associated with SSRI use.[8]

Ginkgo biloba and **muira puama** (*Ptychopetalum olacoides*), in a product

Libidinal herbarium[6,21]

Ginkgo leaf *(Ginkgo biloba)*	**Actions and indications —** reduces compromised circulation, especially associated with antidepressant use **Dosage** — commence with 60 mg standardised extract (or 9–10 g dried herb equivalent) bd or tds — over 2 weeks increase to 120 mg bd — maintain for 4 months **Side-effects** — GI disturbances, headaches, allergic skin reactions, increased CNS stimulation, increased potential for bruising **Precautions/adverse reactions** — taking more than 240 mg/day may cause dermatitis, diarrhoea, and vomiting **Interacts** adversely with some MAOIs **Contraindications** — concomitant anticoagulants or other blood-thinning medications
Ginseng root *(Panax ginseng)*	**Actions and indications** — tonic herb with aphrodisiac reputation, particularly in men. Directly induces vasodilation and relaxation of penile corpus cavernosum **Dosage** — 1–3 g/day dried herb equivalent for several weeks or months **Side-effects** — insomnia, dermatitis, GI disturbances **Precautions/adverse reactions** — people allergic to Araliaceae-family plants should avoid ginseng **Contraindications** — acute inflammatory disease and bronchitis
Damiana leaf *(Turnera diffusa)*	**Actions and indications** — hormonal effect; contains alkaloids that are mildly testosteronic **Dosage** — 2–4 g dried herb equivalent tds **Side-effects** — headache, digestive stress **Precautions/adverse reactions** — potential for hepatic or renal toxicity due to low levels of cyanide-like compounds **Contraindications** — none known
Puncture vine leaf *(Tribulus terrestris)*	**Actions and indications** — hormonal effect; contains alkaloids that are mildly testosteronic. Releases nitric oxide from endothelial cells (similar action to sildenafil) **Dosage** — 2–30 g/day dried herb equivalent in several-week cycles **Side-effects** — GI disturbances **Precautions/adverse reactions** — potential to act as a diuretic **Contraindications** — none known

called Herbal vX (SwissHealth, London), were studied in 202 healthy women with low sex drive. A self-assessment questionnaire after one month found higher average total scores in 65 per cent of the women.[9]

Muira puama alone was investigated in a clinical study in 262 men reporting loss of sexual desire, and more than 60 per cent indicated an improvement over pre-trial levels.[10]

Panax ginseng achieved improvements in libido in an uncontrolled trial of 63 men and women exhibiting antidepressant-induced sexual dysfunction[11] and increased levels of hormones, such as testosterone, in a controlled study of 66 age-matched men.[12]

A 2001 double-blind RCT of 34 women taking ArginMax (Daily Wellness Co., Silicon Valley, US), a product including **L–arginine** (an amino acid that relaxes smooth muscle), **damiana** (*Turnera aphrodisiaca*), *Panax ginseng* and *Ginkgo biloba,* found 'notable improvements' in sexual desire, with no significant side-effects.[13]

A study of 25 diabetic males with erectile dysfunction taking a Thai herbal preparation called Mustong, primarily containing **velvet bean** (*Mucana pruriens*) and **winter cherry** (*Withania somnifera*), found an increased desire to have sexual intercourse, among other findings, including strong erection, hardness and increased duration of coitus.[14]

Traditional Chinese medicine

Low libido is regarded as sharing the same aetiology and pathogenesis as impotence and menopausal symptoms in traditional Chinese medicine (TCM), says Dr Jing Cui, Chinese Herbal Medicine Coordinator at RMIT's Division of Chinese Medicine.

The most common causes are kidney deficiencies, including *yang* (warming energy) and *yin* (cooling energy) deficiencies. Another common cause is a *qi* (vital energy) and blood deficiency associated with stress.

Commonly used acupuncture points include Qi Hai (CV6), Guan Yuan (CV4), Shen Shu (Bl23) and San Yin Jiao (Sp6).

Chinese herbal formulations prepared for OTC use for low libido include Shen Qi Wan for kidney *yang* deficiency, Liu Wei Di Huang Wan for kidney *yin* deficiency and Ba Zhen Wan for *qi* and blood deficiency, Dr Cui says. A further 20 to 30 Chinese herbal preparations are available for treating kidney *yang* and *yin* deficiency, she adds.

There is a paucity of controlled trials on TCM for low libido. A pilot study of acupuncture for 15 women exhibiting menopausal symptoms and taking tamoxifen found no changes to libido.[15]

Homeopathy

'There are approximately 250 listed homeopathic remedies for low libido, but only a few are likely to have any useful effect in any one patient,' says Dr Nick Goodman, a Sydney GP who uses homeopathy in his clinical encounters.

'A detailed history and presenting symptoms will help identify the causative factors and symptoms to guide the choice of the most appropriate treatment,' he explains. 'The guiding symptoms are often the less common symptoms that occur in association with a particular condition or symptoms that fall within the curative power of only a few remedies,' he adds.

'For example, stress is commonly associated with low libido, however stress isn't specific enough to indicate the appropriate remedy. The peculiarities of what stresses this patient and what other symptoms the patient develops in association with low libido may prove more helpful for selecting particular homeopathic remedies.'

There is currently no supporting high-quality research evidence for homeopathic treatments for low libido.

Yoga

Some people relate yoga and sexuality to Tantric yoga (exercises to sublimate and regulate sexual energy for spiritual enlightenment) and the *Kamasutra*. However, Hatha yoga is the preferred style for improving libido, says Janet Lowndes, psychologist and yoga teacher at Melbourne's Jean Hailes Foundation.

'Hatha yoga refers to the traditional system of well-being that focuses on body, breath and mind and emphasises mindfulness and meditation as well as physical postures,' she says.

'The aim is to bring awareness into the connection between the body and mind and this positive relationship can have a very powerful effect on libido.

'Many people have a dissociative relationship between their body and mind — that is, they see the two as separate and often in conflict,' says Ms Lowndes, 'For some of us the only sense we have of our body is a negative one, seeing the body as an obstacle — for example, berating ourselves about our body image or weight. When this happens it is hard to feel positive about our bodies sexually,' she says.

'Enhancing the connection between the body and mind enables us to feel good about ourselves and our bodies, making it more likely that we may want to share our bodies intimately with someone else.'

There is no high-quality research specifically on yoga for low libido, says Ms Lowndes.

Psychological treatment

Scant research has investigated psychological treatments for low libido, including relationship counselling, cognitive behavioural therapy, stress management and relaxation training.

'Low libido is a highly complex issue and an individual assessment needs to be made of the many contributing psychological factors,' says Ms Lowndes.

'In the majority of cases, the main factors will be behavioural and relationship problems, such as not making time for intimacy a priority, or how one person feels about their partner,' she says. 'Problems such as previous sexual abuse are less common.'

Sex therapy

A 1995 review of research on sex therapy for hypoactive sexual desire disorder found seven controlled studies. Most focused on traditional Masters and Johnson sex therapy, which includes sex education, non-genital and genital pleasuring,

Hormone balancing

There is good evidence that hormone therapy can improve low libido in both men and women.[17]

A Cochrane review of testosterone therapy for older men found improvements in libido, among other benefits, for men with low testosterone levels in three studies, although the authors conceded that 'longer term (beyond three years) efficacy and safety are unknown'.[18]

A review of management options for menopausal women with low libido noted that hormone therapies may be an option, but it is unlikely that hormones alone will help unless other contributing issues (psychological, relationships, stress and lifestyle) are also addressed.[19]

Dr Reddish says oestrogen therapy (and progesterone, unless there has been a hysterectomy) using natural oestrogens locally or transdermally is the first line of treatment in postmenopausal women with no contraindications; testosterone may be added if testosterone levels are low.

Bio-identical hormones: for and against

Sydney compounding pharmacist Richard Stenlake recommends prescribing non-synthetic medications and therapy for a larger number of hormones (including DHEA, oestradiol, testosterone, oestrogen and progesterone), 'where the aim of treatment is to achieve a balance of hormones in their normal ranges'.

There is some supporting evidence for this approach. A 2005 Dutch review concluded that 'in female patients with adrenal insufficiency, treatment with DHEA replacement doses of 20 to 50 mg results in improvements in mood, quality of life and libido'.[20]

Mr Stenlake says the specific hormones and dosages prescribed are determined by each patient's history and blood tests.

For women, the hormone therapy can include progesterone, oestradiol and/or DHEA as well as testosterone. An oral compound is prescribed twice daily for 6–8 weeks, followed by a reassessment and blood tests.

For men, testosterone alone is usually prescribed, though in some cases an aromatase inhibitor to block conversion of testosterone into oestradiol may be required. An oral compound is prescribed for 6–8 weeks, followed by a reassessment and blood tests.

'Once hormone levels reach normal, the medications should be continued for postmenopausal women and post-andropausal [male equivalent of postmenopausal] men because their bodies are unable to maintain normal levels,' says Mr Stenlake.

However, Dr Reddish has reservations about the use of bio-identical hormones.

'These preparations are the same hormones given in a different way and are no more natural or bio-identical than many prescribed hormone therapies,' says Dr Reddish.

'There is inadequate safety data available and they are currently being investigated because of reported adverse side-effects including stroke, thrombosis and endometrial cancer,' she says. 'In addition, DHEA is not approved for use in Australia by the TGA and is, in fact, banned for importation.'

Dr Reddish also points to inadequacies of blood tests for determining hormone levels 'due to significant fluctuations in a woman's cycle and the inaccuracy of available laboratory assays'.

'Any form of hormone therapy should only be used for as long as is necessary to relieve symptoms and where the benefits outweigh the risks,' she adds.

communication training and interventions to reduce performance anxiety.[16]

The controlled groups received treatments such as marital therapy, relaxation training and hormone therapy, or sex therapy combined with one of the latter. The review concluded that the studies revealed mixed results due to methodological flaws, but it appeared that sex therapy combined with other treatments achieved the most significant improvements.

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