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Expanding the Analysis of Psychosocial Factors of Sexual Desire in Men

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ABSTRACT

Background: The literature lacks studies of the male sex drive. Most existing studies have focused on hypoactive sexual desire disorder in coupled heterosexual men, highlighting some of the main related biological, psychological, and social factors.

Aim: To evaluate the role of selected psychological and social variables affecting male sexual desire such as quality of life, sexual function, distress, satisfaction, psychological symptoms, emotions, alexithymia, couple adjustment, sexism, cognitive schemas activated in a sexual context, sexual dysfunctional beliefs, and different classes of cognitions triggered during sexual activity about failure anticipation, erection concerns, age- and body-related thoughts, erotic fantasies, and negative attitudes toward sexuality.

Methods: A wide self-administered survey used snowball sampling to reach 298 heterosexual Italian men (age = 32.66 ± 11.52 years) from the general population.

Outcomes: 13 questionnaires exploring psychological and social elements involved in sexual response were administrated: International Index of Erectile Function, Short Form 36 for Quality of Life, Beck Depression Inventory—II, Symptom Check List—90—Revised, Toronto Alexithymia Scale, Premature Ejaculation Severity Index, Sexual Distress Scale, Sexual Satisfaction Scale, Dyadic Adjustment Scale, Ambivalent Sexism Inventory, Sexual Modes Questionnaire, Sexual Dysfunctional Belief Questionnaire, and Questionnaire of Cognitive Schema Activation in Sexual Context.

Results: Results showed lack of erotic thoughts ($\beta = -0.328$), fear ($\beta = -0.259$) and desire to have a baby ($\beta = -0.259$) as the main predictors of the level of sexual desire in this group. Energy-fatigue, depression, premature ejaculation severity, sexual distress, compatibility, subjective sexual response, and sexual conservatism had a weaker effect on sexual desire. Sexual functioning (13.80%), emotional response (12.70%), dysfunctional sexual beliefs (12.10%), and negative automatic thoughts (12.00%) had more variable effects on sexual drive.

Clinical Translation: Analyzed variables could represent important factors that should be considered in the assessment of desire concerns and discussed in therapy.

Strengths and Limitations: The strength of this study is the analysis of novel psychological and social factors on male sexual desire. Recruitment and sample size do not allow generalization of the results, but some crucial points for future research and clinical practice are discussed.

Conclusion: Our findings showed that male sexual desire could be affected by many psychological and social elements. Other factors remain to be explored, in their direct and interactive effects, aiming to better explain male sexual desire functioning. **Nimbi FM, Tripodi F, Rossi R, Simonelli C. Expanding the Analysis of Psychosocial Factors of Sexual Desire in Men. J Sex Med 2017;XX:XXX—XXX.**

Key Words: Desire; Sexual Behavior; Sexual Response; Sexuality; Sex Drive; Biopsychosocial Approach

INTRODUCTION

Sexual desire is frequently attributed to a subjective status (with psychological, physiologic, affective, and cognitive components) to motivate and initiate human sexual behavior. Desire is considered to be triggered by internal and/or external stimuli.[1—3] Levine[4—6] highlighted 3 biopsychosocial elements of desire: drive (a biological aspect including the anatomy and physiology of the neuroendocrine system), motivation (a psychological part including mental states, relational issues, and

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social context), and wish (a cultural element considering ideals, values, and rules for the expression of sexuality). More recently, desire has been closely associated with arousal, being described as "the predisposition to subjectively respond to sexual stimuli with feelings of sexual excitement."[7,8] The classification of male sexual dysfunctions in the *Diagnostic and Statistical Manual of Mental Disorders, 5th Edition* is based on Kaplan's linear model,[9,10] in which desire is described as a distinct phase preceding arousal and activating a sexual "chain reaction" response. Criticisms of this model state that it does not contemplate that male desire can be responsive and influenced by psychosocial factors such as sexual experiences.[11–14] The Fourth International Consultation on Sexual Medicine (ICSM)[15] strongly emphasized that hypoactive sexual desire disorder should be kept separate from arousal dysfunctions. Moreover, considering expert opinions and clinical principles, the ICSM gave a unisex definition of sexual interest-desire disorder as "persistent or recurrent deficiency or absence of sexual or erotic thoughts or fantasies and desire for sexual activity," showing how it is similar in men and women, with some etiologic and prevalence peculiarities. Future research should focus on supporting this definition and elucidating etiologies and prevalence and other characteristics.

The literature lacks studies on the male sex drive. Most existing studies have focused on hypoactive sexual desire disorder, mainly in coupled heterosexual men.[7,16–21] Fewer studies have investigated high-level sexual desire in different populations.[17,22–24]

The biopsychosocial model recognizes a complex interaction among internal cognitive processes, neurophysiologic mechanisms, and affective components in sexual desire.[13,25] Few studies have attempted to describe these relations with rudimentary models.[26,27] However, the current understanding of the specific factors influencing the nature of sexual desire in men is incomplete and remains to be explored.

Early studies identified hormonal factors that act as physiologic predictors of sex drive.[28–36] Recent guidelines[37] indicate that several hormones modulate or promote human sexual behavior, including drive and arousal. Although the literature corroborates the crucial role of testosterone and prolactin on desire,[38,39] results for other hormones are less clear. Hypothalamic neurohormones such as oxytocin and α-melanocyte–stimulating hormones are currently under active research for therapeutic purposes. Hormonal treatment can improve libido in hypogonadal and hyperprolactinemic men. Other evidence has shown that androgen deprivation therapy, which can be used as curative or palliative treatment in advanced prostate cancer, lowers libido.[40] Age and presence of organic disease have a negative effect on overall sexual response.[41–43] It is clear that biological factors play a central role in sexuality, but they are not enough to explain the human sexual response. In addition, it is very difficult to isolate the weight of physical components from their natural interaction with the psychosocial system.[2,16] For these reasons, an increasing importance of cognitive, emotional, relational, and sociocultural variables has been recognized.[44]

Among psychological factors, specific mood states can promote or inhibit sexual desire. Depression and anxiety have been mostly associated with low levels of desire.[16,45–47] However, some studies have found an increase in the level of sexual desire in association with altered mood tone.[23,48–51] Therefore, the mechanisms underlying the relation among anxiety, depression, and sexual interest remain unclear and not necessarily linear.[48]

Regarding emotional management, studies have reported conflicting results. Portuguese researchers have emphasized the centrality of emotions in the male sexual response.[52–54] Nonetheless, negative emotions related to sexual experience (eg, sadness, anger, and disillusionment) do not seem to have played a decisive role in male desire.[2] Sexual dysfunctions have been associated with a lack of positive affect rather than the presence of more negative emotions specific to sexual activity.[55] Alexithymia has been found to have an important impact on male sexuality, principally on arousal and orgasmic phases. A few studies have found a minor connection with hypoactive sexual desire disorder, despite the finding that alexithymia could decrease the ability to daydream and describe erotic thoughts.[56–59]

Distress and satisfaction about sexual activity are recognized as central elements of sexual functioning.[26,60,61] Positive and negative experiences have a direct effect on sexual behavior. Moreover, the presence of other sexual dysfunctions could have a negative effect on interest and overall sexual function.

The association with relational factors also is not clearly defined: sexual interest in men appears to be independent of couple dynamics, especially relational conflict.[62] In addition, the desire for tenderness and closeness with a partner seems to decrease with the length of a relationship, although sexual desire does not decrease.[63] The same trend was confirmed by Murray and Milhausen[64] in a study in which relationship duration was associated with a decrease of sexual activity only in women. Carvalheira et al[16] reported conflicting results: men who were married and cohabitating longer than 5 years, with higher education, work stress, and couple conflicts, presented lower levels of desire. More than relationship duration, dyadic satisfaction could have a role in determining sexual interest.[65] Ridley et al[66] reported that positive feelings such as trust, intimacy, and good communication can increase sexual desire.

The impact of cultural factors has been less studied: myths related to male sexual performance and sexual scripts (eg, hostile and benevolent sexism) have been examined primarily in relation to other sexual problems such as erectile dysfunction.[53,67–73] The most representative factor of low desire in men seems to be the "lack of erotic thoughts" during sexual activity.[2,52,74] Rigid thoughts about virility and a focus on erection and sexual performance foster an unrealistic expectation of male sexuality. Studies have shown that cognitive factors (beliefs related to