Exploring the 7 P's of Sexual Desire

A Screening Tool for Clinicians

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Introduction

Low sexual desire is one of the most common concerns voiced by clients across a range of clinical settings. While it may feel distressing or confusing to some, fluctuations in sexual desire are a normal part of the human experience. Desire is multidimensional – shaped by physical, emotional, relational, and sociocultural factors – and often shifts throughout a person's life in ways that can be temporary, developmentally expected, or indicative of deeper concerns that merit clinical attention (Mitchell, Wellings, & Nazareth, 2011).

This guide and its accompanying screening tool offer clinicians a supportive, inclusive, and non-pathologizing approach to exploring low or shifting sexual desire with clients. Rather than aiming to "fix" desire or label it as a problem, this approach invites curiosity, compassion, and collaboration. It centers client-led exploration and reflection while creating space for honest conversation. A non-pathologizing lens is particularly important in honoring the diversity of sexual experiences and avoiding unnecessary clinical labeling (Brotto & Yule, 2017).

Used as part of a broader clinical evaluation, the tool offers a gentle structure for identifying potential contributing factors and guiding follow-up discussions. It does not diagnose, but rather supports further assessment, validation, and, when appropriate, connection to additional care. The goal is to honor everyone's unique experience and values within a trauma-informed, affirming clinical space.

Understanding Sexual Desire and Arousal

Prevalence and Normalcy

Desire exists on a spectrum and is shaped by a wide range of personal, interpersonal, and contextual factors. Some people are comfortable with low desire; others may feel distressed, especially when desire is mismatched in a relationship or has changed unexpectedly. And while low sexual desire is common among people of all genders, women and individuals assigned female at birth report desire struggles more frequently (Brotto et al., 2021).

Traditional models, and media, often assume that desire is spontaneous, appearing "out of nowhere." In reality, many individuals experience responsive desire, which emerges in reaction to intimacy, touch, or emotional closeness (Nagoski, 2015).

The Dual Control Model of sexual response (Janssen & Bancroft, 2023) also reminds us that desire involves both excitatory and inhibitory systems. High stress, relationship conflict, or self-critical thoughts can suppress desire even in otherwise satisfying relationships.

Key Influences on Desire

Understanding low desire involves looking at the whole person, not just symptoms. Some common influences include:

- **Biological Factors**
  Hormonal changes (e.g., menopause, postpartum, andropause), chronic illness, medication side effects (especially SSRIs), fatigue, and pain conditions can all contribute to changes in desire.
- **Psychological Factors**
  Mental health conditions such as anxiety, depression, and trauma can impact sexual interest. So can stress, poor self-image, or internalized shame around sexuality.
- **Relational Dynamics**
  Conflict, lack of emotional closeness, poor communication, or past breaches of trust may lead to avoidance or withdrawal from sexual intimacy.
- **Sociocultural Messages**
  Upbringing, religious beliefs, and cultural norms may shape internal expectations around sex, roles, and what is “acceptable,” often subconsciously impacting desire.
- **Past Sexual Trauma or Coercion**
  A history of sexual abuse or coercion, even if not recently disclosed, can affect how an individual experiences desire, consent, and safety in sexual settings.

Clinical Considerations

Normalize Desire Variability and Avoid Pathologizing

Sexual desire naturally fluctuates throughout a person's life. These shifts may be influenced by relationship dynamics, physical health, stress, fatigue, aging, parenting, medications, or emotional states. Changes in desire are *not* inherently a problem, nor do they always require clinical intervention. Clients may already feel broken or inadequate. Reassure them that shifts in desire are common and often reversible or adaptive. Clinicians can play a key role in reducing shame by normalizing these shifts and reinforcing that a person is not "broken" if their experience of desire has changed. Avoid labeling the experience as a disorder unless distress and dysfunction are clearly present (Santos-Iglesias, Mohamed, & Walker, 2018). Many clients internalize cultural narratives suggesting they should always want sex or feel instant attraction, which creates distress when reality doesn't align.

> *"There's nothing wrong with you if your desire isn't what it used to be – or what you think it's supposed to be. These changes are normal and common."*

Before using the screening tool, clinicians are encouraged to adopt the following approach:

Use a Sex-Positive, Affirming Approach

A sex-positive approach centers on consent, curiosity, and client-defined goals. It affirms that sexuality exists on a spectrum and includes people who are very sexual, less sexual, asexual, or anything in between. It also respects the idea that sexual well-being may or may not involve partnered sex at all.

In a sex-positive framework:

- Sexuality is treated as a natural and valuable aspect of human experience.
- All consensual expressions of sexuality are affirmed.
- Desire is not pathologized, and there is no "normal" frequency, style, or outcome.
- Clinicians validate the full range of identities, bodies, and sexual experiences.

Introduce the Diversity of Sexual Arousal

Many people believe that sexual desire must be spontaneous in which they have a sudden urge or craving for sex. While that's one valid form of desire, it's not the only one. In fact, many individuals, especially in long-term relationships, or those under chronic stress, experience desire differently.

There are at least three commonly discussed arousal patterns:

- **Spontaneous Desire**: Arousal or interest arises suddenly or independently, often driven by fantasy, attraction, or hormonal cycles. This is the version of desire that's most often depicted in media.
- **Responsive Desire**: Desire follows sexual stimuli, like touch, emotional connection, or physical closeness. This is common among people who do not typically feel desire *before* intimacy but become interested once arousal begins.
- **Contextual Desire**: Desire is influenced heavily by setting, mood, safety, and relationship dynamics. Some people may feel more interested in sex in specific emotional or relational contexts (e.g., feeling appreciated, after rest, decluttered space, in private settings.)

Teaching clients about these variations can reduce anxiety and open alternative ways to cultivate intimacy. Clients may need education on how desire can emerge after arousal begins, or how relationship dynamics, emotional connection, or context affect interest.

Practice Trauma-Informed, Culturally Aware Care

Sexuality and sexual desire are shaped by lived experiences, including past trauma, cultural norms, religion, family upbringing, and social messaging. It is essential to approach each client with cultural humility, respect for autonomy, and sensitivity to potential trauma responses.

Key principles of a trauma-informed approach include:

- **Ask permission** before beginning any conversation about sexual well-being.
  "Is it okay if we talk a little about your sexual health today?"
- **Use inclusive, non-assumptive language.** Avoid gendered assumptions or heteronormative framing. For example: "partner" instead of "husband/wife," "sexual experiences" instead of "intercourse".
- **Be attuned to verbal and nonverbal cues**. Offer space for the client to pause, skip questions, or stop at any time. Let them know they are in control.
- **Validate and affirm.** If a client discloses trauma, the most therapeutic response is to believe them, thank them, and offer options – not to fix or probe details.

"You don't have to answer anything you're not comfortable with. I want this to feel safe and on your terms."

"Some people don't feel interested in sex until they start engaging in closeness or touch – that's called responsive desire, and it's totally valid."

Assessing Sexual Desire and Sexual Satisfaction (Validated Instruments)

Before introducing the 7 P's framework, this section briefly acknowledges some of the standardized instruments clinicians may already be familiar with. These tools can offer a starting point for assessing sexual desire or dissatisfaction, particularly in structured or diagnostic contexts. However, they are limited in scope – most were developed within biomedical models that center cisgender, heterosexual, and able-bodied populations.

While quantitative tools like those listed below offer structured ways to assess sexual desire and satisfaction, they often rely on narrow definitions rooted in clinical or normative assumptions. Most were developed using data from cisgender, heterosexual, and able-bodied populations, which limits their applicability across diverse lived experiences. For queer, trans, racialized, and disabled individuals, desire is shaped not only by physiology but by social, cultural, and political forces – including systemic erasure, medicalization, and trauma.

The following tools have been included not as endorsements, but to recognize what currently exists, and to underscore the need for approaches that are more expansive, affirming, and grounded in lived experience.

- **Sexual Desire Inventory (SDI)** – A self-report tool measuring solitary and dyadic sexual desire.
- **Decreased Sexual Desire Screener (DSDS)** – A short instrument that helps in diagnosing generalized or acquired, HSDD in adult women.
- **Index of Sexual Satisfaction (ISS)** – A brief self-rated scale designed to measure the degree of dissatisfaction in the sexual aspect of a dyadic relationship.
- **Short Sexual Well-Being Scale (SSWBS)** – A short questionnaire made in accordance with the sexual well-being concept and used among cisgender and transgender people.

Qualitative methods – such as narrative interviews, body-based techniques, or story-based inquiry – offer an alternative. These approaches make space for meaning-making that resists standardization, allowing clients to articulate desire in ways that honor complexity, contradiction, and change over time. This is precisely why the 7 P's Framework was developed: to provide an expansive space for inquiry and collaborative exploration. By considering multiple dimensions of desire – such as pleasure, pressure, and pain – the framework invites clients to reflect on the diverse factors influencing their sexual experiences. In the following section, the 7 P's are introduced as a clinical tool designed to guide these meaningful conversations.

"Healing begins when we move beyond the diagnosis and enter into a space of shared understanding."

The 7 P's Framework for Exploring Sexual Desire

Sexual desire rarely has a single cause. This screening tool is grounded in a clinician-created framework known as **The 7 P's of Sexual Desire**[1], designed to support a holistic, trauma-informed, and non-pathologizing approach to assessing low or shifting desire. These seven domains outlined as pleasure, pressure, priming, performance, psychological, physiological, and pain, help structure thoughtful, collaborative conversations with clients and invite reflection on multiple influences at play. These categories are not diagnostic but serve as helpful entry points for discussion and reflection.

Screening the 7 P's of Sexual Desire

This is a brief screening intended to highlight potential sexual desire concerns. This is not a diagnostic assessment or instrument.

Begin by informing the client(s) that you'd like to learn more about their sexual experiences by asking several questions. Be sure to get their consent before beginning.

1. Pleasure

- Is sex pleasurable and satisfying?
- Are there changes you'd like to make that you believe would make sex more pleasurable?
- Are you avoiding or declining sex due to boredom or lack of pleasure?
- Is the sex that's available worth having?

2. Pressure

- Is there an internal sense of pressure, duty, or obligation to have sex?
- Is there an external sense pressure, duty, or obligation to have sex?

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[1] *The 7 P's framework was developed by Rafaella Smith-Fiallo, LCSW, CSE, as part of this clinical screening tool to help guide conversations around low or shifting desire in a holistic and sex-positive way.*

    - This can be from a partner directly or messages/teachings from friends, family, society, etc.
    - Assess for manipulation, coercion, abuse/violence, and consent and boundary violations (inquire and assess everyone both separately and privately as appropriate).

3. Priming

- Is there anything happening internally or externally that is a turn off or distraction?
- What style of sexual initiation do you most prefer and is that happening?
    - Examples can include direct verbal expression, physical gestures/cues, sensation-based, seduction, etc.
- Do all parties feel willing to engage in sex when offered/initiated?

4. Performance

- Do you struggle with being present in the moment due to fearing that you cannot 'perform' well?
    - This can range from worrying that you are taking too long, won't last long enough, wondering if your partner(s) are enjoying themselves, anxiety about how your body should look and perform, etc.

5. Psychological

- What are the influencing mental health factors that make having sex more or less desirable?
    - Consider the history of trauma and current experiences with depression and anxiety.
    - Consider potential side effects of medications be using to treat mental health concerns.

6. Physiological

- Do you experience physical and physiological signs of arousal, such as increased heart rate, change in breathing, hardened nipples, body tension, etc.?
- Are there concerns about obtaining or maintaining an erection?
- Are there concerns about obtaining or maintaining vaginal wetness?

7. Pain

- Does having sex cause any pain or discomfort?

    - This can include stomach, back, knee, etc. pain due to body positioning during sex, vaginal or anal pain, or an exacerbation of pain related to another condition or chronic illness.

- Has any of the above pain been addressed? If so, how?
- Are there any concerns or anxieties that sex will be painful that lead sexual avoidance and decreased sexual desire?

These areas overlap and interact – and not every client will identify with all of them. This is intended to guide gentle, curiosity-based inquiries rather than to create a checklist.

Using the Screening Tool

How to Administer

This screening tool can be integrated into intakes, follow-up sessions, or specialized sexual health assessments. It can be used flexibly, either completed collaboratively in session, offered as a handout, or reviewed selectively based on client context.

Best practices for use include:

- Framing the tool as a conversation guide, not a diagnostic test.
- Asking permission before initiating discussions about sexual desire.
- Giving clients space to respond freely. This isn't a quiz or checklist.
- Using open-ended prompts to invite elaboration.
- Following up gently on themes that arise from the tool.

This tool can be especially helpful for clients struggling with desire discrepancy (i.e., differing levels of desire in a partnership), emotional distress about sexual changes, or confusion about what desire "should" look like (McNulty, Wenner, & Fisher, 2014; Nagoski, 2015).

Interpreting Responses

Patterns in responses can help identify possible contributors to low desire. For example:

- If several relational questions are endorsed: consider couples counseling or communication-focused interventions.
- If medical issues or medications are involved: consider consulting with the client's primary care provider or adjusting medications when appropriate.
- If past trauma or consent-related concerns are identified: provide supportive, non-invasive validation and consider referral to a trauma-informed therapist or counselor.

Next Steps and Referrals

After completing the screening tool, clinicians should consider the following actions based on the client's responses. Using the **PLISSIT model** (Annon, 2015; Tuncer & Oskay, 2021) as a guide, clinicians can assess how much intervention is appropriate for their scope of practice:

- **Permission** – Normalize and validate experiences (e.g., "Many people feel this way…")

- **Limited Information** – Offer brief psychoeducation (e.g., about responsive desire or relationship dynamics)
- **Specific Suggestions** – Share resources, exercises, or communication tips
- **Intensive Therapy** – Refer for sex therapy, couples work, trauma counseling, or medical support.

In certain cases, it may be necessary to refer clients to specialized professionals. Consider referring when:

- The client expresses distress or significant impairment in their sexual well-being.
- The concerns are outside of your clinical scope, such as medical conditions (e.g., hormonal imbalances) or sexual trauma.
- The client requests more specialized support or expresses a need for more in-depth intervention.

Possible Referrals:

- Sex therapy or counseling
- Couples therapy
- Endocrinology, gynecology, urology
- Sexual medicine or pelvic floor therapists

Using the above guidelines will help clinicians ensure they are offering the appropriate level of care and support for their clients.

For more specific suggestions on how to respond to concerns identified in the screening, see **Appendix A: Supporting Clients After the 7 P's Screening** at the end of this guide.

Additional Resources for Clients and Clinicians

Professional Organizations

- American Association of Sexuality Educators, Counselors and Therapists (AASECT): www.aasect.org
- National Sexual Violence Resource Center (NSVRC): www.nsvrc.org
- Planned Parenthood – Sexual Health Information: www.plannedparenthood.org
- The Center for Sexual Pleasure and Health (CSPH): www.thecsph.org

Educational

- The Black Girls' Guide to Couple's Intimacy by Dr. Lexx Brown-James
- Better Sex Through Mindfulness: How Women Can Cultivate Desire by Lori Brotto
- Bringing Desire Back by Esther Perel (course)
- Come As You Are by Emily Nagoski
- Come Together by Emily Nagoski

- Desire: An Inclusive Guide to Navigating Libido Differences in Relationships by Lauren Fogel Mersy & Jennifer A. Vencill (2023)
- Healing Sex: A Mind-Body Approach to Healing Sexual Trauma by Staci Haines

How to Cite This Tool

If referencing this tool or framework in clinical work, publications, or presentations, please use the following citation format:

To cite the full guide:
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Appendix A: Supporting Clients After the 7 P's Screening
(Addressing Each Domain with Practical Strategies and Referrals)

Continue by informing the client(s) that you'd like to provide suggestions, resources, and referrals based on what was shared during the screening. Be sure to get their consent before beginning.

1. Pleasure

- If present, address sexual shame that prevents sharing and expressing sexual interests/preferences.
- Identify, normalize, and explore client(s) needs/interests, kink/fantasies, and common sexual interests.
- Create temporary compromises or changes that lead to increased satisfaction.
- Refer to a sexuality professional if needed.

2. Pressure

- Validate that sexual pressure negatively impacts sexual arousal, can lead to obligation/duty sex, sexual avoidance, and resentment.
    - Name and address any concerning behaviors.
- Teach healthier and appropriate (for the relationship) sexual communication skills and sexual initiation skills.

3. Priming

- Depending on the influencing factors, next steps will vary from providing sex-positive education/counseling, therapy, and referring to other professionals.
- If client(s) are unsure or unaware of their initiation style, provide education or resources.

4. Performance

- Refer to a sex therapist or other mental health therapist for general anxiety or performance anxiety related issues that may be causing arousal concerns.

5. Psychological

- Normalize side effects of medications, validate the client's experience, and provide education as needed.
- Refer to a mental health therapist or psychiatrist for treatment of symptoms or medication adjustment.

6. Physiological

- Normalize non-penetrative sex and provide sex education on non-penetrative sexual intimacy for client(s) to explore.
- Suggest intimacy gels and lubrication for wetness concerns and sex aids, such as cock rings for erectile concerns.
- Refer to a medical professional to rule out cardiovascular, erectile, hormonal, and medical issues that may impact arousal and desire.

- Refer to a sex therapist or other mental health therapist for general anxiety or performance anxiety related disorders that may be causing arousal concerns.

7. Pain

- Advise client(s) to not engage in the type of sex that causes/increases pain to minimize painful sex and the association of pain and sex.
- Provide suggestions about body positions and sex aids, tools, toys that may minimize pain, such as intimacy pillows, intimacy gels and lubrication, and the Ohnut (for painful penetration).
- Depending on the type and cause of pain, refer client(s) to a specialist for follow-up and treatment.
    - This many include a pelvic floor physical therapist, vulvar pain specialist, urogynecologist, gynecologist, urologist, sex therapist