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Assessment and Management of Female Sexual Interest and Arousal Disorders

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Introduction

Female Sexual Interest and Arousal Disorders are complex conditions influenced by biological, psychological, relational, and sociocultural factors. Effective evaluation requires a comprehensive assessment that distinguishes disturbances of desire from disturbances of arousal while considering the patient's level of distress and overall context.

Diagnosis should integrate clinical interviews, validated psychometric measures, physical examination findings, and relevant laboratory investigations. Because symptom presentations vary considerably among individuals, treatment must be individualized and guided by a multi-modal formulation.

Management strategies range from education, counseling, mindfulness-based interventions, and behavioral therapies to hormonal treatments, pharmacological options, pelvic floor rehabilitation, and emerging neuro-modulatory techniques. Collaboration among gynecologists, mental health professionals, pelvic floor specialists, and primary care clinicians often enhances treatment outcomes.

Ultimately, successful care necessitates a compassionate, evidence-based, and ethically grounded approach that prioritizes patient wellbeing, autonomy, and sexual health throughout the therapeutic process. ⁽¹⁾

Executive Summary

The last guidelines published on sexual disorders were in 2017. In that edition, the guidelines were broad, encompassed both male and female disorders. However, among female sexual disorder, the focus was on vaginismus and dyspareunia. Today, the evidence for Female Sexual Arousal and Interest Disorders, both in India and globally is immense. This current guideline, based on collative review and expert consensus on the said area, hopes to bridge the gap between the previous one and current knowledge. ⁽²⁾

Epidemiology

Female Sexual Interest/Arousal Disorder (FSIAD) ranks as the primary sexual dysfunction reported among women. Earlier research struggled to provide consistent data because studies lacked a uniform definition, often distorting the actual numbers. Modern investigations rely on the standardized DSM and ICD criteria, which strictly require the presence of personal distress before diagnosing the condition.

Data from the landmark PRESIDE study highlights how prevalence varies across age groups: Ages 18–44: 8.9%; Ages 45–64: 12.3% (the highest rate); and Ages 65 and older: 7.4%

The overall rate of low sexual desire—regardless of whether it caused emotional strain—reached 38.7% across all age brackets. To filter out non-distressing cases, researchers required a score of 15 or higher on the Female Sexual Distress Scale.

Similarly, the WISHeS study examined women across Western Europe and North America, finding FSIAD rates between 6% and 16% in Europe, compared to 9% to 26% in North America.

While low desire becomes more frequent as women grow older, the emotional distress linked to it tends to decline with age. Consequently, middle-aged women experience FSIAD at higher rates than either younger or older age groups. Going through menopause—whether through natural aging or surgical intervention—significantly elevates the likelihood of developing the disorder.

In a study conducted in South India, which was conducted as a door-to-door epidemiological survey in a rural South Indian population involving 787 sexually active women aged ≥ 18 years; the overall prevalence of female sexual disorders was 14% (110 of 787 women); prevalence of female hypoactive sexual desire disorder (HSDD) was 8.87% and prevalence of female arousal dysfunction was 6.65%. Comorbidity was common, with 44.5% of women diagnosed with more than one sexual dysfunction. The commonest affected age group was 31–50 years. ^[3,4]

Conceptual Evolution and Definitions of Sexual Interest and Arousal

Evolution of Diagnostic Concepts (Figure 1)

Historically, female sexual response was interpreted using the linear models proposed by Masters and Johnson and then refined by Helen Singer Kaplan. These models described sexual response as a fixed progression in which desire preceded arousal, followed by orgasm and resolution. Although this sequence adequately explains many aspects of male sexual function, it does not fully represent the variation and complexity of women's sexual experiences.

A notable revision occurred with the publication of the DSM-5, which combined the previously separate diagnoses of Hypoactive Sexual Desire Disorder (HSDD) and Female Sexual Arousal Disorder (FSAD) into a single condition known as Female Sexual Interest/Arousal Disorder (FSIAD).

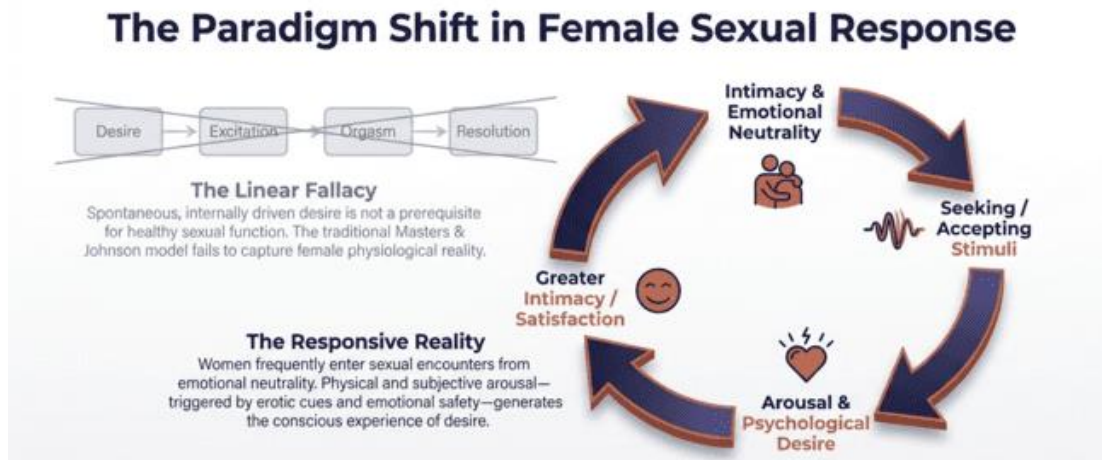
This diagnostic change was based on clinical evidence indicating that impaired sexual desire and difficulties with arousal frequently coexist. These domains typically overlap, showing their close bodily and mental relationship.

The diagnostic framework for FSIAD is strongly influenced by Rosemary Basson's Responsive Desire Model, which questions the traditional assumption that spontaneous sexual desire consistently initiates sexual activity. ^[5]

Instead, the model proposes that many women begin intimate encounters in a state of sexual neutrality, without an immediate experience of desire. In the presence of emotional security, intimacy, and appropriate erotic stimulation, subjective and physiological arousal may develop first. As arousal increases, conscious sexual desire often appears as a consequence of the experience rather than its starting point.

Accordingly, FSIAD recognizes that the absence of spontaneous sexual desire should not automatically be regarded as pathological. Instead, the disorder is characterized by a persistent inability to experience or maintain sexual interest and arousal despite adequate sexual stimulation and favorable interpersonal circumstances.

Figure 1: The Paradigm Shift in Female Sexual Response



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 89 **authors themselves**

90 Diagnostic Classification and Clinical Concepts

91 Distinguishing Sexual Interest from Sexual Arousal

92 Accurate diagnosis of female sexual dysfunction necessitates a clear understanding of the difference
 93 between sexual interest and sexual arousal. Although closely connected, these represent separate
 94 dimensions of sexual functioning.

95 Sexual Interest (Desire)

96 Sexual interest refers to an individual's motivation, willingness, and psychological inclination toward
 97 sexual activity. It may be expressed in several forms:

98 **Spontaneous Desire** This form of desire occurs naturally without external prompting and may involve
 99 sexual thoughts, fantasies, or daydreams that occur independently.

100 **Responsive Desire** Rather than appearing spontaneously, responsive desire develops after exposure
 101 to affectionate touch, emotional intimacy, or erotic stimulation. Sexual interest grows as the
 102 interaction progresses.

103 **Contextual Desire** In some situations, an individual may engage in sexual activity primarily to
 104 strengthen emotional bonds, communicate affection, or enhance relationship intimacy rather than
 105 because of immediate sexual motivation.

106 Sexual Arousal

107 Sexual arousal represents the body and mind's response to sexual stimuli. It includes psychological
 108 experiences as well as bodily changes.

109 **Subjective Arousal** This refers to the personal experience of excitement, pleasure, and emotional
 110 participation during sexual activity.

111 **Genital Arousal** Genital arousal involves physical changes such as increased pelvic blood flow, clitoral
 112 enlargement, vaginal lubrication, and relaxation of vaginal smooth muscle, all of which enable sexual
 113 activity.

Non-Genital Arousal Broader bodily responses may also occur, including elevated heart rate, elevated blood pressure, skin flushing, pupillary dilation, increased respiration rate, and heightened nipple sensitivity.

Importance of the Distress Criterion (Figure 2)

Both DSM-5 TR [6] and ICD-11[7] (Table 1) emphasize that sexual symptoms alone are insufficient for diagnosis. A clinical diagnosis requires that the symptoms produce significant personal distress. [6,7]

This requirement prevents normal variations in sexual interest from being mistakenly labeled as disorders.[8] For example, a woman who experiences little or no sexual desire but is comfortable with this experience and reports no emotional distress would not meet diagnostic criteria for a sexual dysfunction. [6]

The distinction is particularly relevant when considering asexuality. Individuals who identify as asexual generally do not perceive the absence of sexual attraction as problematic. Consequently, asexuality is not classified as a sexual disorder. Clinicians should also ensure that reported distress originates from the patient herself rather than solely from relationship conflict or partner dissatisfaction.

Figure 2: Diagnostic Matrix: Blended vs. Distinct Typologies

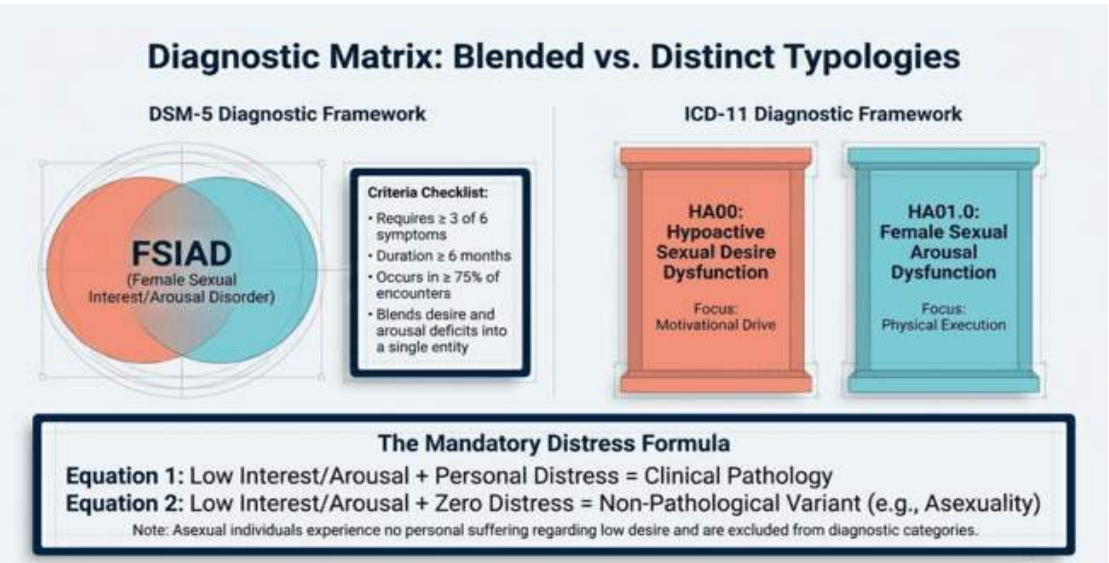


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Table 1: DSM 5 TR and ICD 11 Diagnostic Criteria

Feature	DSM-5-TR: Female Sexual Interest/Arousal Disorder (FSIAD) ^[6]	ICD-11: Female Sexual Desire/Arousal Dysfunction (HA00.0) ^[7]
Diagnostic concept	Combines disorders of sexual interest (desire) and sexual arousal into a single diagnosis.	Also integrates desire and arousal into one disorder but adopts a broader clinical approach emphasizing overall impairment.
Core requirement	Lack of or significantly reduced sexual interest/arousal.	Persistent or recurrent marked reduction or absence of sexual desire and/or arousal.
Required symptoms	At least 3 of the following 6 symptoms: 1. Reduced interest in sexual activity. 2. Reduced sexual/erotic thoughts or fantasies. 3. Reduced initiation of sexual activity and unresponsive to partner's attempts. 4. Reduced excitement or pleasure during sexual activity in almost all (75–100%) encounters. 5. Reduced interest/arousal in response to erotic cues (visual, verbal, written, etc.). 6. Reduced genital or non-genital sensations during sexual activity in almost all encounters.	No fixed symptom count. Clinical features may include: • Markedly diminished or absent sexual desire. • Reduced responsiveness to erotic stimuli. • Reduced subjective sexual excitement. • Reduced physiological arousal or genital sensations. • Decreased initiation or participation in sexual activity.
Duration	Symptoms persist for ≥6 months.	Symptoms are persistent or recurrent over an extended period, with no mandatory 6-month cutoff.
Frequency	Present in approximately 75–100% of sexual encounters.	No specific percentage requirement.
Distress	Must cause clinically significant distress.	Must cause clinically significant distress or functional impairment.
Specifier: Onset	Lifelong or Acquired	May be described clinically as lifelong or acquired (not formal diagnostic specifiers).
Specifier: Context	Generalized or Situational.	Context (generalized or situational) may be noted clinically but is not coded as formal specifiers.
Specifier: Severity	Mild, Moderate, Severe.	No formal severity specifiers. Clinical severity is judged individually.
Exclusion criteria	Not better explained by another mental disorder, severe relationship distress, significant stressors, substance/medication effects, or another medical condition.	Symptoms should not be better explained by another health condition, medication/substance, relationship factors, cultural context, or other mental disorders.
Diagnostic approach	Symptom-count based and operationalized.	Clinical judgment-based, emphasizing individualized assessment and biopsychosocial formulation.

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146 Presenting Symptoms and Illustrative Analysis

147 The application of diagnostic criteria becomes clearer when reviewed through clinical examples. The
148 following cases illustrate how Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition
149 (DSM-5 TR) ^[6] and International Statistical Classification of Diseases and Related Health Problems, 11th
150 Revision (ICD-11) ^[7] frameworks might classify different presentations. (Table 2)

152 **Table 2:** Illustrative Analysis

Feature / Criterion	Female Sexual Desire Disorder	Female Sexual Arousal Disorder
Primary Clinical Focus	Desire / Motivation Deficit: The primary problem lies within the motivational component of sexuality. Both spontaneous and responsive desire are significantly reduced, while physiological capacity remains relatively preserved.	Arousal / Execution Deficit: Failure of peripheral vasocongestive responses and subjective engagement despite intact emotional willingness.
DSM-5 TR Symptoms Present (FSIAD) (Requires ≥ 3 of 6 for ≥ 6 months in ≥ 75% of encounters)	Meets Criteria (3 symptoms present): ^[6] 1. Absent/reduced interest in sexual activity. 2. Absent/reduced sexual or erotic thoughts or fantasies. 3. Absent/reduced initiation of sex and unresponsiveness to partner initiation.	Meets Criteria (3 symptoms present): ^[7] 1. Absent/reduced excitement/pleasure during encounters ("detached observer"). 2. Absent arousal to external or internal erotic cues. 3. Absent/reduced genital or non-genital sensations (no clitoral sensitivity/lubrication).
ICD-11 Classification	Hypoactive Sexual Desire Dysfunction (HA00): Deficit is localized entirely within the loss of motivation, internal drive, and willingness to engage ^[7].	Female Sexual Arousal Dysfunction (HA01.0): Subtype: Genital Arousal Dysfunction; primary failure of physical vasocongestion (lubrication, engorgement) ^[7].
Duration & Frequency Status	8 months (Exceeds the 6-month DSM-5 threshold) ^[6]; occurs consistently across all encounters.	12 months (Exceeds the 6-month DSM-5 threshold) ^[7]; occurs consistently across all encounters.

Feature / Criterion	Female Sexual Desire Disorder	Female Sexual Arousal Disorder
Distress Status	Present; experiences personal anxiety, guilt, and frustration ^[6] .	Present; experiences profound personal distress, sadness, and bodily alienation ^[7] .
Key Subset of Symptoms	Central/Cognitive processing deficits, loss of appetitive phase, lack of responsive feedback loop.	Peripheral neurovascular deficits, autonomic blunting, urogenital tissue atrophy, subjective-objective dissociation.

Clinical Assessment

A complete assessment is essential because sexual complaints often arise secondary to medical, psychological, or relationship-related factors more than from a primary sexual disorder.^[8] (Table 3)

Table 3: Clinical Assessment with focus on specific aspects in symptom history

Common Features (Assessed in Both)	More Specific to Sexual Desire	More Specific to Sexual Arousal
Onset and progression of symptoms	Current level of sexual interest compared with previous functioning	Ability to become mentally excited by erotic stimuli
Degree of distress/emotional impact	Frequency of partnered and solitary sexual activity	Awareness of genital changes during stimulation (e.g., lubrication/engorgement)
Presence of sexual fantasies/imagination	Presence of sexual attraction toward others	Responses to direct sexual stimulation
Sexual enjoyment/satisfaction	Frequency of erotic thoughts and fantasies	Situations where desire exists without physical arousal
Responsiveness to erotic stimuli	Masturbatory practices	Occurrence of physical arousal without desire
Relationship factors (emotional intimacy, partner relationship)	Presence of responsive desire	Situations involving desire but limited enjoyment of touch
Whether symptoms are generalized or situation-specific	Reactions to partner initiation	Sensitivity of erogenous zones
Partner-related sexual difficulties	Comfort discussing sexual matters	Body image and sexual performance concerns
Impact on relationship and quality of life	Treatment expectations and goals	Pregnancy and fertility-related worries
Feelings toward the sexual partner	—	Emotional reactions to arousal

Common Features (Assessed in Both)	More Specific to Sexual Desire	More Specific to Sexual Arousal
Experiences of pressure, coercion, or unwanted sexual activity	—	—

Differential Diagnosis

Table 4: Detailed Differential Diagnosis

Suspected Diagnosis	Clinical Overlap with FSIAD / HSDD / FSAD	Key Clinical Differentiators & Exclusion Rules	Diagnostic Strategy / Tools
Primary FSIAD / HSDD / FSAD	Loss of sexual interest, lack of fantasies, reduced lubrication, and subjective numbness.	Localized Anhedonia: The deficit is restricted to sexual functioning. The patient remains highly functional, motivated, and capable of experiencing pleasure in other life domains (e.g., career, hobbies, social life).	Diagnostic thresholds met via DSM-5 "3 of 6" rule; low scores on FSFI Female Sexual Function Index (FSFI) (≤ 26.55); high scores on FSDS-R Female Sexual Distress Scale-Revised.
Major Depressive Disorder (MDD)	Low libido, lack of energy, reduced pleasure during sexual encounters, and emotional flattening.	Systemic Anhedonia: Severe loss of interest and pleasure across <i>all</i> aspects of life (food, hobbies, socializing, work). Accompanied by neurovegetative symptoms (sleep disruption, appetite changes, suicidal ideation, psychomotor retardation).	PHQ-9 (Patient Health Questionnaire-9); clinical interview assessing DSM-5 neurovegetative criteria for depression.
Generalized Anxiety Disorder (GAD)	Inability to relax during sex, impaired lubrication, and avoidance of intimacy due to performance fears.	Systemic Hyperarousal: Chronic, pervasive, uncontrollable worry regarding multiple life domains (finances, health, family) that extends far beyond the bedroom. Sexual avoidance is typically a coping mechanism to minimize overall stress.	GAD-7 (Generalized Anxiety Disorder-7); clinical tracking of generalized autonomic hyperarousal symptoms.
Medication-Induced Sexual Dysfunction	Abrupt loss of desire, delayed or absent orgasm, and profound genital numbing.	Temporal Correlation: Onset of sexual dysfunction matches the introduction or dose escalation of a causative medication. Most frequently caused by SSRIs, SNRIs (which stimulate 5HT _{2A} receptors and inhibit dopamine),	Detailed chronological pharmacological review; trial of medication holiday or medication switch (e.g., to Bupropion) if clinically appropriate.

Suspected Diagnosis	Clinical Overlap with FSIAD / HSDD / FSAD	Key Clinical Differentiators & Exclusion Rules	Diagnostic Strategy / Tools
		oral contraceptives (which elevate Sex Hormone-Binding Globulin, lowering free testosterone), and spironolactone.	
Genitourinary Syndrome of Menopause (GSM)	Severe reduction in lubrication, clitoral numbness, and secondary avoidance of sexual encounters.	Primary Anatomical Atrophy: Physical findings of vulvovaginal atrophy (tissue pallor, loss of vaginal rugae, petechiae, introital narrowing) and primary dyspareunia (pain with initial penetration). Low desire is often a secondary, defensive response to anticipated physical pain.	Pelvic examination; vaginal pH monitoring (pH > 5.0 indicates hypoestrogenism); response to localized topical estrogen therapy.
Severe Interpersonal & Relational Distress	Absolute unresponsiveness to partner's initiation, absence of desire within the relationship.	Situational Specificity: The loss of desire is confined strictly to the current partner. Spontaneous fantasies or desire toward alternative individuals, or masturbatory interest, often remain intact. Associated with chronic resentment, lack of trust, unmanaged partner dysfunction (e.g., severe erectile dysfunction), or historical infidelity.	Couples interview; DAS (Dyadic Adjustment Scale); assessing for the presence of domestic abuse, coercion, or hidden safety concerns.
Other female sexual disorders	Female Orgasmic Disorder	Repeated inability to achieve orgasm leads to reduced anticipation of pleasure and secondary loss of desire.	Detailed sexual history focusing on orgasmic phase; FSFI Orgasm Domain; assess adequacy of stimulation, medications, pelvic floor disorders, and relationship factors.
	Genito-Pelvic Pain/Penetration Disorder (GPPPD)	Dyspareunia, vaginismus, and fear of pain result in avoidance of intimacy and reduced arousal.	Pelvic examination; cotton-swab test for vulvodynia; pelvic floor assessment; vaginal examination; FSFI Pain Domain; gynecological evaluation.

Suspected Diagnosis	Clinical Overlap with FSIAD / HSDD / FSAD	Key Clinical Differentiators & Exclusion Rules	Diagnostic Strategy / Tools
	Persistent Genital Arousal Disorder (PGAD)	Distressing unwanted genital arousal causes avoidance of sexual activity and diminished sexual interest.	Careful history documenting persistent spontaneous genital sensations; neurological and pelvic evaluation; MRI lumbosacral spine when indicated; medication review (SSRI withdrawal, etc.).

Figure 3: Differential Diagnosis Matrix

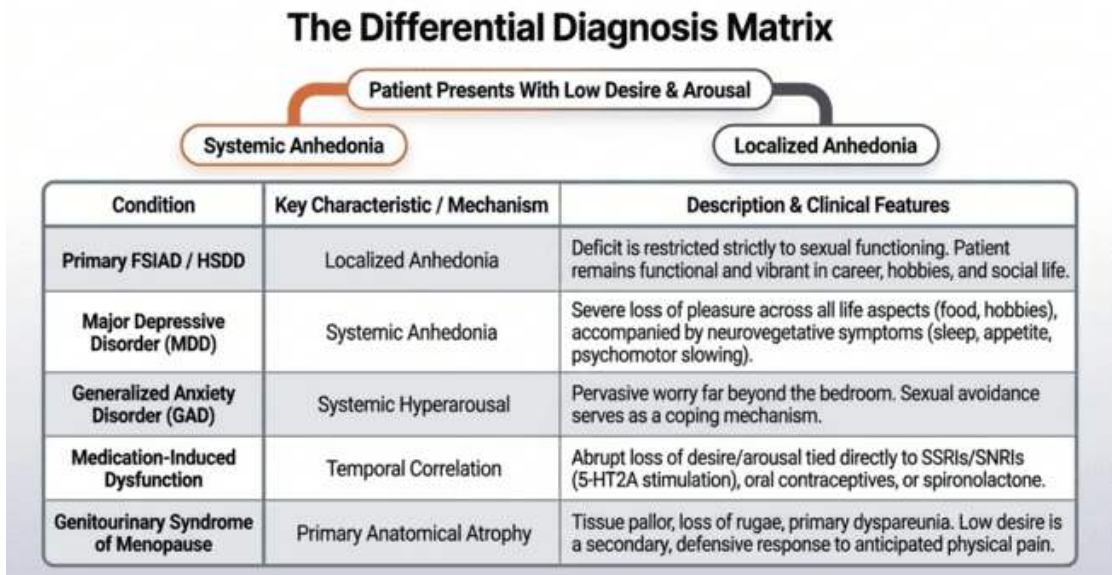


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Psychometric Assessment Tools

Validated instruments provide objective measures of symptom severity, associated distress, and affected domains of sexual functioning. (Figure 4)

Decreased Sexual Desire Screener (DSDS)

The DSDS is a brief clinician-administered instrument developed to identify acquired Hypoactive Sexual Desire Disorder in women. ^[9]

The first four questions determine whether a meaningful reduction in desire exists, whether it has persisted, whether it causes distress, and whether the patient wishes her desire were greater.

A fifth item evaluates alternative explanations such as medical illnesses, medications, or significant relationship problems.

A positive pattern of responses supports the diagnosis of acquired HSDD when alternative causes are excluded.

Female Sexual Function Index (FSFI)

The FSFI is a widely used 19-item self-report questionnaire assessing sexual functioning during the previous four weeks.^[10]

The instrument evaluates six domains: Sexual desire, Sexual arousal, Lubrication, Orgasm, Satisfaction, Pain

Scores from each domain are combined to generate a total score ranging from 2 to 36 where a total score of ≤ 26.55 reliably indicates clinically significant sexual dysfunction.

The FSFI is particularly useful for identifying specific patterns of dysfunction, such as isolated lubrication problems or generalized impairment across multiple domains.

Female Sexual Distress Scale-Revised (FSDS-R)

The FSDS-R measures the degree of distress associated with sexual difficulties. Since distress is a central diagnostic requirement, this tool is highly valuable in clinical practice.^[11]

It is a 13-item distress quantification scale that measures the degree of distress associated with sexual difficulties over the previous month. A total score of ≥ 11.0 confirms clinically significant sexually related distress.

The questionnaire assesses feelings such as frustration, guilt, inadequacy, anger, and distress over the previous month using a graded response scale.

It is commonly employed to monitor treatment outcomes because of its sensitivity to clinical change.

Additional Assessment Measures

Other validated instruments include:

- Sexual Function Questionnaire (SFQ) ^[12]
- PROMIS Sexual Function and Satisfaction Profile (PROMIS SexFS) ^[13]
- Brief Sexual Symptom Checklist for Women (BSSC-W)
- Brief Index of Sexual Functioning for Women (BISF-W) ^[14]

Together, these tools provide a comprehensive assessment of sexual functioning, symptom severity, and treatment response.

Figure 4: Psychometric Assessment Tools

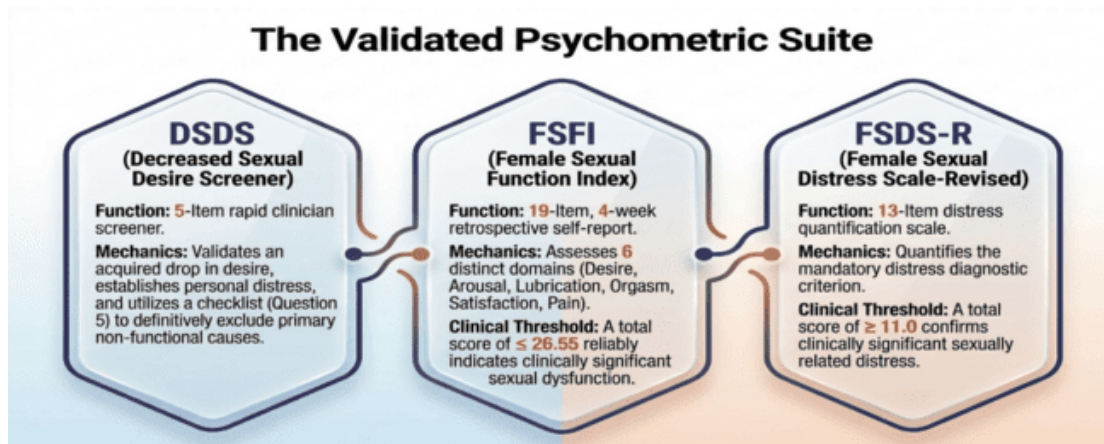


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Comprehensive Investigations

A structured investigative approach is necessary to identify biological factors that may contribute to impaired sexual desire or arousal. Evaluation should focus on endocrine, metabolic, vascular, neurological, and anatomical contributors that can affect sexual functioning. (Figure 5)

Endocrine Assessment

Hormonal abnormalities frequently influence libido, arousal, and genital tissue health. Therefore, endocrine evaluation forms an essential element of assessment. ^[15]

Thyroid Function Tests

Measurement of thyroid-stimulating hormone (TSH) and free thyroxine (T4) helps identify thyroid disorders. Hypothyroidism may contribute to fatigue, mood changes, reduced libido, and secondary elevations in prolactin levels.

Serum Prolactin

Elevated prolactin concentrations can suppress hypothalamic gonadotropin-releasing hormone secretion, resulting in reduced gonadal hormone production and diminished sexual interest. Screening is particularly important when symptoms suggest pituitary dysfunction.

Testosterone Evaluation

Assessment of total and free testosterone may be valuable in women presenting with loss of sexual motivation, especially following menopause or surgical removal of the ovaries. Highly sensitive laboratory techniques such as liquid chromatography–mass spectrometry are preferred because conventional assays are often inaccurate at female hormone concentrations.

240 *Sex Hormone-Binding Globulin (SHBG)*

241 Measurement of SHBG helps determine the proportion of biologically available testosterone. Elevated
242 SHBG can reduce free androgen levels and contribute to diminished sexual desire.

243 *Follicle-Stimulating Hormone and Estradiol*

244 These investigations help determine menopausal status and identify estrogen-deficient states
245 that may contribute to vaginal atrophy, dryness, and impaired genital responsiveness.

246 Metabolic and Systemic Evaluation

247 Systemic medical disorders can indirectly affect sexual functioning through fatigue, vascular
248 compromise, or neurological impairment.

249 *Glucose Regulation*

250 Fasting blood glucose and glycated hemoglobin (HbA1c) should be assessed to detect
251 diabetes mellitus. Chronic hyperglycemia may damage autonomic nerves and small blood
252 vessels involved in genital arousal.

253 *Hematological Assessment*

254 Complete blood count and serum ferritin testing help identify anemia, a reversible condition
255 associated with fatigue, reduced energy, and diminished sexual interest.

256 *Lipid Profile*

257 Evaluation of lipid levels assists in identifying atherosclerotic risk factors that may impair
258 pelvic blood flow and reduce genital vasocongestion.

259 *Liver Function Testing*

260 Baseline liver assessment is recommended before prescribing medications that undergo
261 significant hepatic metabolism.

262 Advanced Physiological Assessment ^[16,17]

263 Specialized investigations may be considered in selected patients with severe or unexplained
264 arousal difficulties.

265 *Pelvic Duplex Doppler Ultrasound*

266 This technique evaluates blood flow within genital vascular structures and can identify arterial
267 insufficiency affecting genital engorgement.

268 *Quantitative Sensory Testing*

269 Sensory threshold testing assesses nerve function within the genital and perineal regions and
270 may help detect neuropathic abnormalities.

271 *Vaginal Photoplethysmography*

272 This research-based assessment measures changes in vaginal blood volume during exposure
273 to erotic stimuli and provides an indirect indicator of genital arousal.

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294 Figure 5: Comprehensive Investigations Panels

Investigating the Female Sexual Response Axis: A Clinical Protocol

Structured framework for identifying biological drivers suppressing libido, motivation, and physical arousal.

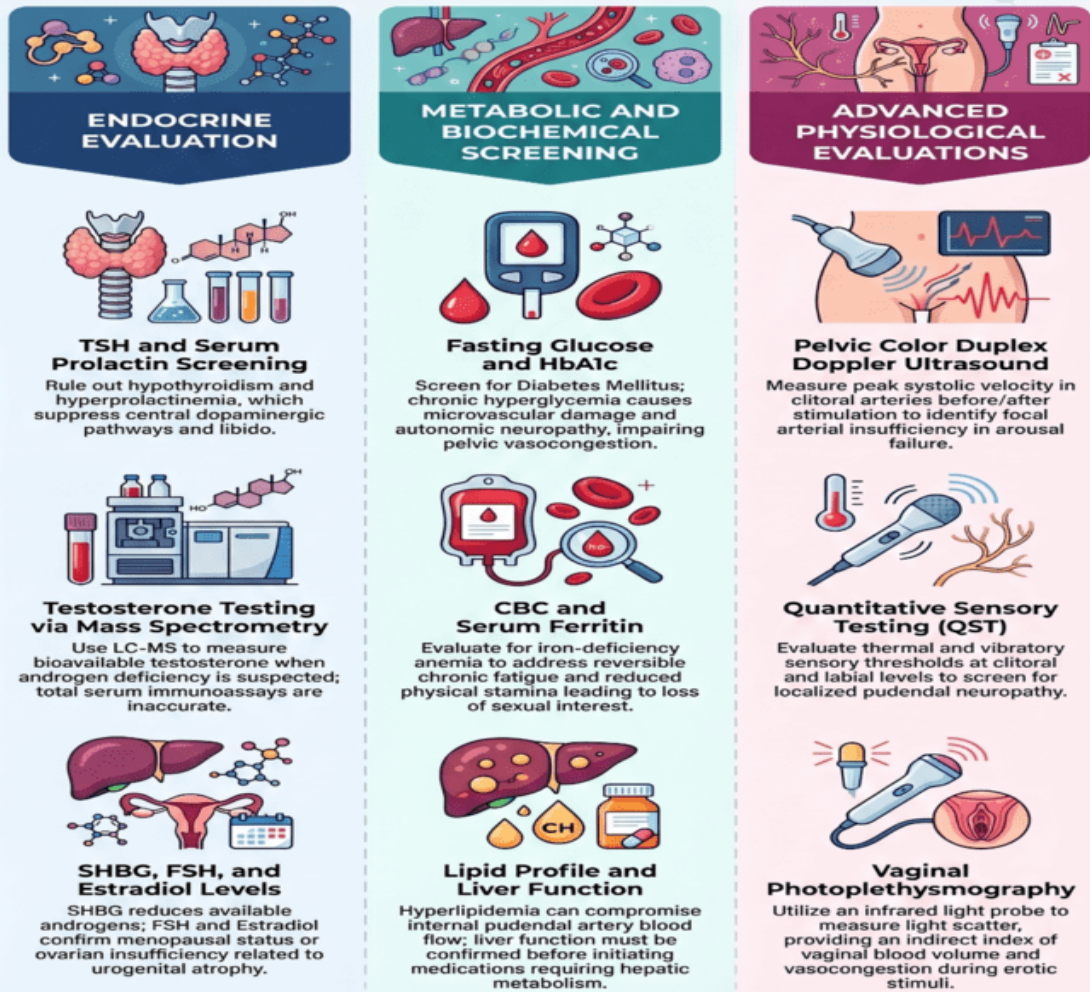


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Liaison Referrals and Interdisciplinary Management

Female sexual dysfunction is influenced by biological, psychological, and interpersonal factors. Consequently, multidisciplinary collaboration is often necessary for optimal care. (Figure 6)

Gynecological and Uro-gynecological Referral

Referral is indicated when symptoms are associated with genital pain, menopausal changes, structural abnormalities, pelvic floor disorders, or previous pelvic surgery.

Specialist assessment may include examination of vulvovaginal tissues, evaluation of vaginal elasticity and lubrication, identification of localized pain syndromes, and management of Genitourinary Syndrome of Menopause.^[18]

Pelvic Floor Physiotherapy

Women experiencing dyspareunia, chronic pelvic pain, urinary symptoms, or excessive pelvic floor muscle tension may benefit from pelvic floor rehabilitation.

Assessment focuses on muscle tone, trigger points, coordination, and functional movement patterns. Treatment strategies commonly include:

- Myofascial release techniques
- Biofeedback training
- Relaxation exercises
- Graduated vaginal dilator programs

These interventions help reduce pain, improve muscle function, and facilitate normal sexual responses.

Psychosexual and Relationship Therapy

Referral for psychosexual counseling is appropriate when symptoms are associated with relationship difficulties, sexual trauma, cultural conflicts, performance anxiety, or maladaptive beliefs regarding sexuality.

Therapeutic goals include:

- Improving communication between partners
- Addressing cognitive distortions
- Exploring relationship dynamics
- Reducing performance pressure
- Enhancing emotional intimacy

Figure 6: Interdisciplinary Liaison Pathways



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339 Assessment of psychotropic associated sexual disorders

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341 Table 5. Psychotropic Drug–Associated Sexual Dysfunction

Drug/Class	Common Sexual Dysfunction	Proposed Mechanism	Risk	Clinical Pearls/Management
SSRIs (Fluoxetine, Sertraline, Paroxetine, Escitalopram, Citalopram)	↓ Libido, impaired arousal/lubrication, delayed orgasm, anorgasmia	↑ Serotonin (5-HT _{2A} /5-HT _{2C}), ↓ dopamine, inhibition of spinal sexual reflexes	Very High	Dose reduction, drug holiday (selected patients), switch to bupropion or mirtazapine, augmentation with bupropion
SNRIs (Venlafaxine, Duloxetine, Desvenlafaxine)	Similar to SSRIs; delayed orgasm and reduced desire	Serotonergic inhibition	High	Similar management as SSRIs
TCAs (Amitriptyline, Imipramine, Clomipramine)	Reduced desire, arousal problems, anorgasmia	Anticholinergic, antihistaminic, α-blockade, serotonergic effects	Moderate–High	Consider alternative antidepressants if troublesome
MAOIs	Reduced libido, anorgasmia	Increased monoamines with serotonergic effects	Moderate	Less commonly used today
Bupropion	Usually improves libido and orgasm; rarely causes dysfunction	Dopamine & norepinephrine reuptake inhibition	Very Low	Preferred antidepressant when sexual dysfunction is a concern; useful for SSRI-induced dysfunction
Mirtazapine	Minimal sexual dysfunction	5-HT ₂ and 5-HT ₃ antagonism	Low	Useful alternative when SSRIs cause sexual adverse effects
Vortioxetine	Lower rates of sexual dysfunction than SSRIs	Multimodal serotonergic action	Low	May improve SSRI-induced dysfunction
Agomelatine	Minimal sexual dysfunction	Melatonergic agonist; 5-HT _{2C} antagonist	Very Low	Consider when preserving sexual function is important
Typical Antipsychotics (Haloperidol, Chlorpromazine)	↓ Libido, arousal difficulty, anorgasmia, amenorrhea	D ₂ blockade → hyperprolactinemia; sedation	High	Check serum prolactin; consider switching if clinically feasible
Risperidone/Paliperidone	Marked loss of desire, lubrication difficulty, orgasmic dysfunction	Significant hyperprolactinemia	Very High	Commonest antipsychotic cause; switch to prolactin-sparing agent if possible
Olanzapine	Mild–moderate sexual dysfunction	Weight gain, sedation, mild prolactin elevation	Moderate	Monitor metabolic effects
Quetiapine	Relatively low incidence	Minimal prolactin elevation	Low	Often preferred when sexual adverse effects occur
Aripiprazole	Lowest risk; may improve antipsychotic-induced dysfunction	Partial D ₂ agonist lowers prolactin	Very Low	Useful as switch or augmentation for hyperprolactinemia

Ziprasidone/Lurasidone	Low incidence	Minimal prolactin elevation	Low	Better sexual tolerability than risperidone
Mood Stabilizers (Lithium, Valproate, Carbamazepine)	Reduced libido, erectile/arousal problems, menstrual disturbances	Hormonal changes, sedation, weight gain	Low–Moderate	Optimize dose; address endocrine/metabolic effects
Benzodiazepines	Reduced desire and arousal	CNS depression, sedation	Low–Moderate	Use lowest effective dose
Stimulants	Variable—may improve or impair libido	Dopaminergic/noradrenergic effects	Variable	Individualized assessment required

Clinical Approach to Suspected Psychotropic-Induced Sexual Dysfunction

- Establish a temporal relationship between starting/increasing the medication and onset of symptoms.
- Exclude depression, anxiety, endocrine disorders, and relationship issues.
- Assess prolactin if antipsychotic-induced dysfunction is suspected.
- Consider dose reduction, switching to a lower-risk agent, or augmentation (e.g., bupropion for antidepressant-induced dysfunction; aripiprazole for antipsychotic-induced hyperprolactinemia).
- Balance sexual adverse effects against psychiatric stability before changing treatment.

Multimodal Management Strategies

Successful treatment requires an individualized approach that addresses biological, psychological, and interpersonal contributors simultaneously.

Non-Pharmacological Interventions (Figure 7)

The PLISSIT Framework

The PLISSIT model provides a stepwise approach to psychosexual care. ^[19]

Permission Creating a safe environment in which patients feel comfortable discussing sexual concerns.

Limited Information Providing education regarding sexual functioning and correcting misconceptions.

Specific Suggestions Presenting practical recommendations adapted to identified difficulties.

Intensive Therapy Referring complex cases for specialized psychosexual treatment.

Therapeutic Interventions

Sensate Focus Therapy

Sensate focus is a structured behavioral intervention developed by Masters and Johnson designed to reduce performance anxiety and increase awareness of pleasurable sensations.

Treatment progresses gradually from non-sexual touch to genital stimulation and eventually to penetrative activity, emphasizing sensory awareness rather than performance goals. ^[20]

Cognitive Behavioral Therapy

CBT targets maladaptive beliefs and cognitive patterns that contribute to sexual dysfunction. Treatment addresses unrealistic expectations, negative self-evaluations, avoidance behaviors, and anxiety. ^[21]

Mindfulness-Based Interventions

Mindfulness training encourages present-moment awareness during intimate experiences. By reducing distraction and self-monitoring, these techniques facilitate greater responsiveness to sexual stimuli and bodily sensations. ^[22]

Figure 7: Non-Pharmacological Interventions

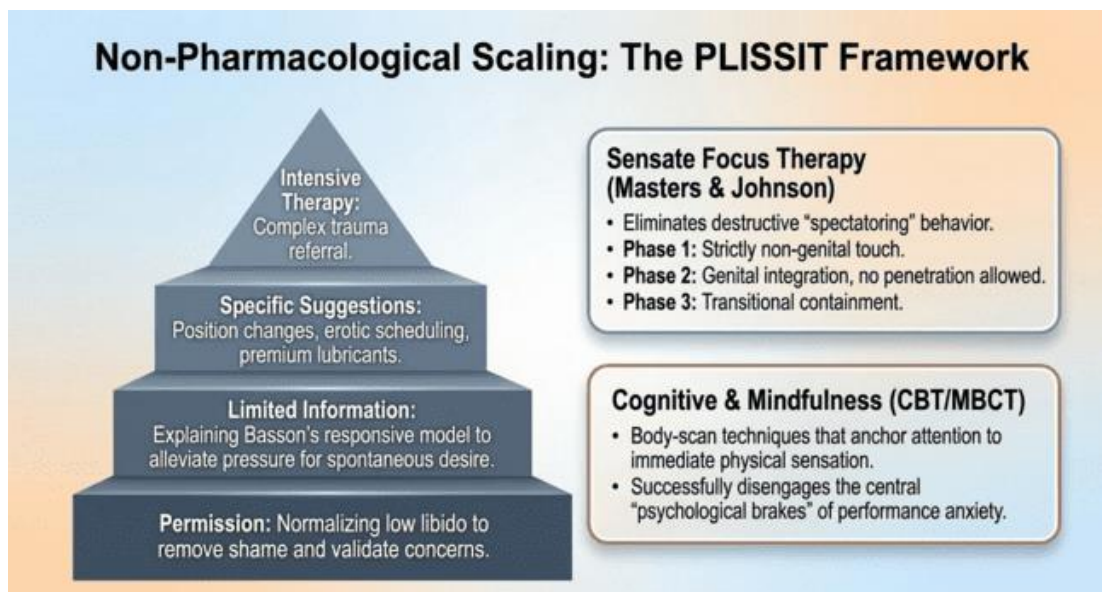


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Restorative Interventions

Management of Genitourinary Syndrome of Menopause

Localized estrogen therapy may improve vaginal lubrication, tissue elasticity, and comfort during sexual activity.

Intravaginal dehydroepiandrosterone (DHEA) preparations can also improve tissue health through local hormonal conversion without substantial systemic hormone exposure.

Pelvic Floor Rehabilitation

When pelvic floor dysfunction contributes to symptoms, treatment may include:

- Trigger-point release techniques
- Electromyographic biofeedback
- Graduated vaginal dilator therapy

These interventions improve comfort and reduce muscular guarding.

394

395 Pharmacological Management

396 Medication may be considered when behavioral and educational interventions alone are
397 insufficient. (Table 6)

398 Flibanserin

399 Flibanserin is approved for selected premenopausal women with acquired, generalized
400 hypoactive sexual desire disorder.

401 Its therapeutic effects are thought to involve modulation of serotonin, dopamine, and
402 norepinephrine pathways involved in sexual motivation.

403 Common adverse effects include dizziness, sleepiness, nausea, and hypotension. Bedtime
404 administration is recommended to minimize side effects. ^[23]

405 Bremelanotide

406 Bremelanotide is an injectable melanocortin receptor agonist administered before
407 anticipated sexual activity. ^[24]

408 The medication enhances central pathways involved in sexual motivation and desire.

409 Potential side effects include nausea, transient increases in blood pressure, and skin
410 pigmentation changes.

411 Transdermal Testosterone

412 Although frequently prescribed off-label, testosterone therapy may benefit carefully selected
413 postmenopausal women with reduced sexual desire.

414 Treatment requires regular monitoring to maintain hormone levels within physiological
415 female ranges and to detect adverse androgenic effects. ^[25]

416 Bupropion

417 Bupropion has been used off-label in women experiencing reduced sexual desire, particularly
418 when symptoms are associated with antidepressant use.

419 Because it may lower the seizure threshold, careful patient selection is essential.

420 Ospemifene

421 Ospemifene is a selective estrogen receptor modulator indicated for postmenopausal women
422 experiencing dyspareunia associated with vulvovaginal atrophy.

423 The medication improves vaginal tissue health and reduces discomfort during intercourse. ^[26]

424 Table 6: Pharmacological Management of Decreased Sexual Interest and Arousal

Parameter	Flibanserin (US FDA approved)	Bremelanotide (US FDA approved)	Transdermal Testosterone (Off- Label)	Bupropion (Off- Label)	Ospemifene
Mechanism of Action	• Postsynaptic 5-HT_{1A} agonist • 5-HT_{2A} antagonist • ↓ Serotonin-mediated inhibition • ↑ Dopamine & norepinephrine release in prefrontal cortex	• Synthetic α-MSH analog • Non-selective melanocortin receptor agonist • Primarily acts on central MC4R receptors • Enhances sexual motivation pathways	• Activates central androgen receptors • ↑ Dopamine synthesis and release in hypothalamus • Enhances sexual motivation and peripheral sensitivity	• Norepinephrine-Dopamine Reuptake Inhibitor (NDRI) • ↑ Synaptic dopamine and norepinephrine • Enhances central appetitive activation	• Selective Estrogen Receptor Modulator (SERM) • Estrogen agonist on vaginal epithelium • Antagonistic effects in breast tissue
Indication	• Premenopausal women with generalized, acquired HSDD	• Premenopausal women with generalized, acquired HSDD	• Postmenopausal women (natural or surgical menopause) with HSDD • Usually combined with estrogen therapy	• SSRI-induced sexual dysfunction • Off-label augmentation for FSIAD/HSDD	• Moderate-to-severe dyspareunia due to vulvovaginal atrophy in postmenopausal women
Dosing	• 100 mg orally once daily • Strictly at bedtime	• 1.75 mg SC injection (abdomen/thigh) • At least 45 minutes before anticipated sexual activity • As needed	• 300 mcg/day transdermal patch, cream, or gel • Female-specific dosing required	• 150–300 mg/day orally (XL formulation preferred)	• 60 mg orally once daily • Taken with food
Key Adverse Effects	• Dizziness • Somnolence • Nausea • Hypotension • Syncope	• Nausea (~40%) • Transient facial/gum hyperpigmentation • Increased blood pressure	• Acne • Hirsutism • Clitoromegaly (may be irreversible) • Voice deepening	• Insomnia • Anxiety/agitation • Dry mouth • Headache • Dose-related seizure risk	• Hot flashes • Leg cramps • Vaginal discharge
Key Warnings / Clinical Considerations	• Risk of severe hypotension and syncope • Avoid alcohol close to dosing (separate by ≥2 hours or skip dose)	• Maximum 8 doses/month • Not more than 1 dose/24 hours • Contraindicated in uncontrolled hypertension	• Male formulations/doses should not be used • Monitor total testosterone at baseline and every 3–	• Contraindicated in seizure disorders • Contraindicated in anorexia nervosa or bulimia nervosa • Lowers seizure threshold	• Potential thromboembolic risk • Requires cardiovascular risk assessment before initiation

Parameter	Flibanserin (US FDA approved)	Bremelanotide (US FDA approved)	Transdermal Testosterone (Off- Label)	Bupropion (Off- Label)	Ospemifene
	• Bedtime administration essential	• Avoid in significant cardiovascular disease	• 6 months (LC-MS preferred) • Maintain levels within female physiological range • Discontinue if ineffective after 6 months		• May worsen hot flashes in early menopause
Availability in India	Not Available	Not Available	No female specific product in India	Available	Not Available

Sildenafil: It is a PDE5 inhibitor which increases the blood flow to the genitals. There are reports that sildenafil may help to improve vaginal lubrication and hence arousal. Sildenafil as a cream can be applied on clitoris, labia or vagina by women^[8]. Sildenafil is available in India.

Other pharmacological agents: Over the counter medications like oral phentolamine, topical prostaglandin E (alprostadil), oral oxytocin, ginseng, ginkgo biloba, L arginine, and caffeine have been tried, However, they are not approved for the treatment of female sexual dysfunctions. ^[8]

Table 7: Consolidated Review

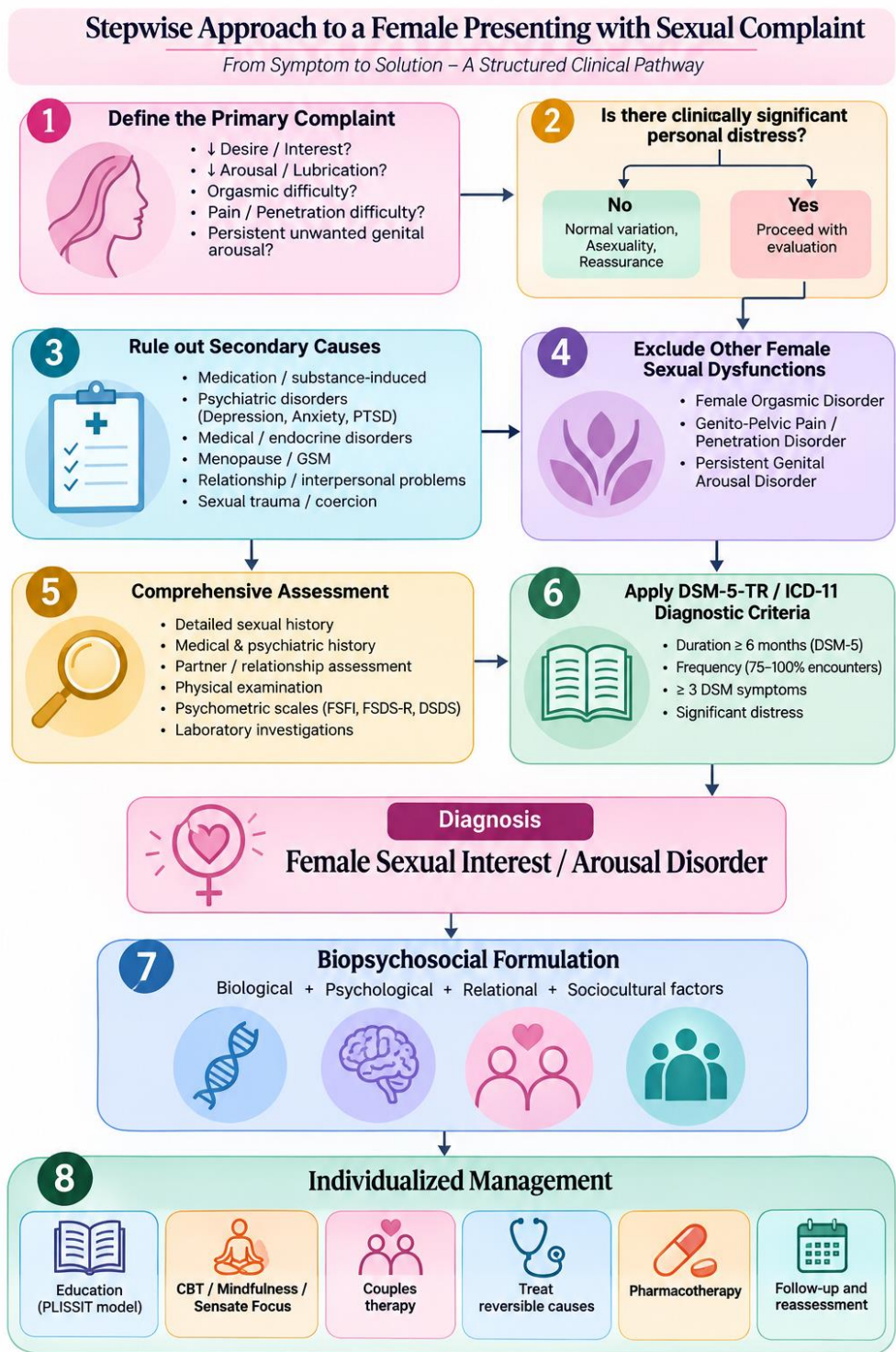
When we put all of the above together and put in context of the two scenarios discussed:

Desire Dysfunction	Genital Arousal Dysfunction
<i>Biopsychosocial Formulation</i> Biological Factors No significant hormonal, structural, or medical abnormalities are identified. Psychological Factors Anxiety, guilt, and rigid expectations regarding sexual desire appear to play a major role in symptom maintenance. Relationship Factors Although the relationship remains supportive, mismatched expectations regarding intimacy have created emotional strain.	<i>Biopsychosocial Formulation</i> Biological Factors Postmenopausal hormonal changes have contributed to tissue atrophy and impaired genital responsiveness. Psychological Factors Repeated experiences of failed arousal have led to heightened self-monitoring and reduced engagement during intimacy. Relationship Factors Although the relationship remains emotionally supportive, fear of discomfort has reduced sexual activity.
<i>Diagnostic Impression</i> DSM-5 TR diagnosis: Female Sexual Interest/Arousal Disorder ICD-11 diagnosis: Hypoactive Sexual Desire Dysfunction	<i>Diagnostic Impression</i> DSM-5 TR diagnosis: Female Sexual Interest/Arousal Disorder ICD-11 diagnosis: Female Sexual Arousal Dysfunction (Genital Arousal Type)
<i>Physical Exam:</i> Normal vulvovaginal anatomy; well-estrogenized tissue; no localized tenderness or hypertonicity. <i>Laboratory Findings:</i> TSH, Prolactin and HbA1c are normal. Total Testosterone (LC-MS): Low-normal. Free Testosterone: Normal.	<i>Physical Exam:</i> Classic signs of Genitourinary Syndrome of Menopause (GSM). Thin, pale, friable vulvovaginal mucosa; loss of vaginal rugae; introital narrowing; vaginal pH: indicative of significant hypoestrogenism. Mild tenderness at the posterior fourchette. <i>Laboratory Findings:</i> TSH and Prolactin are normal; FSH: Confirmed Postmenopausal range); Estradiol: Severe hypoestrogenism; Total Testosterone (LC-MS): Low.
<i>Psychometrics:</i> FSFI Total Score: clinically significant sexual dysfunction FSDS-R Score: confirms clinically significant sexually related distress. DSDS: "Yes" to questions 1–4; question 5 rules out primary medical or pharmacological causes.	<i>Psychometrics:</i> FSFI Total Score: clinically significant sexual dysfunction FSDS-R Score: confirms clinically significant sexually related distress

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440

441 Figure 8. Stepwise approach to female sexual dysfunction



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444 themselves
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446 Advanced Interventions and Emerging Therapies

447 As research into female sexual physiology continues to evolve, several innovative therapies
448 are being explored. (Figure 8)

EROS Clitoral Therapy Device (EROS)

This handheld vacuum device enhances blood flow to the clitoral tissues through controlled negative pressure. It is FDA approved.^[27]

Regular use may improve genital sensitivity, vascular responsiveness, and subjective arousal in selected patients.

The EROS Clitoral Therapy Device is not commercially available in India.

Vibrators

Vibrator therapy is an evidence-based adjunctive treatment for Female Sexual Interest/Arousal Disorder. Regular external clitoral stimulation (5–10 minutes, 2–3 times/week for approximately 3 months) has been shown to improve sexual desire, arousal, orgasm, satisfaction, and overall sexual function, while also providing benefits for pelvic and mental health.^[28]

Neuromodulation Approaches

Emerging technologies aim to influence neural pathways involved in sexual response.

Transcutaneous Afferent Patterned Stimulation (TAPS)

This non-invasive technique applies electrical stimulation to peripheral nerves associated with sexual function, potentially enhancing arousal mechanisms.

Transcutaneous Afferent Patterned Stimulation (TAPS) remains an investigational technique without routine clinical availability.

Repetitive Transcranial Magnetic Stimulation (rTMS)

Clinical studies are investigating whether targeted stimulation of cortical regions involved in attention and inhibition can improve sexual responsiveness in treatment-resistant cases.

rTMS is the only modality that is widely available in India, although its use in female sexual dysfunction remains experimental

Low-Intensity Extracorporeal Shockwave Therapy (LI-ESWT)

Adapted from therapies used in vascular erectile dysfunction, low-intensity shockwave treatment seeks to improve genital blood flow by stimulating tissue repair and angiogenesis.

The proposed benefits include enhanced vascular function, improved lubrication, and restoration of genital responsiveness, although further evidence is required before routine clinical implementation.

LI-ESWT is available primarily for male erectile dysfunction, with limited research use in women.

Figure 9: Advanced Interventions

Advanced Biophysical Interventions for Female Sexual Dysfunction (FSD)

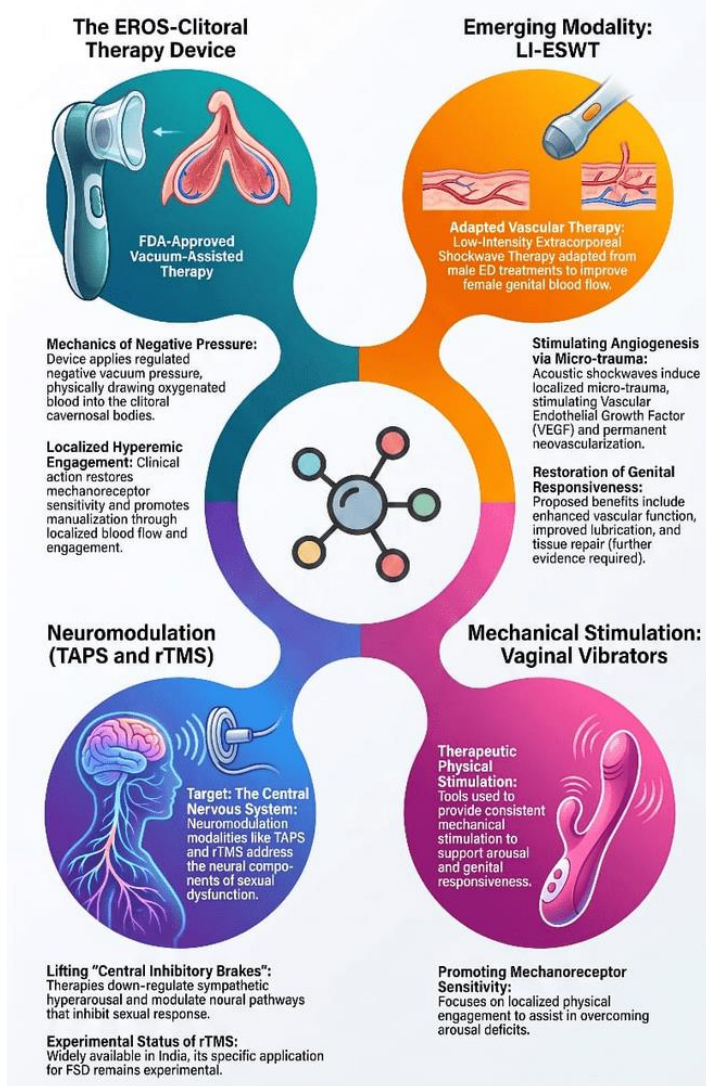


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Legal, Safety, and Ethical Considerations

The assessment and treatment of Female Sexual Interest and Arousal Disorders must be conducted within a framework that prioritizes patient autonomy, safety, confidentiality, and ethical clinical practice. Because sexual health concerns are highly personal and frequently influenced by relationship dynamics, clinicians must exercise particular sensitivity when evaluating and managing these conditions.

Informed Consent and Off-Label Treatment

The limited number of approved pharmacological options for female sexual dysfunction often leads clinicians to consider medications that are prescribed outside their formally approved indications. Examples include transdermal testosterone and bupropion in carefully selected patients.

495 When off-label therapies are recommended, comprehensive informed consent is essential.
496 Patients should receive clear information regarding the intended therapeutic purpose of the
497 medication, the fact that regulatory approval for the specific indication may be absent, the
498 expected benefits and limitations of treatment, potential adverse effects and safety concerns
499 and available alternative treatment options.

500 Documentation of this discussion should be maintained within the medical record to ensure
501 transparency and support shared clinical decision-making.

502 **Monitoring and Safety Requirements**

503 Certain off-label interventions require ongoing clinical surveillance. For example, women
504 receiving testosterone therapy should undergo periodic laboratory assessment to ensure
505 hormone concentrations remain within the normal physiological female range.

506 Regular monitoring helps minimize potential risks, including metabolic complications,
507 cardiovascular adverse effects, acne and hirsutism, voice deepening, clitoral enlargement and
508 other signs of androgen excess.

509 Treatment should be reviewed periodically and discontinued if meaningful clinical
510 improvement is not achieved or if adverse effects outweigh potential benefits.

511 **Respect for Patient Autonomy**

512 A central ethical principle in sexual medicine is respect for individual autonomy. Decisions
513 regarding sexual activity, treatment participation, and therapeutic goals should always reflect
514 the patient's personal values, preferences, and priorities.

515 Clinicians should avoid imposing societal, cultural, or relationship-based expectations
516 regarding sexual frequency, desire, or behavior. Variations in sexual interest are common,
517 and treatment is appropriate only when symptoms cause significant personal distress or
518 impairment.

519 **Screening for Coercion and Abuse**

520 One of the most important responsibilities during assessment is determining whether
521 reported sexual difficulties arise from an intrinsic sexual disorder or from external
522 circumstances such as coercion, abuse, or unsafe relationship dynamics.

523 Women may present with reduced sexual desire or arousal as a protective response to
524 intimate partner violence, emotional abuse, sexual coercion, controlling relationship
525 behaviors and chronic interpersonal conflict.

526 In such situations, diminished sexual interest should not be viewed as evidence of a primary
527 sexual dysfunction.

528 **Independent Clinical Interview**

529 Whenever concerns regarding coercion or abuse are possible, the patient should be
530 interviewed privately and separately from her partner. This creates a safe environment in
531 which sensitive information can be disclosed without fear of retaliation or judgment.

Assessment should explore Relationship safety, emotional wellbeing, experiences of pressure or coercion, physical and sexual abuse, control over sexual decision-making and availability of social support.

If abuse or coercion is identified, clinical priorities should shift toward patient safety, protection, and appropriate referral pathways.

Trauma-Informed Care

Many women presenting with sexual difficulties have histories of adverse sexual experiences or psychological trauma. A trauma-informed approach recognizes the impact of these experiences on sexual functioning and seeks to avoid re-traumatization during assessment and treatment.

Key principles include establishing emotional and physical safety, maintaining patient control throughout consultations, seeking explicit consent before examinations, using respectful and non-judgmental language and collaboratively planning treatment goals.

Referral to mental health professionals with expertise in trauma may be necessary when trauma-related factors significantly contribute to sexual symptoms.

Confidentiality and Professional Boundaries

Strict confidentiality is fundamental to sexual health practice. Information disclosed during consultations should be protected according to professional and legal standards.

Clinicians must also maintain clear professional boundaries, ensuring that discussions regarding sexuality remain therapeutic, respectful, and clinically appropriate. Accurate documentation, transparent communication, and adherence to professional ethical codes are essential components of responsible care.

Figure 10: Overview Chart

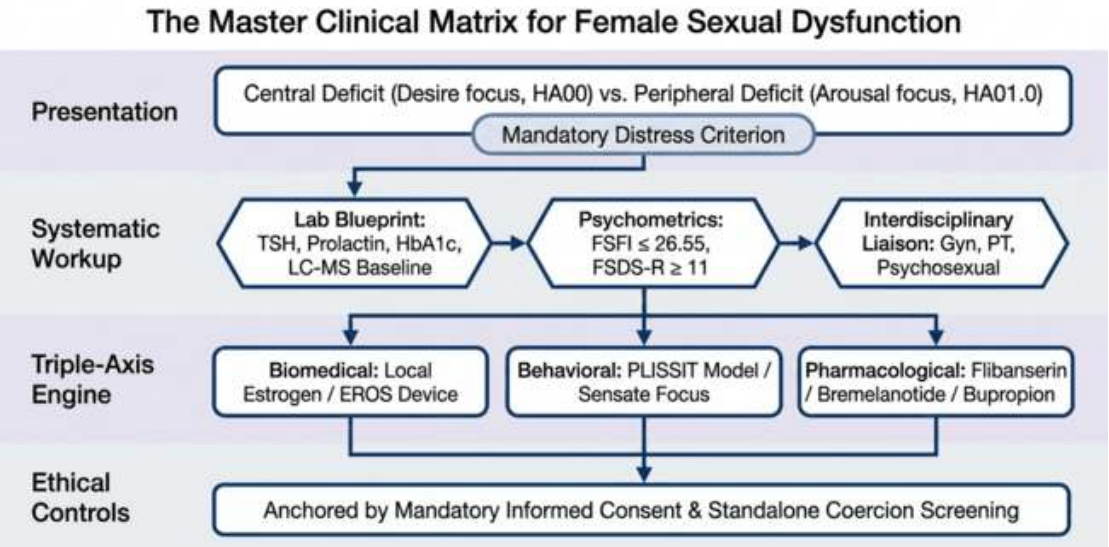


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The algorithm above, equips the clinician to approach FSIAD comprehensively, ensuring that holistic assessment, diagnostics and management are covered while dealing with every patient.

Disclaimer: AI has been used to research and review literature of the above guidelines, and generate images wherever indicated in the manuscript. The rest of the content is original and by the authors themselves.

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