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Female Sexual Interest and Arousal Disorder

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Continuing Education Activity

Female sexual interest/arousal disorder (FSIAD), previously termed hypoactive sexual desire disorder and female sexual arousal disorder, is a prevalent condition that primarily affects older and postmenopausal women. FSIAD encompasses a lack of or significantly reduced sexual interest/arousal, often leading to distress or interpersonal difficulties. This condition is frequently underdiagnosed due to sociocultural barriers and limited clinician understanding. Diagnostic criteria include several symptoms, such as reduced sexual thoughts or fantasies, decreased initiation of sexual activity, and diminished sexual pleasure. Diagnosis also requires the presence of distress related to these symptoms for at least 6 months. Various factors, including physiological, psychological, and sociological elements, may contribute to FSIAD. Management approaches range from counseling and therapy to United States Food and Drug Administration-approved and off-label medications. Monitoring and individualizing treatment are crucial due to potential adverse effects and variability in response.

In this course, healthcare professionals gain an in-depth understanding of the etiology, prevalence, diagnostic criteria, and current therapeutic approaches of FSIAD. Participants learn to individualize treatment plans, considering psychotherapeutic and pharmacological options to improve patient care. The course also emphasizes the importance of interprofessional collaboration, with clinicians working alongside psychologists, therapists, and other specialists to develop comprehensive treatment plans. This teamwork ensures a holistic approach to managing FSIAD, ultimately improving patient outcomes.

Objectives:

- Differentiate female sexual interest/arousal disorder from other sexual dysfunctions and conditions that may present with similar symptoms.
- Screen for potential contributing factors to female sexual interest/arousal disorder, such as physiological, psychological, and sociocultural influences, to guide comprehensive assessment.
- Implement appropriate diagnostic tools and questionnaires to assess the presence and severity of female sexual interest/arousal disorder.
- Apply interprofessional team strategies to improve care coordination and outcomes in patients with female sexual interest/arousal disorder.

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Introduction

Female sexual interest/arousal disorder (FSIAD), a combination of 2 formerly separate disorders, is a poorly treated and underdiagnosed disorder that is highly prevalent among women.[1][2] Sociocultural barriers, shame, and healthcare professionals' limited understanding contribute to underdiagnosis and inadequate management.[2] FSIAD comprises the conditions previously known as hypoactive sexual desire disorder, which was defined in the *Diagnostic and Statistical Manual of Mental Disorders*, *Fourth Edition, Text Revision* (*DSM-IV-TR*) as a recurrent or persistent deficiency or absence of sexual desire and fantasies for sexual activity that results in marked distress or interpersonal difficulty, and female sexual arousal disorder, defined as reduced sensation, pleasure, or excitement during sexual activity.[2][3][4] Therefore, the perception of distress stemming from the absence of sexual desire or experience differentiated hypoactive sexual desire disorder from female sexual arousal disorder, which was a sexual desire disorder without distress.[2][5][3][4] Due to the link between sexual desire, interest, and physical arousal, both female sexual arousal disorder and hypoactive sexual desire disorder were reclassified as the singular condition FSIAD in *DSM-IV-TR*.[2][5][6]

The extensively researched findings on FSIAD, as defined in *DSM-IV-TR*, serve as the foundation for the current understanding of and management approaches to sexual desire disorders.[1][2][5] The prevalence of FSIAD ranges from 7.4% in women older than 65 to as high as 12.3% among women between 45 and 64.[7][8] With the emergence of advancements in early diagnosis and new management strategies, valuable opportunities and evolving treatment options offering hope for previously hesitant women to seek assistance are now available.[5]

Etiology

Female sexuality is controlled by complex interactions among physiological, psychological, anatomical, neurochemical, hormonal, pharmacological, and social factors.[1][2][9] Factors such as age, menopausal status, sociocultural challenges, stress, challenging relationships, medical comorbidities, medication interactions and adverse events, and anatomic factors such as female genital mutilation or circumcision, among others, play causative and contributory roles in the development of FSIAD.[2][9][10] Other factors that have been associated with sexual disorders include life situations, ethnicity, and culture.[2]

According to study results, single and Black women are diagnosed with FSIAD less than married and White women.[5] Furthermore, psychosocial and interpersonal relationships with sexual partners may significantly affect the sexual desire of female partners.[7] Additionally, female circumcision, commonly practiced in some countries and cultures, can have a significant effect on female sexuality.[10] Various data have shown that circumcised women are more likely to experience low sexual desire, poor sexual satisfaction, poor sexual excitement with or without stimulation, and painful experiences during sexual intercourse.[10][11] Female sexual dysfunction and, by extension, FSIAD are reported to be much more common among circumcised women than among their uncircumcised peers.[10][11][12][13]

Sex hormones, including progesterone, testosterone, and estrogen, also modulate sexual desire and sexuality in women through their effects when interacting with various neurotransmitters, resulting in the control of sexual desire and enjoyment.[1][2][14][2] Some neurotransmitters are responsible for excitatory pathways, primarily controlled by dopaminergic substances, including dopamine and norepinephrine.[2][7] Dopamine enhances sexual excitement and desire, while norepinephrine (noradrenalin) enhances arousal and orgasm.[2][7][15] Inhibitory pathways for sexual desire and enjoyment occur primarily via the serotonergic system.[2][7][15] Excessive release of serotonin or a reduction in its metabolism may result in the loss of libido and reduced sexual desire or arousal. Selective serotonin reuptake inhibitors may cause symptoms similar to those of FSIAD by increasing serotonin levels. Medications and conditions that increase brain serotonin or decrease dopamine levels have been associated with FSIAD.[2][7][16]

Epidemiology

FSIAD is the most common female sexual dysfunction.[17] Results from previous studies that assessed the prevalence of sexual desire disorders in women lacked a standardized definition, rendering the reported prevalence unreliable.[18][2] In recent years, many studies have documented the prevalence of FSIAD based on the standardized definition defined in *DSM-IV-TR*, with emphasis on the inclusion of the presence of distress.[2][5][18] The Pharmacogenomics in Depression Study (PRESIDE) reported the prevalence of FSIAD as ranging from 7.4% among women aged 65 and older to 12.3% among women aged between 45 and 64. Younger women between 18 and 44 had a prevalence of 8.9%.[2][5][10][18] Of note, in the same PRESIDE study, cumulative unadjusted prevalence of sexual desire disorder with and without distress was reportedly 38.7% among all age groups. To identify patients with distress when classifying a patient as having FSIAD, the PRESIDE study used a Female Sexual Distress Scale score of 15 or greater before diagnosing FSIAD.[2][5]

In the Women's International Study of Health and Sexuality (WISHeS), another cross-sectional study conducted among women residing in the United Kingdom, France, Italy, Germany, and North America, the results showed that the prevalence of FSIAD ranged between 6% and 16% in Europe and between 9% and 26% in North America.[1][2] Other study results have shown that although the prevalence of low libido increases with age, the prevalence of distress associated with this low libido simultaneously decreases. This trend makes FSIAD more common among middle-aged women than older and younger women. In addition, postmenopausal women have a much greater incidence of FSIAD than premenopausal women, whether the postmenopausal status is natural or surgically induced.[5] Obesity, current smoking status, current depression, educational level, and hormone replacement therapy are other factors that have been associated with FSIAD.[1][5][19] FSIAD has also been associated with low self-esteem, dissatisfaction with sexual partners, emotional distress, back pain, fatigue, memory deficits, and relationship difficulties.[2][16][17]

Pathophysiology

Certain excitatory and inhibitory hormones and neurotransmitters affect the brain, which helps explain the pathophysiology of FSIAD. The female genitalia are richly innervated by nerve fibers which transmit tactile and pleasurable sensations to the brain. These signals travel to brain regions like the insula and thalamus for processing.

Visual stimuli also influence human sexuality.[20][21][22] Neuroimaging studies have identified the sexual desire brain network, which involves various brain regions responding to sexual stimuli. Atrophy in excitatory areas and hyperactivity in inhibitory areas of the brain are associated with FSIAD.[20][21][22] Increased neuroimaging activity in brain regions, including the ventromedial prefrontal cortex, amygdala, and insula, during sexual inhibition may contribute to FSIAD. In contrast, heightened activity in areas including the anterior cingulate cortex and ventral striatum during sexual excitation is associated with normal sexual response. The ventral occipitotemporal cortex tracks sexual arousal and response to visual sexual stimuli, even with closed eyes, showing a preference for body parts.[9][23]

Various neurotransmitters, including dopamine, estrogen, and testosterone, contribute to increasing sexual desire and arousal. Conversely, serotonin, prolactin, and opioids have inhibitory effects on these processes. Notably, testosterone significantly influences sexual desire.[20][21][22] As women age, especially after menopause, ovarian and adrenal production of testosterone decreases. In women who have undergone surgical menopause, testosterone levels are half of the testosterone level in women who undergo menopause naturally.[24]

History and Physical

The evaluation of a patient with FSIAD should encompass a thorough medical history and physical examination to help identify the underlying cause and duration of the sexual disorder, allowing the clinician to devise effective management strategies. A crucial initial step is to determine the primary concern or issue, which may include diminished sexual desire, arousal difficulties, vaginal dryness, insufficient response to foreplay, discomfort during sexual activity, or challenges in achieving orgasm. Gathering and documenting a comprehensive medical history is imperative for diagnosing FSIAD. The evaluation process outlines critical elements essential for assessing a patient with FSIAD (see **Table.** Assessing Patients with Female Sexual Interest/Arousal Disorder).

Evaluation

Women with FSIAD may present in different healthcare settings, including primary care offices, emergency departments, gynecology clinics, psychiatry clinics, and sexual health or therapy clinics.[7][25] A common challenge, however, is that many of these patients will not voluntarily provide relevant information that may suggest a proper diagnosis because of fear of embarrassment to themselves or the clinicians. Symptoms may be subtle or ignored. In addition, many healthcare professionals are either ill-equipped or do not have enough time to assess properly patients who have sexual desire or function concerns.[26]

In a survey of a multispecialty annual meeting in which 1946 physicians responded, approximately 60% of participants rated their knowledge of and their comfort level at diagnosing or managing female sexual dysfunctions as poor or fair.[27][28] Harsh et al also surveyed 53 resident physicians (78%) and faculty members (22%) of a university internal medicine clinic.[28] In that survey, approximately 90% of the participants reported not being confident diagnosing FSIAD. Many clinicians consider sexual desire disorders to be unrelated to their purview or professional expertise, feeling inadequately equipped to diagnose and adequately manage sexual disorders.

Eliciting and documenting an adequate history is critical for diagnosing FSIAD. Key important points in assessing a patient with FSIAD are listed below (see **Table.** Assessing Patients with Female Sexual Interest/Arousal Disorder). These key points include poor or low desire for sex, difficulty with sexual arousal; vaginal dryness; inability to respond adequately to foreplay, pain before, during, or after sexual activity; and delay or inability to reach orgasm or climax. Furthermore, clinicians should keep in mind that not every woman with sexual desire disorder has FSIAD, and a patient may have more than 1 sexual disorder.[29][30] To diagnose FSIAD, establishing the presence of associated distress or interpersonal relationship concerns related to the expressed sexual disorder symptoms is critical.[31] The presence of sexual disorder symptoms without associated distress excludes the diagnosis of FSIAD. However, such symptoms may indicate the presence of sexual desire disorders other than FSIAD.

Laboratory studies may include a complete blood count, thyroid stimulation hormone, vitamin D, and prolactin levels if an underlying disease process causing FSIAD is suspected. Testing sex hormone steroid levels, including testosterone levels, is not recommended. Physical examination may be performed at the clinician's discretion.[26]

In 2000, Rosen et al developed the Female Sexual Function Index (FSFI), which measures scores in 6 domains: desire, lubrication, arousal, orgasm, satisfaction, and pain. Each domain is assessed on a scale from 1 to 5, with 1 being very low, 2 being low, 3 being moderate, 4 being high, and 5 being very high. The questions center on the patient's perception of these 6 domains over the last 4 weeks.[32][33] Wiegel et al conducted another study that cross-validated the FSFI and developed cutoff scores.[34] This study's results concluded that scores less than or equal to 26.55 out of 30 indicated sexual dysfunction.

Another option for screening patients is the Decreased Sexual Desire Screener (DSDS) tool, which was initially developed as a short screening tool for hypoactive sexual desire disorder (HSDD) by Rosen et al in 2007, based on *DSM-IV-TR* criteria for HSDD diagnosis (see **Table.** Decreased Sexual Desire Screener).[29] This tool is easy to use, even for those without sexual health specialty training. With DSDS, a patient who answers "yes" to all questions 1 through 4 and "no" to all factors in part 5 meets the diagnostic criteria for generalized acquired HSDD.

Interpretation of the DSDS Screen Results

According to *DSM-V*, the duration of symptoms should be at least 6 months.[35] In addition, the *DSM-V* removes the prerequisite of a patient having "desire" dysfunction as a condition for diagnosing female sexual dysfunction. However, this distinction is limited to women.[5] Instead of "desire," the *DSM-V substituted* "interest" and replaced both HSDD and female sexual arousal disorder with the consolidated diagnosis of FSIAD.[5][6] The definition and assessment of desire have been significant points of contention in diagnosing FSIAD.[35] Women's perception of desire is influenced by various factors such as emotional, psychological, cognitive, and interpersonal elements. Notably, the desire for sex may not always be the primary motivation for women to engage in sexual activity.[35] Many women have reported participating in sexual intercourse for reasons beyond desire, such as feeling obligated to satisfy their partner's needs, for emotional connection, or in exchange for nonsexual favors.

Consequently, since many women engage in sexual activity for motives other than desire, the absence of desire may not always clearly indicate a sexual disorder. The replacement of "desire" with "interest" and consolidation of female sexual disorder into FSIAD in the *DSM-V* was done to specify the duration and severity of symptoms required for diagnosing a female sexual disorder, to avoid classifying normal female functioning as pathological and to underscore the fact that sexual experiences in women are best described as being "subjective and relational."[35][36][37][38]

Diagnosing Female Sexual Interest/Arousal Disorder

To diagnose FSIAD, 3 of the following 6 symptoms must be present for at least 6 months and need to be causing clinically significant distress:

1. Absent or reduced interest in sexual activity
2. Absent or reduced sexual or erotic thoughts or fantasies
3. Absent or reduced initiation of sexual activity and typically unreceptive to a partner's attempts to initiate sex
4. Absent or reduced sexual excitement or pleasure during sexual activity in all or almost all, between 75% and 100%, of sexual encounters (in identified situational contexts if limited to specific situations or in all contexts if generalized)
5. Absent or reduced sexual interest or arousal in response to any internal or external sexual or erotic stimuli or cues
6. Absent or reduced genital or nongenital sensations during sexual activity in almost all or all, between 75% and 100 %, sexual encounters (with this being identified as situational if limited to specific contexts or in all contexts if generalized) [37][38]

The duration of the problem should be established during the assessment, including whether the symptoms have been lifelong or acquired and whether they are situational or generalized. Lifelong symptoms indicate the problem has been present since the patient became sexually active. Acquired symptoms indicate that the problem began after a time of relatively normal sexual function. Generalized symptoms are not limited to specific situations, partners, or stimulation, while situational symptoms occur only with certain situations, partners, or stimulation. The severity should also be categorized as causing the patient mild, moderate, or severe distress.

Extracting etiological history is imperative in diagnosing FSIAD. History about childhood female circumcision or genital mutilation, cultural orientation and upbringing about sexuality, and recent or previous history of genital tract trauma, including parturition-related trauma, may individually or collectively affect the sexual functionality of the glans clitoris and vestibule, which are associated with reception and perception of sexual stimuli.[5] Clitoral amputation or surgical damage of the clitoris and or surrounding genital tissue may affect the perception of sexual stimulation of such affected women.[10][12]

Additionally, physiological, psychological, and sociological factors that may predispose to or perpetuate sexual desire or interest disorder should be sought.[2][5][17] Comorbidities like diabetes, cardiorespiratory disorders, liver disease, thyroid disease, pituitary disorders, neurological conditions, and malignancy have been associated with the development of sexual desire disorders.[5][17] A woman with a new onset of symptomatology coinciding with lifestyle changes, including a new relationship, newly diagnosed medical condition, or treatment of a medical, surgical, psychological, or psychiatric disorder, may have a different etiology for the newly developed sexual desire disorder when compared to a woman with similar symptoms but of much longer or lifelong duration, without an identifiable recent change in life situation.[29]

Adequate gynecological history should focus on identifying the menopausal status, particularly premature or surgical menopause, and other chronic gynecologic conditions that may cause dyspareunia, including vaginal atrophy, endometriosis, and pelvic inflammatory disease.[5][29] Eliciting current and previous medication history is equally important since antipsychotics, antidepressants, antihypertensives, corticosteroids, and hormones can all affect sexuality.[19][39] In some situations, further investigation may be required to exclude other medical comorbidities, assess amenorrhea or oligomenorrhea, and identify sex steroid deficiency.[26] The limitations in testosterone measurement make it difficult to correlate testosterone levels clinically with FSIAD.[24]

Treatment / Management

Nonpharmacological and pharmacological interventions are available to treat and manage FSIAD.

Treatment with Counseling and Therapy

In most cases, managing FSIAD includes a combination of psychotherapy and pharmacotherapy.[2][5] Office-based counseling should be the first approach for managing female sexual dysfunction.[40][41] This involves providing patients with basic education about sexuality and recommended lifestyle changes to improve sexual desire, interest, and experience. Some of the psychotherapies that have been documented as helpful include cognitive behavioral therapy (CBT), basic psychosexual counseling, mindfulness meditation therapy, body awareness education, and relationship counseling. Initial management may include basic psychosexual counseling, which is an office-based therapy that focuses on educating patients about sexual physiology and anatomy, along with normal responses to sexual stimulation and how such responses may be affected by natural developments, including aging, comorbid conditions, and the quality of the relationship.[2][5][40][41]

CBT is an advanced therapy for patients who require a deeper exploration of thoughts and behaviors.[2][5][42] Many study results have documented the effectiveness of CBT in managing female sexual dysfunctions, including FSIAD. Developed by Beck and Ellis, CBT premises that emotional distress and behavioral problems are products of maladaptive cognitions.[43] CBT focuses on strategies that change these maladaptive cognitions. Such changes result in relief or resolution of the emotional distress and problematic behaviors experienced by the patient being treated.

Treatment with Food and Drug Administration-Approved Medications

United States Food and Drug Administration (FDA)-approved medications for managing female sexual dysfunction are limited.[2][44] The following pharmacologic treatments target the sexual inhibitory and excitatory pathways that modulate responses to sexual stimulation or cues:

- **Flibanserin:** A serotonin 1A (5-HT1A) agonist and 2A (5-HT2A) antagonist, flibanserin decreases serotonin levels and increases norepinephrine and dopamine levels.[25] This was FDA-approved in August 2015 for the treatment of generalized, acquired FSIAD in premenopausal women. The drug should be taken at a dose of 100 mg every night before bed and at least 2 hours after drinking alcohol because the most common adverse effects include dizziness and somnolence. Improvement in sexual desire should be noted after 4 to 8 weeks of use.[26]
- **Bremelanotide:** In June 2019, the FDA approved bremelanotide for treating FSIAD in premenopausal women.[25][45] Bremelanotide, a melanocortin agonist, is administered at a dose of 1.75 mg subcutaneously as needed once daily, approximately 45 minutes before the commencement of sexual activity. No more than 1 dose should be administered in 24 hours, and no more than 8 doses per month are recommended. Bremelanotide primarily activates presynaptic melanocortin receptor 4 (MC4R), which stimulates dopamine in brain areas that regulate arousal, motivation, and sexual appetite.[25] This drug should be used with caution in women with concerns for cardiovascular disease, and blood pressure should be monitored and well-controlled. Nausea is the most common reason for the discontinuation of therapy with bremelanotide.[46]

Off-Label Medication Therapies

Off-label medications used to treat FSIAD include:

- **Bupropion:** Bupropion, a dopamine and serotonin reuptake inhibitor, is an off-label treatment option for female sexual dysfunction.[47] In addition to the antidepressant effects of the dopaminergic activities of bupropion, its enhancement of available dopamine in the brain areas that control sexuality could explain the effectiveness of bupropion in the management of FSIAD when compared with placebo.[46]
- **Testosterone:** Available data show that testosterone treatment is effective in menopausal women with sexual desire dysfunction or decreased libido.[48] Evidence is mixed concerning the use of testosterone in premenopausal women, and further studies are needed for validation of its effectiveness. Most practice guidelines concerning testosterone supplementation for FSIAD in women do not recommend testing testosterone levels because no age-specific normal values for testosterone in women have been established. A common approach to treatment with testosterone is to individualize the dosing to resolve the symptoms while keeping adverse events to a minimum.[24] Oral and intramuscular preparations of testosterone are not recommended for women as they result in high fluctuations in levels. Similarly, subcutaneous implants are also not recommended due to the inability to titrate doses. Compounded testosterone cream is also not recommended because of the inability to regulate its concentration. Transdermal formulations, including patches, gel, cream, or spray, are preferred for use in women. Hand washing should be done after applying formulations to the upper thigh, back of the calf, or buttocks. The starting dose of testosterone gel for women is 5 mg/day (0.5 mL),

which is one-tenth the starting dose used in men. Small increases can be made up to 10 mg/day (1.0 mL) if needed.[24] Baseline lipid panel and liver function testing should be initially obtained and monitored yearly with the use of testosterone therapy in women. Clinical benefits may be seen in 6 to 8 weeks, but 12 weeks of treatment may be needed to see maximum results.[24] Adverse events include acne, deepening of the voice, alopecia, adverse effects on lipid profile, and abnormal hair growth. On the other hand, testosterone is likely protective against the development of breast cancer. Therapy should be discontinued after 6 months if symptoms are not improved. Further studies on the long-term use of testosterone, adverse events, and metabolic and cardiovascular outcomes are needed.[49]

- **Flibanserin in postmenopausal women:** Although flibanserin is FDA-approved for use in premenopausal women, it has only been effectively used off-label in early studies with postmenopausal women, showing significant improvements in sexual desire and satisfying sexual events and a decrease in distress associated with low desire. Adverse events were found to be similar to when used in premenopausal women, including tiredness, dizziness, headache, and nausea.[26]

Differential Diagnosis

FSIAD can be mimicked by conditions included in its relatively large differential diagnosis.[25] Low sexual desire disorder shares many symptoms and features with FSIAD but does not require the associated distress, which is mandatory for FSIAD diagnosis. Other conditions that may mimic FSIAD include depression, obsessive-compulsive disorder, and personality disorders.[50]

Adverse events related to some medications may cause symptoms that mimic FSIAD. The serotonergic effects of medications such as selective serotonin receptor inhibitors, tricyclic antidepressants, first-generation antipsychotics, and monoamine oxidase inhibitors may mirror FSIAD.[51] The development of sexual dysfunctions in patients taking these medications may be treated by reducing the dose or switching to other medications without requiring definitive FSIAD treatment. Some antihypertensives, such as beta-blockers and calcium channel blockers, may also cause symptoms suggestive of FSIAD.[52]

Other medical conditions, such as hyperprolactinemia, diabetes, connective tissue disorders, and liver disease, may produce symptoms mimicking FSIAD.[52] Sexual trauma, physical trauma, and substance abuse or dependence are also in the differential diagnosis. Dysfunction resulting from sexual arousal, orgasm, or painful sex may be mistaken for FSIAD, but treatment approaches for these dysfunctions may be completely different from those used for FSIAD.

Prognosis

FSIAD in women can have various prognoses depending on factors such as underlying causes, individual characteristics, and treatment effectiveness. While the overall prognosis can vary, with appropriate diagnosis and treatment, many individuals experience improvements in sexual desire and overall well-being. Individuals experiencing FSIAD should seek support from healthcare professionals who can provide personalized treatment recommendations and support throughout the process. Patients with FSIAD tend to have a good prognosis if diagnosed promptly and adequately treated. The challenges, however, include delays in diagnosis, which may be caused by several factors, including a lack of willingness of patients to seek help, failure of healthcare professionals to explore the possibility of FSIAD in female patients presenting for other related or remotely connected reasons, and a lack of confidence in the competence and capability of clinicians to diagnose and adequately manage FSIAD.

Complications

FSIAD, if not promptly diagnosed and treated, may result in a low quality of life, poor affect, low self-esteem, low happiness and satisfaction with partners, emotional distress, and overall dissatisfaction. Both physical and psychological complications may occur and can affect individual well-being, interpersonal relationships, and overall quality of life. Some potential complications of FSIAD include relationship issues, decreased intimacy, and negative self-image. Patients with sexual dysfunctions have a 13% to 21% greater risk of having depression than patients without sexual dysfunctions. Individuals experiencing FSIAD must seek support from healthcare professionals who can provide a comprehensive evaluation, offer appropriate treatment options, and address any associated complications. Open communication with partners and seeking therapy or support groups can also help navigate the challenges related to FSIAD and improve overall well-being and relationship satisfaction.

Deterrence and Patient Education

Deterrence and prevention efforts for FSIAD primarily revolve around addressing underlying risk factors and promoting sexual health and well-being. Educating individuals about the importance of healthy sexual expression, communication, and intimacy within relationships can help mitigate the development of FSIAD. Encouraging open discussions about sexual concerns, reducing stigma surrounding sexual issues, and providing access to comprehensive sexual education can empower individuals to seek assistance early if experiencing symptoms of FSIAD. Additionally, promoting a supportive and understanding environment within healthcare settings can

facilitate timely identification and intervention for individuals at risk of FSIAD. By addressing modifiable risk factors, fostering positive sexual attitudes, and ensuring access to appropriate resources and support, deterrence and prevention efforts can play a pivotal role in reducing the incidence and impact of FSIAD on individuals and relationships.

Enhancing Healthcare Team Outcomes

Interprofessional collaboration plays a crucial role in addressing FSIAD. Advanced clinicians, nurses, pharmacists, and other healthcare professionals should possess skills in empathetic communication, active listening, and sexual health assessment to address sensitive issues associated with FSIAD. Healthcare team members should also be proficient in utilizing standardized assessment tools to screen and diagnose FSIAD accurately and conducting thorough assessments to identify underlying factors contributing to FSIAD, such as hormonal imbalances, psychological issues, and relationship dynamics. Prioritizing patient autonomy and respecting confidentiality are ethical imperatives in discussing sensitive sexual health topics.

Interprofessional communication is critical for developing comprehensive treatment plans encompassing pharmacological, psychological, and behavioral interventions, including psychoeducation, cognitive-behavioral therapy, pharmacotherapy, and lifestyle modifications. Nurses provide valuable support through counseling, education, and follow-up care, promoting patient engagement and treatment adherence. Pharmacists ensure medication safety, provide dosing information, and monitor potential drug interactions. Referrals to sexual health specialists or therapists may be imperative. Effective communication among team members is crucial for coordinated care. Regular case conferences, interprofessional meetings, and shared health records facilitate information exchange, decision-making, and continuity of care.

Healthcare professionals are responsible for staying updated on current research and guidelines for managing FSIAD, enhancing their clinical expertise and competence. Effective care coordination streamlines services, minimizes gaps in care, and ensures continuity across healthcare settings while facilitating access to specialized services. Team-based approaches involving referrals to sexual health specialists, psychologists, or pelvic floor therapists optimize patient outcomes. By working together as a cohesive team, healthcare professionals can optimize treatment outcomes, promote patient safety, and address the complex challenges of FSIAD in women.

Review Questions

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Tables

Table. Assessing Patients with Female Sexual Interest/Arousal Disorder

Symptomatology	**Primary concern or complaint** • Persistently or recurrently deficient or absent sexual desire (*DSM-IV*) or interest (*DSM-V*) • Sexual arousal (*DSM-V*) • Vaginal dryness • Poor response to sexual stimulation or foreplay • Pain • Orgasm or climax deficit
	Onset of complaint • Lifelong • Recent onset, persisting for at least 6 months
	Situational or Generalized: Specific to certain events or relationships or not?
	Presence or absence of associated distress
Etiology	**Genital anatomic factor** • History of female circumcision or female genital mutilation • Genitourinary history • History of birth trauma
	Physiologic factors • Gynecological history: Menarche, regularity of menstruation, contraception, menopausal status • Obstetrical history: Parity, nature of previous deliveries and experiences • Medical comorbidities: Obesity, illicit substance use, medications
	Psychologic factors • Life stressors • Psychiatric history: Depression, anxiety, body dysmorphism • History of abuse: Sexual, emotional, physical, or domestic

Table. Decreased Sexual Desire Screener

Name of the Patient and Date of Screening:	Yes	No
1. In the past, was your level of sexual desire or interest good and satisfying to you?		
2. Has there been a decrease in your level of sexual desire or interest?		
3. Are you bothered by your decreased level of sexual desire or interest?		
4. Would you like your level of sexual desire or interest to increase?		
5. Please circle all the factors that you feel may be contributing to your current decrease in sexual desire or interest: A. An operation, depression, injuries, or other medical condition B. Medications, drugs, or alcohol you are currently taking C. Pregnancy, recent childbirth, menopausal symptoms D. Other sexual issues you may be having (pain, decreased arousal, or difficulty with orgasm) E. Your partner's sexual problems F. Dissatisfaction with your relationship or partner's stress or fatigue		

Please verify each of the answers she has given to the patient. *DSM-IV-TR* characterizes HSDD as a deficiency or absence of sex fantasies and desire for sexual activity, which causes marked distress or interpersonal difficulty and which is not better accounted for by a medical, substance-related, psychiatric, or other sexual condition. HSDD can be either generalized (not limited to certain types of stimulation, situations, or partners) or situational and can be either acquired (develops only after a period of normal functioning) or lifelong.

If the patient answers "YES" to questions 1 through 4, and your review confirms "NO" to all factors in question 5, she qualifies to diagnose generalized acquired HSD. If the patient answers "YES" to questions 1 through 4 and "YES" to any of the factors in question 5, then decide if the answers to question 5 indicate a primary diagnosis other than generalized acquired HSDD. Co-morbid conditions such as arousal or orgasmic disorder do not rule out a concurrent diagnosis of HSDD. If the patient answers "NO" to questions 1 through 4, then she does not qualify for the diagnosis of generalized acquired HSDD.

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