FSD

Female sexual dysfunctions (FSD), which have a major impact on a women and couples quality of life, can occur throughout the lifespan. Despite the high prevalence rates, FSD is frequently underdiagnosed and untreated. FSD classified into four domains in DSM-5: Combination of former hypoactive sexual desire disorder (HSDD) and female sexual arousal disorder (FSAD) into female sexual interest/arousal disorder (FSIAD), female orgasmic disorder (FOD), Genito-pelvic pain/penetration disorder (GPPPD) and substance/medication-induced sexual dysfunction

FSIAD

FSIAD is defined in the DSM-5 as significantly reduced, sexual interest/arousal as manifested by any of the three of the following stet characteristics for a minimum of months.

1. absent or reduced interest in sexual activity six

2. absent or reduced sexual/erotic thoughts

3 . no or reduced initiation of sexual activity and unreceptive to partner’s attempts to initiate

4 . absent or reduced sexual excitement/pleasure during sexual activity in almost all or all (75-100%) sexual encounters

5. absent or reduced sexual interest/arousal in response to any internal or external sexual/erotic cues (written, verbal, visual)

6. Absent or reduced genital or non genital sensations during sexual activity in almost all or all (75-100%) sexual encounters

These symptoms must not be better explained by a nonsexual mental disorder, severe relationship distress or other stressors, or effect of a substance or medication or another medical condition.
FSIAD can be classified as generalized or situational, lifelong or acquired, and mild, moderate, or severe in distress. In other words, if a woman has been distressed by her level of sexual interest for greater than 6 months, but goes on vacation with her partner and finds herself in a sea of erotic bliss, she is not likely to have a diagnosis of generalized FSIAD, but rather situational FSIAD.

EPIDEMIOLOGI

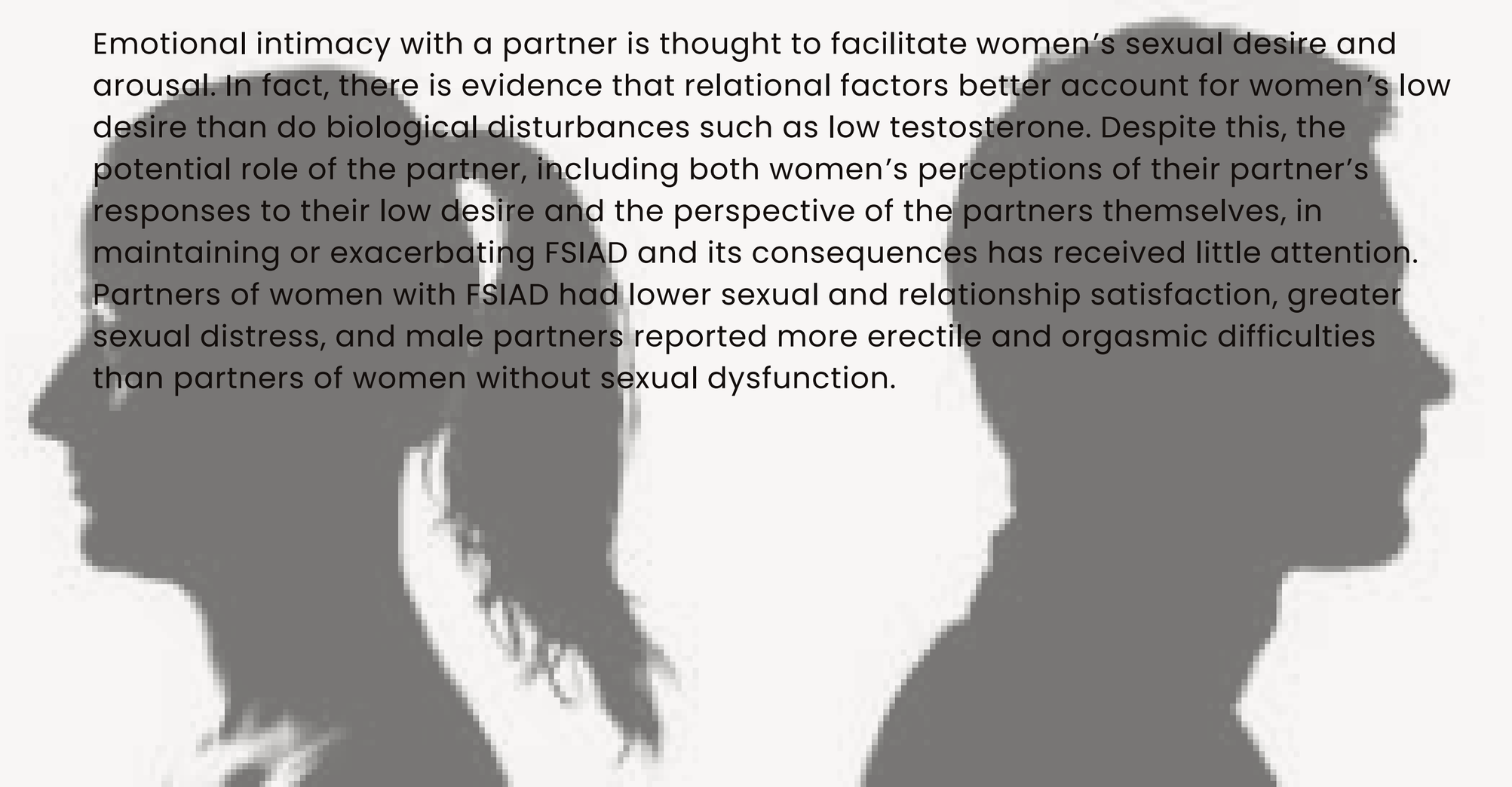
In a nationally representative sample, 39% of women reported low sexual desire, 26% reported low arousal, and 30% of women with low desire were also sexually distressed

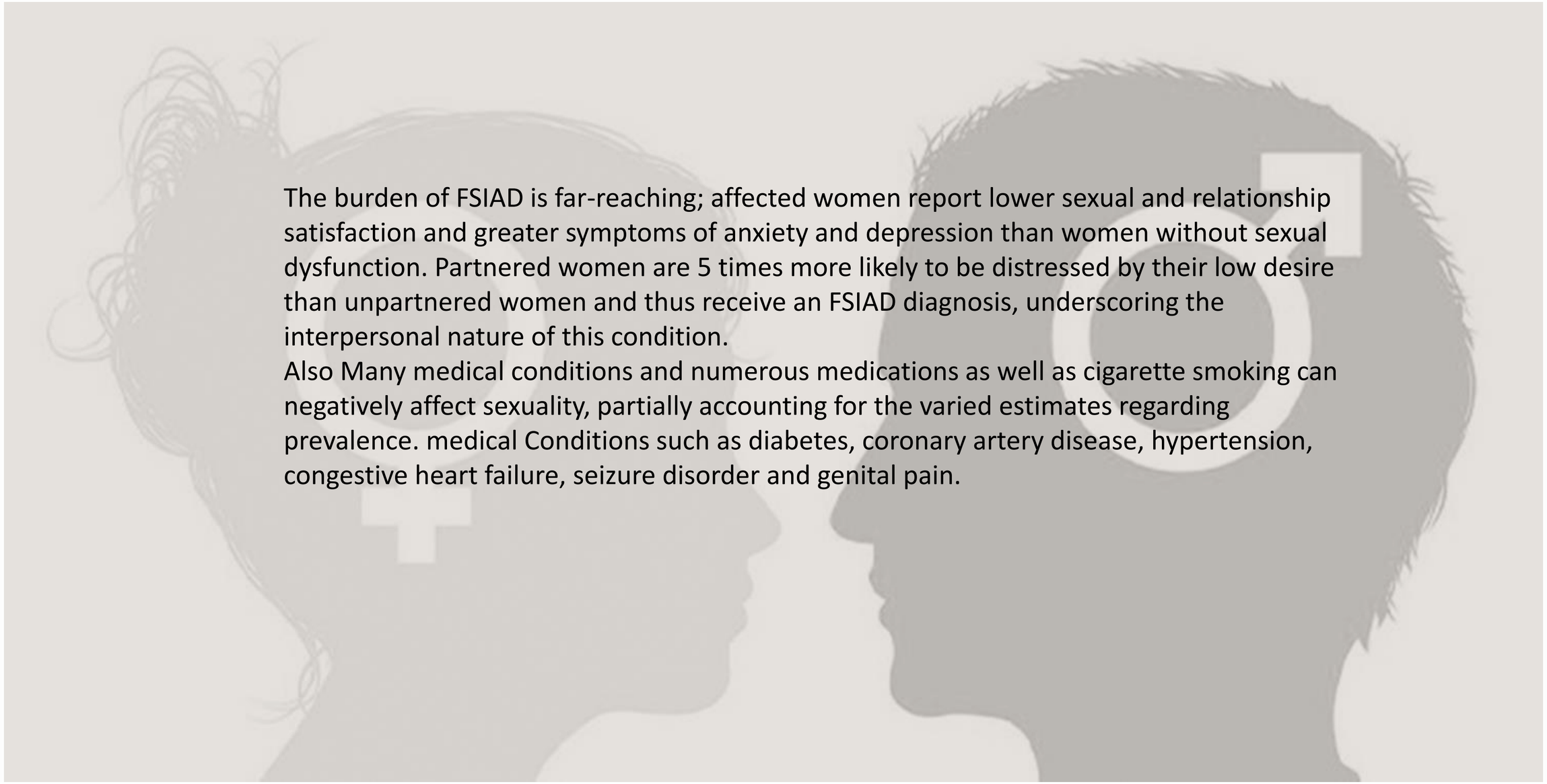
A study sampling 741 women across Australia, the Americas, Europe, and Asia reported the prevalence of problems with sexual desire varied from 3.0% to 31.0%.

Etiology

The etiology of FSIAD is multifactorial and includes biological, psychological, and interpersonal factors. The latter have been neglected in research despite theoretical and clinical models of FSIAD suggesting a significant role for relationship processes.

Emotional intimacy with a partner is thought to facilitate women’s sexual desire and arousal. In fact, there is evidence that relational factors better account for women’s low desire than do biological disturbances such as low testosterone. Despite this, the potential role of the partner, including both women’s perceptions of their partner’s responses to their low desire and the perspective of the partners themselves, in maintaining or exacerbating FSIAD and its consequences has received little attention. Partners of women with FSIAD had lower sexual and relationship satisfaction, greater sexual distress, and male partners reported more erectile and orgasmic difficulties than partners of women without sexual dysfunction.





The burden of FSIAD is far-reaching; affected women report lower sexual and relationship satisfaction and greater symptoms of anxiety and depression than women without sexual dysfunction. Partnered women are 5 times more likely to be distressed by their low desire than unpartnered women and thus receive an FSIAD diagnosis, underscoring the interpersonal nature of this condition.

Also Many medical conditions and numerous medications as well as cigarette smoking can negatively affect sexuality, partially accounting for the varied estimates regarding prevalence. medical Conditions such as diabetes, coronary artery disease, hypertension, congestive heart failure, seizure disorder and genital pain.

Treatment

Nonhormonal treatment of FSAD includes:

- Psychotherapy
- Psychopharmacology, such as Folinerin, Sildenafil and Bupropion
- Herbal therapy, such as ginkgo biloba extract (GBE)
- Eros-clitoral device
- topical lubricants are other options to enhance treatment of FSIAD

Hormonal treatment of FSAD includes:

- Hormone replacement with systemic or vaginal estrogen
- Androgen supplementation
- Tibolone, a selective estrogen receptor modulator (SERM)
- Ospemifene (SERM)

In line with the Interpersonal Emotion Regulation Model of Sexual Dysfunction, partner responses to FSIAD that are more supportive and validating may allow couples to better process their emotional reactions (reduced threat value) and cope with the related stressors (conflict over sex) by using more adaptive (problem-solving, acceptance) emotion regulation strategies. In contrast, more negative and invalidating partner Sex responses interfere with couples' emotion regulation by making couples more sensitive and reactive to the stressors (heightened catastrophizing) and promoting the use of less-adaptive emotion regulation strategies (avoidance, emotional suppression). In turn, individual and couple coregulation of emotions are thought to affect couples' adjustment to FSIAD.

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