Female Sexual Interest & Arousal Disorder

Understanding Reduced Female Arousal, Causes, Diagnosis, Treatment and the Unani Approach

By Dr. Nizamuddin Qasmi
Founder & Chief Physician, Saira Health Care
Focused Practice in Sexual Disorders & Infertility

Qualifications:
BUMS – Hamdard University, Delhi
MD, CGO
Certificate in Infertility – MGBIMS, Delhi
Certificate in Urology – London, UK
Masters in Male Infertility – MasterHealthPro (HealthPro)
Integrated Sexual and Reproductive Health – ISRH, UNFPA

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Introduction

One of the most difficult sexual-health concerns for many women to discuss is a loss or reduction of sexual excitement.

A woman may tell me:

“Doctor, I love my partner and I want a normal relationship, but I do not feel mentally excited during intimacy.”

Another patient may say:

“I have interest, but my body does not respond properly.”

Another may experience very little lubrication, reduced genital sensation or difficulty remaining aroused after sexual activity begins.

These are genuine sexual-health concerns. They should not automatically be dismissed as weakness, lack of affection or something a woman simply has to tolerate.

Female sexual arousal is a complex process involving the **brain, emotions, hormones, genital nerves, blood flow, lubrication, physical health, sexual stimulation, relationship circumstances and sense of safety and privacy**. Because these systems interact, female arousal difficulties rarely have only one universal cause.

Modern medicine therefore increasingly uses a **biopsychosocial approach**, meaning that biological, psychological and relationship factors are considered together. MSD Manual's January 2026 clinical guidance likewise describes female sexual interest/arousal problems as

potentially arising from psychological factors, medications, menopause, chronic disease, hormonal change, inadequate stimulation and relationship difficulties.

This comprehensive view is also one reason I find the individualized philosophy of the **Unani system of medicine** useful. Unani medicine traditionally considers a person's **Mizaj, physical health, nutrition, sleep, mental state, activity level and general vitality**, rather than looking at one symptom in isolation. The Ministry of AYUSH describes Unani medicine as a system that gives significant importance to temperament, the four humours, lifestyle, diet and prevention of disease.

At **Saira Health Care**, my aim is not simply to give every woman an aphrodisiac or so-called "female power medicine." My first responsibility is to understand **which part of sexual response is actually affected and why**.

An Important Update in Medical Terminology

Older medical literature often used the term **Female Sexual Arousal Disorder, or FSAD**, for women who had persistent difficulty becoming physically or mentally aroused.

Modern diagnostic terminology has changed.

The DSM-5-TR now generally uses the term **Female Sexual Interest/Arousal Disorder, or FSIAD**, because sexual desire and sexual arousal often overlap considerably in women.

Modern criteria consider persistent reduction or absence in areas such as sexual interest, erotic thoughts, initiation of sexual activity, pleasure, responsiveness to stimulation and genital or non-genital sensations. For a formal diagnosis, several symptoms generally need to persist for **at least six months and cause significant personal distress**.

This terminology is important because sexual response in women does not always follow a simple sequence of:

Desire → arousal → intercourse → orgasm.

For many women, desire can be **responsive**.

That means a woman may not initially feel strong spontaneous desire, but after affection, emotional closeness or appropriate stimulation begins, she becomes interested and aroused.

ACOG specifically notes that it can be normal for some women not to experience desire until sexual activity has already started.

Therefore, lack of spontaneous desire alone does not automatically mean disease.

Female Arousal Disorder, HSDD and Orgasmic Disorder Are Not Exactly the Same

These terms are frequently mixed together in internet articles, but professionally they should be distinguished.

Female Sexual Interest/Arousal Disorder

This involves persistently reduced sexual interest and/or reduced mental or physical arousal causing distress.

Hypoactive Sexual Desire Disorder — HSDD

HSDD is a term still widely used in sexual-medicine research and prescribing guidelines to describe **acquired or persistent low sexual desire that causes meaningful distress**.

It is particularly important because several prescription medicines have been studied or approved specifically for HSDD.

Female Orgasmic Disorder

This refers mainly to persistent difficulty reaching orgasm, markedly delayed orgasm or significantly reduced orgasm intensity despite adequate arousal and stimulation.

It is considered a separate disorder.

A woman can therefore:

- have normal desire but reduced physical arousal;
- have low desire but respond normally once activity begins;
- experience good arousal but difficulty reaching orgasm;
- or experience difficulties in several areas simultaneously.

Treatment depends upon identifying which pattern is present.

What Is Female Sexual Arousal?

Sexual arousal involves both **subjective—or mental/emotional—arousal and physical genital response**.

During normal sexual stimulation, a woman may experience:

- Mental excitement.
- Emotional involvement.
- Increased genital blood flow.
- Increased clitoral and vulval sensitivity.

- Vaginal lubrication.
- A feeling of warmth or pleasurable sensation.
- Increased heart rate and breathing.
- Greater responsiveness to touch.

However, physical response and emotional excitement do not always occur at exactly the same time.

A woman may feel emotionally excited but notice little lubrication.

Another woman may have lubrication without experiencing strong subjective desire.

This is why **lubrication alone should not be used as a test of whether a woman is sexually interested or consenting**.

Female sexual response is more complicated than one physical sign.

When Does Reduced Arousal Become a Medical Disorder?

Temporary changes are extremely common.

Sexual interest and arousal may reduce temporarily because of:

- Fatigue.
- Stress.
- Illness.
- Pregnancy.
- Breastfeeding.
- Menstruation.
- Relationship difficulties.
- Work pressure.
- Lack of privacy.

A disorder is more likely when the problem is **persistent, recurrent and distressing**.

Current DSM-5-TR criteria for Female Sexual Interest/Arousal Disorder generally require a significant reduction in at least three areas, such as:

- interest in sexual activity;
- sexual or erotic thoughts;

- initiation of sexual activity or response to a partner's initiation;
- excitement or pleasure during sexual activity;
- response to sexual stimuli;
- genital or non-genital sexual sensations.

Symptoms should generally have persisted for at least **six months and cause significant distress**.

I consider the distress criterion particularly important.

A woman who naturally has relatively low sexual interest but is completely comfortable with it does not automatically have a disease.

Symptoms of Female Arousal Difficulties

Women may experience this condition in different ways.

Possible symptoms include:

Mental and Emotional Symptoms

- Little or no feeling of sexual excitement.
- Reduced interest in intimacy.
- Difficulty remaining mentally engaged during sexual activity.
- Reduced pleasure.
- Few sexual thoughts or fantasies.
- Feeling emotionally disconnected during intimacy.
- Reduced response to affectionate or sexual stimulation.
- Frustration or anxiety about sexual function.
- Reduced confidence.

Physical Symptoms

- Reduced vaginal lubrication.
- Reduced genital sensitivity.
- Limited pleasurable sensation from stimulation.
- Reduced sensation of genital swelling or excitement.
- Difficulty maintaining physical arousal.

- Discomfort developing because lubrication is inadequate.

Relationship Effects

- Avoidance of intimacy.
- Partner misunderstanding.
- Feelings of rejection on either side.
- Anxiety before sexual encounters.
- Repeated arguments about sexual frequency.
- Reduced relationship satisfaction.

These symptoms frequently overlap with low desire, orgasmic difficulty and sexual pain.

Why Female Sexual Arousal Can Become Difficult

There is rarely one universal cause.

When a woman consults me, I usually divide possible contributors into **physical, hormonal, medication-related, psychological, sexual and relationship factors**.

Hormonal Changes

Female reproductive hormones influence vaginal tissue, sexual response and certain brain pathways involved in sexual interest.

Changes may occur during:

- Pregnancy.
- Breastfeeding.
- Perimenopause.
- Menopause.
- Certain ovarian disorders.
- Some medical treatments.

Hormone changes do not affect every woman in the same way.

A normal laboratory estrogen value also does not automatically mean that every sexual-health concern is hormonal.

Menopause and Genitourinary Syndrome of Menopause

Around menopause, falling estrogen can make vaginal and vulval tissue thinner, drier and more sensitive.

This is known as **Genitourinary Syndrome of Menopause, or GSM**.

GSM can cause:

- Vaginal dryness.
- Burning.
- Reduced lubrication.
- Painful intercourse.
- Urinary symptoms.
- Reduced comfort during sexual stimulation.

When sexual activity becomes painful, sexual excitement often decreases naturally.

India's 2026 Menopause Society guideline identifies local estrogen therapy as one of the most effective treatments for GSM and reports improvement in lubrication and sexual function in appropriate postmenopausal women.

Therefore, a woman experiencing reduced arousal after menopause may not need an “aphrodisiac.”

She may primarily need treatment of **vaginal tissue changes and pain**.

Pregnancy and Breastfeeding

Pregnancy can increase or decrease sexual desire and arousal.

Both patterns may be normal.

After childbirth, breastfeeding is associated with hormonal changes that can reduce estrogen temporarily and contribute to vaginal dryness.

Other factors also matter:

- Sleep deprivation.
- Physical recovery from childbirth.
- Fear of pregnancy.
- Perineal pain.

- Breastfeeding responsibilities.
- Body-image changes.
- Postpartum anxiety or depression.

It would therefore be incorrect to diagnose every postpartum reduction in sexual interest as a permanent sexual disorder.

Diabetes and Chronic Medical Disease

Diabetes can affect nerves and blood vessels.

This may reduce genital sensation and contribute to sexual dysfunction.

Chronic neurological disorders such as multiple sclerosis may also interfere with nerve pathways involved in genital sensation. MSD's 2026 review identifies diabetes and multiple sclerosis among medical conditions capable of reducing sexual sensation or responsiveness.

Other medical problems may influence arousal indirectly through:

- Fatigue.
- Chronic pain.
- Reduced mobility.
- Depression.
- Medication burden.
- Poor sleep.

A good sexual-health consultation therefore needs to look beyond the reproductive organs.

Thyroid and Prolactin Problems

Selected hormonal disorders can contribute to reduced sexual interest.

For example, unusually high prolactin can reduce reproductive hormone activity and libido.

Thyroid disease can affect mood, energy, menstruation and sexual well-being.

However, I do not recommend that every woman with reduced arousal undergo an enormous “hormone package.”

Testing should be chosen according to symptoms.

Medications

One of the most important questions I ask is:

“Did the sexual problem begin after you started a new medicine?”

Certain medicines can interfere with sexual desire or arousal.

Particularly important examples include some:

- SSRIs and other antidepressants.
- Antiseizure medicines.
- Beta-blockers.
- Other medications affecting the nervous system.

Excessive alcohol can also interfere with sexual response.

Patients should not suddenly stop antidepressants or other prescription medicines.

Instead, the prescribing clinician can review:

- Dose.
- Timing.
- Alternatives.
- Whether another treatment can reduce the sexual side effect.

Antidepressant-Related Sexual Dysfunction

SSRIs can sometimes cause:

- Reduced desire.
- Reduced arousal.
- Delayed orgasm.
- Difficulty reaching orgasm.

This is particularly important because depression itself can reduce sexual interest.

Therefore, when sexual difficulty appears during antidepressant treatment, we need to determine whether the underlying depression, the medication or both are contributing.

In selected patients, changing therapy or adding a medicine such as bupropion may be considered by the treating physician. MSD notes that evidence for sildenafil in women has

generally been inconsistent, so sildenafil should **not be considered a routine treatment for female arousal disorder**.

Stress

Stress is one of the most common contributors I encounter.

A woman may be physically present with her partner while mentally thinking about:

- Children.
- Work.
- Family conflict.
- Financial problems.
- Fertility treatment.
- Household responsibilities.
- Illness.

Sexual arousal requires the brain to have sufficient capacity to respond to pleasurable stimulation.

Constant mental overload can interfere considerably.

Anxiety

Anxiety can make it difficult to remain present during intimacy.

A woman may think:

“Will I become aroused?”

“Will intercourse hurt?”

“Will I disappoint my partner?”

“Why is my body not responding?”

This self-monitoring can itself interrupt sexual response.

The more she checks whether she is becoming aroused, the more difficult spontaneous arousal may become.

Depression

Depression can reduce interest and pleasure across many areas of life.

Sexual interest is often affected.

This does not mean that every woman with reduced arousal has depression, but persistent low mood, loss of enjoyment, fatigue, hopelessness and sleep disturbance should be assessed.

Past Sexual Trauma

A previous experience of sexual violence, coercion, painful intercourse or another traumatic experience may influence later sexual response.

Some women may experience:

- Fear.
- Muscle tightening.
- Emotional disconnection.
- Flashbacks.
- Anxiety.
- Avoidance.

Trauma-informed psychological care can be extremely valuable.

The goal is never to pressure a patient to disclose more than she wishes.

Relationship Problems

Sexual arousal is closely connected with the relationship for many women.

Potential contributors include:

- Unresolved conflict.
- Lack of emotional closeness.
- Distrust.
- Communication problems.
- Different expectations regarding sex.
- Repeated painful or unsatisfying encounters.
- Fear of pregnancy.

- Feeling pressured.

Modern clinical guidance recognizes relationship difficulties and lack of communication among important causes of female interest/arousal problems.

Medicine alone cannot repair every relationship problem.

Inadequate Sexual Stimulation

This is frequently overlooked.

A woman may have completely normal sexual physiology but not receive the type, duration or intensity of stimulation that her body requires.

ACOG recognizes that physical and emotional arousal vary considerably among women, and current MSD guidance emphasizes education about sexual anatomy, communication and adequate stimulation as part of treatment.

Female arousal does not have to develop instantly.

Some women require:

- More time.
- Emotional closeness.
- Privacy.
- Affection.
- Different forms of touch.
- Reduced performance pressure.

This is normal individual variation.

Sexual Pain Can Suppress Arousal

If intercourse is repeatedly painful, the brain may begin associating intimacy with discomfort rather than pleasure.

Important causes include:

- Vaginal dryness.
- Vulvodynia.
- Vaginismus.

- Endometriosis.
- Pelvic inflammatory disease.
- Pelvic-floor dysfunction.
- Menopausal GSM.

MSD emphasizes that effectively treating sexual pain can sometimes improve reduced interest and arousal.

This is why a woman with pain should not simply be given a libido medicine.

Body Image and Self-Confidence

Sexual confidence can be affected by:

- Weight changes.
- Acne.
- Scarring.
- Pregnancy-related body changes.
- Breast surgery.
- Menopause.
- Infertility.
- Unrealistic beauty standards.

Some women become so focused on how they look during intimacy that they cannot pay attention to pleasurable sensations.

Psychological counselling can be helpful in selected cases.

Cultural and Social Factors

Female sexual dysfunction remains especially under-discussed in many societies.

An Indian study involving women attending a gynecology clinic found that sexual problems were often not discussed even with partners and almost none of the women experiencing difficulties had previously sought professional assistance.

This does not mean that Indian women experience fundamentally different sexual physiology.

It means that cultural embarrassment may prevent women from obtaining appropriate care.

At Saira Health Care, I consider confidentiality particularly important for this reason.

Female Arousal Problems Do Not Mean Lack of Love

This is an important message for couples.

Reduced arousal does not automatically mean:

- that the woman no longer loves her partner;
- that she is attracted to someone else;
- that she is permanently sexually weak;
- or that the relationship has failed.

Sometimes the problem is hormonal.

Sometimes it is psychological.

Sometimes medication is responsible.

Sometimes pain is responsible.

Sometimes the couple needs better communication.

Blame usually makes sexual dysfunction worse.

How I Diagnose Female Arousal Difficulties

There is no single blood test for female sexual arousal disorder.

Diagnosis begins with conversation.

I ask the patient to describe the problem in her own words.

I may ask:

When did the problem begin?

Was sexual arousal normal previously?

Is sexual interest present?

Does arousal begin but disappear?

Is lubrication reduced?

Is intercourse painful?

Can pleasure be experienced with other forms of stimulation?

Is orgasm possible?

Does the problem occur every time or only with a particular situation?

Are menstrual cycles normal?

Is pregnancy or breastfeeding relevant?

Has menopause begun?

Are there symptoms of vaginal dryness?

Which medicines are being used?

Is diabetes present?

Is there significant anxiety or depression?

Is the relationship supportive?

These questions help separate **desire, arousal, orgasm and pain problems**.

The Female Sexual Function Index

The **Female Sexual Function Index, or FSFI**, is a widely used questionnaire that assesses several domains:

- Desire.
- Arousal.
- Lubrication.
- Orgasm.
- Satisfaction.
- Pain.

It can help structure assessment and research.

However, a questionnaire score alone should not be used to diagnose every woman.

Modern sexual dysfunction remains primarily a **clinical diagnosis based on symptoms, context and distress**.

Is a Pelvic Examination Always Required?

No.

If the main problem is reduced mental sexual interest with no pain, discharge, bleeding or physical symptoms, a pelvic examination may not always be necessary.

Examination becomes more relevant when there is:

- Painful penetration.
- Vaginal dryness.
- Abnormal bleeding.
- Genital skin changes.
- Abnormal discharge.
- Suspected pelvic disease.

Current sexual-medicine recommendations favour clinically indicated examination rather than automatically examining every woman presenting with low desire.

Blood Tests

Blood tests should be selected according to the patient's symptoms.

Possible tests may include:

- Thyroid function.
- Prolactin.
- Blood glucose or HbA1c.
- Complete blood count.
- Selected reproductive hormone tests.
- Other investigations based on medical history.

There is no universal “female sexual hormone panel” that diagnoses FSIAD.

Likewise, a single testosterone result does not diagnose female sexual desire disorder.

Modern Treatment of Female Sexual Arousal Disorder

Modern evidence supports a **multimodal treatment approach** rather than one universal medicine.

A major systematic review and meta-analysis published in **January 2026** evaluated 36 studies of female desire, arousal and orgasmic dysfunction. It found evidence supporting

mindfulness-based CBT, flibanserin and bremelanotide for selected sexual dysfunctions, while noting that evidence for many other treatments remains limited or heterogeneous.

Treatment should therefore be matched to the cause.

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1. Education About Female Sexual Response

Sometimes education itself produces major improvement.

A woman may have spent years believing that:

- desire must appear spontaneously before intimacy;
- penetration alone should always produce arousal;
- orgasm should occur every time;
- lubrication is proof of desire;
- every woman should respond at the same speed.

Correcting these misconceptions can reduce anxiety.

Sex education is a legitimate therapeutic intervention.

A 2026 network meta-analysis involving 45 studies and more than 4,700 women found that sexual education, CBT, mindfulness-based interventions and sexual counselling were associated with improvements in female sexual-function scores.

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2. Communication Between Partners

I often tell couples:

Arousal should not become an examination that the woman is expected to pass.

The couple may benefit from discussing:

- what feels comfortable;
- what creates anxiety;
- how much time is needed;
- what kind of affection feels supportive;
- whether pain is present;
- whether privacy is adequate.

Communication should remain respectful and consensual.

3. Cognitive Behavioural Therapy

CBT can help a woman recognize thoughts such as:

“Something is wrong with me.”

“I must become excited immediately.”

“My partner will judge me.”

These thoughts can increase anxiety and interfere further with arousal.

CBT has one of the stronger psychological evidence bases in female sexual dysfunction.

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4. Mindfulness-Based Therapy

Mindfulness helps a person pay attention to present physical sensations rather than constantly judging their sexual response.

A woman learns to notice:

- touch;
- breathing;
- emotional connection;
- bodily sensations;

without repeatedly asking:

“Am I aroused enough yet?”

A randomized 2025 trial of women with Sexual Interest/Arousal Disorder found meaningful improvements from both mindfulness-based and cognitive-behavioural online interventions, with benefits maintained during follow-up.

The January 2026 meta-analysis similarly found improvements in desire, arousal and orgasm with mindfulness-based CBT.

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5. Sex Therapy

Sex therapy is a professional therapeutic approach to sexual-health problems.

It can help address:

- inaccurate beliefs.

- performance pressure.
- communication.
- differences in sexual desire.
- anxiety.
- previous negative experiences.
- relationship patterns.

It should not be confused with sexual contact between therapist and patient.

Professional sex therapy is counselling-based.

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6. Treat Vaginal Dryness

When inadequate lubrication is part of the problem, a suitable lubricant can reduce friction.

For ongoing dryness, vaginal moisturizers may provide additional comfort.

If the underlying problem is menopausal GSM, local treatment may be more effective than simply applying lubricant before every encounter.

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7. Local Vaginal Estrogen for Menopausal GSM

For appropriate postmenopausal women with GSM, **local estrogen therapy can improve vaginal tissue health, lubrication and sexual function**.

The Indian Menopause Society's 2026 clinical guideline identifies local estrogen as the most effective GSM treatment and also recognizes vaginal DHEA, moisturizers and oral ospemifene as evidence-based options in selected patients.

This treatment does not mean that estrogen is a universal arousal medicine.

It treats a specific underlying condition.

Women with certain hormone-sensitive cancers require individualized discussion with their gynecologist and oncologist.

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8. Vaginal Prasterone and Ospemifene

For selected women with menopausal genital symptoms, additional options include:

Vaginal prasterone (DHEA), which acts locally within vaginal tissue.

Ospemifene, an oral selective estrogen receptor modulator.

These treatments can improve GSM-related dryness and painful intercourse and may indirectly improve sexual comfort and arousal.

Availability varies between countries.

Prescription Treatment for Low Sexual Desire

This section requires an important distinction.

Several medicines commonly described online as “female arousal medicines” are actually approved or studied primarily for **Hypoactive Sexual Desire Disorder**, not every form of physical arousal difficulty.

Flibanserin — Addyi

There was an important U.S. regulatory update in **December 2025**.

Current FDA labeling indicates that **flibanserin is approved in the United States for women younger than 65 years with acquired, generalized HSDD**, including appropriately selected postmenopausal women under 65.

The low desire must cause significant distress and must not primarily result from a medical or psychiatric condition, relationship problems or another medicine or drug.

Flibanserin is taken daily at bedtime.

Important concerns include:

- Dizziness.
- Sleepiness.
- Low blood pressure.
- Fainting.
- Drug interactions.
- Alcohol-related safety precautions.

Moderate or strong CYP3A4 inhibitors and hepatic impairment are contraindications under current U.S. labeling. Treatment should be stopped after eight weeks if there is no improvement.

The important point for patients is:

Flibanserin is not a general female sexual-performance enhancer.

Regulatory approval and availability outside the United States differ.

Bremelanotide — Vyleesi

Bremelanotide is an injectable medication approved in the United States for **premenopausal women with acquired, generalized HSDD**.

It is used before anticipated sexual activity.

The current FDA label does not indicate it as treatment for all postmenopausal women, all arousal disorders or sexual-performance enhancement.

Possible adverse effects include:

- Nausea.
- Flushing.
- Headache.
- Transient increases in blood pressure.
- Skin hyperpigmentation.

A recent 2026 meta-analysis found evidence that bremelanotide can improve desire and arousal scores in selected women, but again this should not be interpreted as a universal treatment for every sexual problem.

Testosterone Therapy

Patients frequently ask:

“Should I simply take testosterone?”

The answer is no.

Low sexual desire in women is not diagnosed solely from a low testosterone blood value.

ISSWSH guidance supports carefully monitored **transdermal testosterone** primarily for appropriately selected postmenopausal women with HSDD after a full biopsychosocial assessment.

Evidence suggests a moderate benefit, while long-term safety remains incompletely established. Testosterone treatment for women is also off-label or unavailable for this indication in many countries.

High-dose testosterone, bodybuilding preparations or unsupervised injections should not be used as female libido treatment.

Why "Blood-Flow Medicines" Are Not the Answer for Every Woman

It can sound logical to say:

"Male erectile dysfunction is treated by improving blood flow, so women with arousal difficulty should simply take the same medicine."

Female sexual response is not that simple.

Studies of sildenafil in women have produced inconsistent results, and most have not established it as an effective routine treatment for FSIAD.

Therefore, I do not advise treating every woman's arousal difficulty as the female equivalent of male erectile dysfunction.

Female Arousal Disorder According to Unani Medicine

When discussing this condition from the Unani perspective, I believe accuracy is important.

Classical Unani physicians did not describe **Female Sexual Interest/Arousal Disorder** using today's DSM terminology.

It would therefore be historically incorrect to claim that one classical Unani diagnosis is exactly identical to FSIAD.

Instead, traditional Unani medicine discusses sexual health through broader concepts involving:

- **Mizaj — temperament**
- **Akhlat — humours**
- **Quwa — faculties**
- **A'za — organs**
- **Af'al — functions**
- general vitality;
- reproductive health;
- psychological condition;
- diet and lifestyle.

This allows the physician to examine the sexual complaint as part of the woman's complete health.

The Four Humours

Classical Unani medicine recognizes:

Dam — blood
Balgham — phlegm
Safra — yellow bile
Sauda — black bile

These humours form part of the traditional Unani explanatory framework. The Ministry of AYUSH confirms these four humours and the associated principles of Mizaj and bodily constitution as fundamental to Unani medicine.

However, they should not be presented as scientifically identical to:

- estrogen;
- progesterone;
- testosterone;
- serotonin;
- dopamine.

Traditional Unani physiology and contemporary neuroendocrinology are two different medical frameworks.

Why the Unani Approach Can Be Valuable

One of the major strengths I find in Unani medicine is its insistence that the physician examine **the complete person**.

Consider a woman with low arousal who:

- sleeps four hours a night;
- has significant anxiety;
- is physically inactive;
- has vaginal dryness;
- feels exhausted;

- is undergoing infertility treatment.

Giving an aphrodisiac without addressing these issues is unlikely to provide complete care.

Unani medicine emphasizes the regulation of essential lifestyle factors and individualized treatment.

Asbab-e-Sitta Zarooriya — Six Essential Factors

For the preservation of health, Unani medicine gives importance to the **Asbab-e-Sitta Zarooriya**, or six essential factors.

They include:

1. Air and environment.
2. Food and drink.
3. Physical activity and rest.
4. Mental or psychological activity and rest.
5. Sleep and wakefulness.
6. Appropriate retention and elimination.

Ministry of AYUSH publications identify these factors as central elements of preventive and promotive Unani healthcare.

These principles remain highly relevant to sexual health.

Sleep affects energy.

Stress affects arousal.

Physical health affects sexual response.

Nutrition affects general vitality.

Emotional well-being affects intimacy.

Ilaj-bil-Ghiza — Dietary Management

Ilaj-bil-Ghiza means treatment through appropriate dietary regulation.

For female sexual-health problems, I consider:

- General nutritional status.
- Iron deficiency.

- Diabetes.
- Body weight.
- Digestive health.
- Pregnancy or breastfeeding.
- Menopausal status.
- Associated endocrine disease.

A balanced diet may include sufficient protein, vegetables, fruits, healthy fats and micronutrients.

Traditional foods such as dates, almonds, figs and honey are nutritious and have long-standing cultural roles, but I do **not** present them as scientifically proven cures for Female Sexual Interest/Arousal Disorder.

Nutrition supports treatment.

It does not replace diagnosis.

Ilaj-bil-Tadbir — Lifestyle and Regimental Care

Unani medicine also uses **Ilaj-bil-Tadbir**, or regimental therapy.

CCRUM officially recognizes Ilaj-bil-Tadbir, Ilaj-bil-Ghiza, Ilaj-bil-Dawa and Ilaj-bil-Yad as major treatment approaches within Unani medicine.

For a woman with reduced arousal, an individualized regimen may emphasize:

- Better sleep.
- Physical activity.
- Stress reduction.
- Healthy weight.
- Reduction of mental overload.
- Appropriate relaxation.
- Treatment of associated physical illness.

These changes can improve general sexual well-being even when no herbal medicine is prescribed.

Ilaj Nafsani — Psychological Support

The mind plays a major role in sexual response.

A contemporary Unani approach should therefore take emotional and psychological health seriously.

When anxiety, relationship stress, body-image concerns or previous trauma are important, counselling should be integrated rather than treating the problem only with herbs.

This is strongly supported by modern evidence.

The 2026 network meta-analysis of psychological interventions found benefits from **sexual education, CBT, mindfulness and sexual counselling**.

This is an area where holistic Unani thinking and contemporary sexual medicine can complement each other very well.

Ilaj-bil-Dawa — Individualized Unani Pharmacotherapy

Unani pharmacotherapy includes single medicinal substances and compound formulations selected according to:

- Mizaj.
- General health.
- Associated symptoms.
- Reproductive stage.
- Cause of sexual difficulty.

I do not recommend one universal Unani medicine for every woman.

A menopausal woman with painful vaginal dryness requires a different treatment from a young woman whose primary problem is anxiety.

A woman with uncontrolled diabetes requires metabolic treatment.

A patient whose sexual dysfunction began after an SSRI needs medication review.

The medicine should follow the diagnosis.

Saffron — Zafran

Zafran, or saffron (Crocus sativus), has a long history of traditional medicinal use and has also been investigated in modern clinical research.

A randomized placebo-controlled study of women experiencing fluoxetine-associated sexual dysfunction reported greater improvement with saffron in areas including **arousal and lubrication**.

A later multicentre randomized trial also investigated saffron in women with sexual dysfunction, and additional research published in 2024 continued to explore saffron-containing interventions for female sexual function.

These findings are encouraging.

But they do not prove that:

every saffron product improves sexual function, or that saffron can replace treatment for depression, GSM, endocrine disease or serious relationship problems.

Dose, formulation and patient selection matter.

Ashwagandha — Asgand

Ashwagandha, or **Asgand (Withania somnifera)**, is another traditional medicinal plant frequently used in South Asian systems of medicine.

A small randomized pilot study involving 50 women reported improvements with a standardized Ashwagandha extract in overall sexual-function measures including arousal, lubrication, orgasm and satisfaction.

A later randomized placebo-controlled study involving **80 women** similarly reported greater improvements in FSFI scores, including desire and arousal domains, with a standardized Ashwagandha root extract.

These results provide useful scientific signals.

However, these were relatively small studies using standardized preparations.

They do not justify claiming that every Ashwagandha powder, capsule or compound medicine will treat every female sexual disorder.

What About Ginseng, Ginger and Other "Aphrodisiac Herbs"?

Many herbs are marketed internationally as female libido enhancers.

The evidence varies considerably.

Traditional usage should be distinguished from:

- standardized clinical trial evidence;

- proven dose;
- long-term safety;
- interaction data.

This is especially important during:

- pregnancy;
- breastfeeding;
- fertility treatment;
- cancer treatment;
- liver disease;
- use of antidepressants or other medicines.

Natural substances can have pharmacological effects.

“Natural” does not automatically mean “safe for everyone.”

Herbal Medicines During Fertility Treatment

Because my clinical practice is focused on sexual disorders and infertility, I consider this especially important.

A woman trying to conceive may begin several “female sexual wellness” supplements without telling her fertility specialist.

This can create problems because:

- ingredients may not be standardized;
- some herbs may interact with medicines;
- pregnancy may occur before the patient realizes it;
- safety during early pregnancy may be unknown.

Therefore, women actively trying to conceive should disclose all traditional and herbal medicines to their treating clinicians.

No Reliable Fixed “Success Percentage”

I do not believe a professional disease article should claim:

“Unani treatment cures 90% of female arousal disorder.”

There is no high-quality evidence supporting one fixed cure percentage.

The condition itself has many different causes.

A woman with medication-induced dysfunction may improve when her medication is adjusted.

Another may improve after treatment of menopausal dryness.

Another may respond to counselling.

Another may benefit from individualized Unani support.

Another may need treatment for depression or diabetes.

The outcome depends upon the cause.

My Specialized Clinical Approach at Saira Health Care

At **Saira Health Care**, I begin by separating the different components of female sexual function.

I ask:

Is sexual desire reduced?

Is desire present but physical arousal weak?

Is lubrication insufficient?

Is pleasure reduced?

Is orgasm difficult?

Is pain interfering?

Is fear or anxiety present?

These distinctions guide treatment.

Step 1: Identify the Primary Sexual Problem

A patient may call everything “low libido.”

But on detailed discussion, she may actually have severe vaginal dryness.

Another woman may call the problem “weakness,” while the real issue is painful penetration.

Another may have normal physical arousal but persistent difficulty reaching orgasm.

The first consultation should clarify the problem.

Step 2: Review Physical Health

I consider conditions such as:

- Diabetes.
- Thyroid problems.
- Hormonal disturbance.
- Anemia.
- Menopause.
- Neurological disease.
- Chronic pain.
- Fatigue.

Appropriate investigations are selected when clinically indicated.

Step 3: Review Medications

I ask about:

- Antidepressants.
- Blood-pressure medicines.
- Neurological medicines.
- Hormonal treatment.
- Other prescription drugs.
- Supplements.

If symptoms began after medication changes, that timing is important.

Step 4: Assess Gynecological Health

I look for:

- Vaginal dryness.
- Pain.

- Infection.
- GSM.
- Endometriosis.
- Pelvic-floor dysfunction.
- Abnormal bleeding.

Sexual arousal often improves when pain is treated correctly.

Step 5: Assess Mental and Relationship Health

I ask about:

- Stress.
- Anxiety.
- Depression.
- Past trauma.
- Relationship conflict.
- Privacy.
- Communication.
- Performance pressure.

This discussion should remain confidential and non-judgmental.

Step 6: Unani Mizaj and Lifestyle Assessment

From the Unani perspective, I assess:

- Mizaj.
- Diet.
- Digestion.
- Sleep.
- Physical activity.
- Mental activity and rest.
- General strength.

- Reproductive stage.

This helps individualize diet, lifestyle and Unani pharmacotherapy where appropriate.

Step 7: Create a Combined Treatment Plan

Depending upon the woman, treatment may include:

- Patient education.
- Partner communication.
- Sleep and lifestyle correction.
- Stress management.
- Ilaj-bil-Ghiza.
- Individualized Unani medication.
- Lubricants or vaginal moisturizers.
- Treatment of vaginal dryness.
- CBT.
- Mindfulness therapy.
- Sex therapy.
- Pelvic-floor physiotherapy.
- Medication review.
- Endocrine treatment.
- Evidence-based prescription HSDD treatment where appropriate.
- Referral to gynecology, psychiatry or another specialist when required.

I consider this more rational than giving all women the same aphrodisiac.

Four Clinical Examples

Patient A: Menopausal Dryness

A 52-year-old woman reports reduced excitement and painful intercourse.

She still has affection for her partner, but penetration has become uncomfortable.

Her main problem may be **GSM**, not loss of sexual desire.

Treating vaginal dryness and pain may restore much of her sexual response.

Patient B: Antidepressant-Related Dysfunction

A 32-year-old woman says her sexual response changed after beginning an SSRI.

Here the treatment may involve psychiatric medication review rather than simply adding an aphrodisiac.

Patient C: Stress and Performance Anxiety

A 28-year-old woman has normal health and normal menstrual cycles but constantly worries about whether she is becoming aroused.

Counselling, sexual education, mindfulness and communication may be more helpful than hormonal medicine.

Patient D: Diabetes With Reduced Genital Sensation

A woman with poorly controlled diabetes experiences reduced genital sensitivity.

Here metabolic control and neurological/vascular health are important components of sexual treatment.

All four patients describe “lack of arousal.”

Their treatments are different.

Female Arousal Difficulties and Infertility

Female arousal disorder does **not automatically cause infertility**.

Pregnancy primarily depends upon:

- Ovulation.
- Egg and sperm factors.
- Fallopian-tube health.
- Uterine factors.
- Timing of intercourse.
- Age and other reproductive conditions.

However, severe sexual dysfunction can indirectly interfere with fertility.

For example:

- Pain may reduce intercourse frequency.

- Vaginismus may prevent penetration.
- Low desire may make regular intercourse difficult.
- Infertility-related stress may itself worsen arousal.

When infertility and sexual dysfunction occur together, both need to be addressed.

Because my practice focuses on **sexual disorders and infertility**, I consider this relationship particularly important.

Emotional and Relationship Complications

Persistent arousal problems can lead to:

- Anxiety.
- Reduced confidence.
- Feelings of inadequacy.
- Avoidance of intimacy.
- Misunderstanding between partners.
- Relationship tension.
- Reduced sexual satisfaction.

In Indian clinical settings, female sexual difficulties are often underreported, making respectful questioning particularly important.

One of our priorities at Saira Health Care is therefore to make sexual-health consultation a normal medical conversation.

Contribution of Saira Health Care in Sexual Disorders and Infertility

At **Saira Health Care**, our approach in the field of sexual disorders and infertility is based on confidentiality, careful history-taking and individualized treatment.

Women frequently consult with concerns such as:

- Low sexual desire.
- Reduced arousal.
- Painful intercourse.
- Vaginismus.

- Vaginal dryness.
- Orgasmic difficulty.
- PCOS/PMOS.
- Abnormal vaginal discharge.
- Infertility.

These conditions may overlap.

A woman experiencing infertility can also have anxiety and reduced desire.

A menopausal patient may simultaneously have vaginal dryness and low arousal.

A woman with vaginismus may develop fear and avoidance.

Therefore, sexual medicine should not be divided into isolated symptoms.

At Saira Health Care, my clinical approach aims to combine **appropriate Unani principles, lifestyle and dietary management, sexual-health education and contemporary diagnostic knowledge**, with referral whenever gynecological, psychiatric, pelvic-floor or other specialist care is necessary.

About Dr. Nizamuddin Qasmi

I am **Dr. Nizamuddin Qasmi**, Founder and Chief Physician of **Saira Health Care**, with a focused and specialized clinical practice in **Sexual Disorders & Infertility**.

My professional training includes:

BUMS – Hamdard University, Delhi
MD
CGO
Certificate in Infertility – MGBIMS, Delhi
Certificate in Urology – London, UK
Masters in Male Infertility – MasterHealthPro (HealthPro)
Integrated Sexual and Reproductive Health – ISRH, UNFPA

My work in sexual and reproductive health has repeatedly shown me that sexual dysfunction requires more than medicine.

The physician must be able to listen.

A woman needs an environment where she can explain intimate concerns without embarrassment.

We need to distinguish sexual desire from arousal.

We need to recognize pain.

We need to ask about medications.

We need to consider hormones without blaming every symptom on hormones.

And we need to know when psychological, gynecological or another specialist form of care is required.

Common Myths About Female Arousal

“A normal woman should become aroused immediately.”

Incorrect. Female sexual response varies greatly, and some women require considerably more time and stimulation.

“If lubrication is absent, the woman is not interested.”

Incorrect. Lubrication and subjective arousal do not always correspond exactly.

“If lubrication occurs, she must want sexual activity.”

Incorrect. Physical response does not equal consent.

“Low arousal means she no longer loves her partner.”

Not necessarily. Physical, hormonal, psychological and medication-related factors can all contribute.

“Every female arousal disorder is caused by low hormones.”

Incorrect.

“Testosterone cures female sexual problems.”

No. Testosterone has a limited, carefully selected role mainly in HSDD and requires monitoring.

“Sildenafil works in women the same way it works in men.”

Routine evidence does not support this.

“One herbal aphrodisiac can treat every woman.”

No. Treatment needs to match the cause.

“Female sexual dysfunction is only psychological.”

Incorrect. Physical and psychological factors often interact.

SAIRA HEALTH CARE
An ISO Certified Clinic
SEXUAL DISORDERS & INFERTILITY CENTER

Frequently Asked Questions

Is Female Sexual Interest/Arousal Disorder common?

Female sexual difficulties are frequently reported but also substantially under-discussed. Prevalence estimates vary widely because diagnostic definitions, cultures and study populations differ.

What is the difference between desire and arousal?

Desire refers mainly to interest or motivation for sexual activity. Arousal refers to the mental and physical response to stimulation.

The two often overlap.

Can a woman have arousal without desire?

Yes. Physical genital response and subjective desire do not always occur together.

Can desire appear after intimacy starts?

Yes. Responsive desire is normal for many women.

Does every woman need hormone testing?

No. Testing should be based on symptoms and medical history.

Can menopause cause arousal problems?

Yes, especially when GSM causes dryness, reduced lubrication and painful intercourse. Effective treatment is available.

Can diabetes affect female arousal?

Yes. Diabetes can affect nerves, blood vessels and genital sensation.

Can antidepressants affect sexual arousal?

Yes, particularly some SSRIs. Patients should discuss the problem with their treating physician rather than stopping medication themselves.

Does psychotherapy help?

Yes. Recent evidence supports CBT, mindfulness-based therapy and sexual counselling for selected women with desire and arousal difficulties.

Is Addyi a female arousal medicine?

Flibanserin is specifically indicated in the United States for selected women under 65 with **acquired, generalized HSDD**, not every female arousal problem.

Can postmenopausal women use flibanserin?

Under the updated December 2025 U.S. FDA label, appropriately selected women under age 65 may be eligible regardless of menopausal status. Country-specific approval and availability differ.

What is Vyleesi?

Bremelanotide is a prescription injection approved in the United States for selected **premenopausal women with acquired, generalized HSDD**.

Does Ashwagandha help female sexual function?

Small randomized studies using standardized Ashwagandha extracts have reported improvements in several sexual-function measures including arousal. Larger independent trials are still desirable.

Does saffron help?

Several small clinical trials have produced encouraging findings, including improvements in arousal and lubrication in selected populations. It should not be considered a universal treatment.

Is Unani medicine useful?

An individualized Unani approach can be particularly useful for addressing **Mizaj, diet, sleep, stress, physical activity, psychological balance and general vitality**, with carefully selected pharmacotherapy when appropriate.

However, specific medical causes such as diabetes, vaginal atrophy, depression, medication effects or endocrine disease should receive appropriate condition-specific treatment.

Can female arousal disorder be cured?

Many women experience meaningful improvement once the underlying causes are identified.

However, there is no single treatment and no honest universal cure percentage.

When Should You Consult a Doctor?

A woman should seek professional assessment when:

- reduced sexual arousal has persisted for several months;
- the problem causes significant personal distress;
- sexual interest has suddenly changed without explanation;
- intercourse is painful;

- vaginal dryness is persistent;
- genital sensation has noticeably decreased;
- menstrual or hormonal symptoms are also present;
- symptoms began after starting a medicine;
- diabetes or another chronic disease is present;
- depression or anxiety is affecting intimacy;
- the problem is causing serious relationship tension;
- pregnancy is not occurring and sexual difficulties are interfering with intercourse.

Seek more urgent assessment if there is unexplained genital bleeding, severe pelvic pain, significant depression, suicidal thoughts or other serious physical or mental-health symptoms.

A Personal Message From Dr. Nizamuddin Qasmi

When a woman sits in front of me and says:

“Doctor, I do not become excited the way I used to,”

I do not want her to feel ashamed.

I also do not want her first conclusion to be that she is permanently sexually weak.

Instead, I want to understand what has changed.

Did childbirth occur?

Is she breastfeeding?

Has menopause begun?

Is intercourse painful?

Did the problem start after an antidepressant?

Does she have diabetes?

Is she sleeping properly?

Is she experiencing severe stress?

Is the relationship under pressure?

Does she actually have normal responsive desire but expect spontaneous desire to appear before every sexual encounter?

These questions are much more useful than immediately prescribing a libido booster.

As a physician trained in the Unani system, I value the principles of **Mizaj, Asbab-e-Sitta Zarooriya, Ilaj-bil-Ghiza, Ilaj-bil-Tadbir and individualized Ilaj-bil-Dawa**.

They remind us that sexual health is connected with the health of the whole person.

Modern sexual medicine gives us increasingly strong evidence for education, CBT, mindfulness, treatment of GSM, medication review and selected pharmacological therapies.

I believe patients benefit when these strengths are used responsibly together.

If a Unani herb is appropriate, we can use it carefully.

If the patient needs vaginal estrogen, we should not delay it because we want to prove that herbs alone are sufficient.

If depression is the primary cause, mental-health treatment is important.

If diabetes is affecting genital sensation, diabetes needs proper control.

And if the main problem is lack of communication between partners, a medicine alone cannot correct that.

My clinical principle is simple: do not treat a woman as though she is merely a sexual symptom. Understand the person, identify the cause and individualize the treatment.

Conclusion

Female Sexual Interest/Arousal Disorder is a complex sexual-health condition involving persistent reduction in sexual interest, excitement or response to sexual stimulation that causes meaningful distress.

Modern medicine recognizes that **desire and arousal overlap**, which is why contemporary DSM terminology combines them under Female Sexual Interest/Arousal Disorder. HSDD remains an important related diagnosis used in sexual-medicine research and medication indications, while Female Orgasmic Disorder is a separate condition.

The causes are often multifactorial and may include:

menopause, vaginal dryness, medication effects, diabetes, neurological disease, depression, anxiety, stress, relationship difficulties, previous trauma, inadequate stimulation and sexual pain.

Current evidence strongly supports individualized care.

A major 2026 systematic review found benefits from mindfulness-based CBT and selected pharmacological treatments, while another 2026 network meta-analysis found improvements with sex education, CBT, mindfulness and sexual counselling.

Specific medical treatments have clearly defined roles. Local estrogen and related treatments can help menopausal GSM. Flibanserin and bremelanotide are treatments for carefully selected HSDD populations rather than universal female aphrodisiacs. Testosterone has a specialized role mainly for selected women with HSDD and requires professional monitoring.

The **Unani system of medicine** contributes an individualized holistic framework centred on **Mizaj, the four humours, diet, physical activity, sleep, mental well-being and appropriately selected pharmacotherapy**. Official Ministry of AYUSH and CCRUM sources recognize these preventive, dietary, regimenal and pharmacological principles as central components of Unani healthcare.

Research on traditional medicinal plants such as **Zafran and Asgand** is encouraging, with small randomized studies showing improvements in some female sexual-function measures. These findings deserve further scientific study but should not be converted into exaggerated claims of guaranteed cure.

At **Saira Health Care**, my approach is therefore to combine **confidential sexual-health assessment, individualized Unani care, lifestyle and dietary guidance, appropriate modern investigations, psychological support and evidence-based medical treatment whenever required**.

Female sexual arousal difficulties are treatable in many circumstances.

The first step is not embarrassment.

The first step is understanding the cause.

Dr. Nizamuddin Qasmi
Founder & Chief Physician
Saira Health Care
Focused Practice in Sexual Disorders & Infertility

BUMS – Hamdard University, Delhi | MD | CGO | Certificate in Infertility – MGBIMS, Delhi | Certificate in Urology – London, UK | Masters in Male Infertility – MasterHealthPro (HealthPro) | Integrated Sexual and Reproductive Health – ISRH, UNFPA

Medical Disclaimer: This article is intended for patient education and general health awareness. It does not replace individualized medical, gynecological or mental-health assessment. Sexual-health medicines, hormonal therapy, testosterone, antidepressant adjustments and herbal or Unani treatments should only be used after appropriate

professional evaluation, particularly during pregnancy, breastfeeding, fertility treatment, menopause, cancer treatment or when other medical conditions are present.