Understanding Reduced Libido, Loss of Sexual Interest, Arousal Difficulties and Female Sexual Well-Being

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Introduction

One of the most sensitive concerns a woman may bring to a sexual-health consultation is:

"Doctor, I have completely lost interest in intimacy. I love my partner, but I no longer feel sexual desire. Is something wrong with me?"

My first response is that **reduced sexual desire is common, but it should not automatically be labelled a disease**.

A woman's sexual interest naturally changes throughout life. Stress, poor sleep, pregnancy, breastfeeding, childbirth, menopause, medications, relationship circumstances, depression, anxiety, pain during intercourse and chronic medical illness can all influence desire.

The important question is not simply:

"How often does she want sex?"

The more clinically useful questions are:

Has her desire changed from her usual pattern?

Is the change persistent?

Does it cause her personal distress?

Is another physical, psychological, relationship or medication-related factor explaining it?

Historically, women with reduced sexual interest were often described using terms such as **"frigidity" or "frigid."** These expressions are imprecise, stigmatizing and medically outdated because they suggest emotional coldness rather than recognizing the complex biological,

psychological and relational nature of female sexual desire. The supplied background material appropriately traces this evolution from older stigmatizing language toward modern diagnostic concepts such as HSDD and female sexual interest/arousal disorder.

Today we understand low female sexual desire through a **biopsychosocial model**.

That means we look at the **body, brain, emotions, relationship and social circumstances together**.

What Is Hypoactive Sexual Desire Disorder?

Hypoactive Sexual Desire Disorder, commonly abbreviated **HSDD**, describes a persistent reduction or absence of sexual desire that causes significant personal distress and is not better explained by another medical condition, psychiatric disorder, medication effect or major relationship problem.

The term remains widely used in sexual-medicine research and in drug regulation.

However, the current **DSM-5/DSM-5-TR psychiatric classification** uses the broader term:

Female Sexual Interest/Arousal Disorder – FSIAD

This diagnosis combines problems involving sexual interest and arousal because these aspects of female sexual response frequently overlap.

ACOG explains that a disorder involving reduced sexual interest/arousal generally requires persistent symptoms for at least **six months**, involving several features such as reduced interest in sexual activity, fewer sexual thoughts or fantasies, reduced initiation or receptivity and reduced pleasure or arousal, together with significant personal distress.

HSDD and FSIAD therefore overlap substantially, but they are **not completely identical diagnostic terms**.

For website education, I find it useful to explain both.

Low Desire Is Not Automatically HSDD

This distinction is extremely important.

A woman may naturally have less sexual interest than her partner.

She may also temporarily experience reduced libido during:

- severe work stress;
- pregnancy;

- breastfeeding;
- menopause;
- sleep deprivation;
- illness;
- grief;
- relationship conflict.

If she is personally comfortable with her level of desire, simply wanting sex less frequently than somebody else does **not** automatically make her medically abnormal.

The diagnosis becomes relevant when reduced desire is persistent and **causes meaningful personal distress**.

Sexual medicine should not turn normal human variation into disease.

Desire Is Not Always Spontaneous

Many people imagine sexual desire as:

desire first → sexual activity second.

That pattern certainly exists.

But many women experience **responsive desire**.

A woman may initially feel emotionally neutral. After affection, privacy, kissing, touch or other welcomed stimulation, arousal develops and sexual desire appears.

ACOG notes that it can be normal not to experience desire until sexual activity has begun.

Therefore, a woman who rarely experiences sudden spontaneous sexual thoughts can still have healthy sexual functioning.

The important questions are whether she can experience interest or pleasure under appropriate circumstances and whether she is distressed by her current sexual response.

The Modern Understanding: Sexual "Accelerators" and "Brakes"

One useful way to explain female sexual desire is through the **dual-control model**.

Sexual response is influenced by both:

excitatory processes – the accelerator

and

inhibitory processes – the brake.

The source material provided for this article discusses this model extensively and describes dopamine, norepinephrine, steroid hormones and inhibitory signalling as components of the neurobiology of desire.

In everyday language, I tell patients:

Sometimes the problem is not that the accelerator is weak. Sometimes too many brakes are being applied.

Those brakes may include:

- exhaustion;
- fear of painful intercourse;
- depression;
- relationship resentment;
- performance pressure;
- body-image anxiety;
- medications;
- chronic illness;
- poor sleep.

In such circumstances, simply prescribing an aphrodisiac without removing the brake may accomplish very little.

The Role of Dopamine

Dopamine participates in:

- motivation;
- reward;
- anticipation;
- goal-directed behaviour.

It is therefore involved in sexual motivation.

However, I avoid telling patients:

"Your dopamine is low, therefore you have HSDD."

Routine brain neurotransmitter testing is not how female low desire is diagnosed.

The neurochemical model helps us understand the condition, but the actual clinical diagnosis remains based primarily on **history, symptoms, distress and contributing factors**.

Serotonin and Sexual Function

Serotonin is essential to normal brain function and mood regulation.

However, enhanced serotonergic signalling can inhibit aspects of sexual function in some people.

This is particularly relevant because **selective serotonin reuptake inhibitors—SSRIs—**may cause:

- lower desire;
- reduced arousal;
- delayed orgasm;
- inability to reach orgasm.

ACOG identifies SSRIs and several other medications among possible causes of female sexual problems.

Women should never stop antidepressants independently.

Instead, sexual side effects should be discussed with the prescribing clinician because alternative treatment strategies may sometimes be possible.

Hormones Matter—but Female Desire Is Not Controlled by One Hormone

Patients frequently ask me:

"Should I check my testosterone because my libido is low?"

Sometimes hormonal evaluation is useful.

But female desire cannot reliably be diagnosed from one testosterone result.

ISSWSH specifically states that **total testosterone should not be used to diagnose HSDD**. When testosterone treatment is considered in appropriate women, the level is used primarily as a baseline and for monitoring—not to establish the diagnosis.

This is one of the most important corrections to internet discussions of female libido.

A woman can have normal serum testosterone and still experience HSDD.

Another can have relatively low testosterone without being sexually distressed.

The Five Major Groups of Causes of Low Female Desire

The supplied clinical material organizes the causes of low libido into five broad areas:

1. hormonal and endocrine factors;
2. psychological factors;
3. physical illness and fatigue;
4. relationship factors;
5. medication-related factors.

This is a useful framework, although individual causes often overlap.

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1. Hormonal and Reproductive-Life Changes

Menopause

Menopause can affect sexuality in several ways.

Reduced estrogen can contribute to **genitourinary syndrome of menopause**, causing:

- vaginal dryness;
- burning;
- tissue irritation;
- reduced lubrication;
- pain during penetration.

Pain naturally reduces willingness to repeat the experience.

Therefore, what looks like “loss of libido” may sometimes begin as:

dryness → painful intercourse → fear of pain → avoidance → reduced desire.

This does not mean every postmenopausal woman loses sexual desire.

Many women remain sexually active and satisfied after menopause.

The individual symptoms should be identified and treated.

Pregnancy, Childbirth and Breastfeeding

Sexual interest may change during pregnancy and after childbirth.

Important contributors include:

- hormonal changes;
- breastfeeding;
- exhaustion;
- sleep deprivation;
- body-image changes;
- perineal pain;
- pelvic-floor injury;
- demands of caring for a baby.

A woman who has recently delivered a child should not be labelled sexually dysfunctional merely because intercourse is not currently a priority.

Recovery requires time.

Hormonal Contraception

Some women report changes in libido after beginning hormonal contraception.

Research findings vary, and effects differ substantially between individuals and contraceptive preparations.

If a woman notices a clear and persistent change after starting a contraceptive, medication review is reasonable.

However, one should not automatically assume that every low-libido problem is caused by contraception.

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2. Psychological Factors

Depression

Depression can produce **anhedonia**, meaning reduced capacity to experience pleasure.

That can affect:

- sexual interest;

- motivation;
- emotional connection;
- orgasmic response.

Additionally, some antidepressant treatments can themselves produce sexual side effects.

Both the illness and the treatment therefore deserve consideration.

Anxiety

Anxiety can make it difficult to remain mentally present during intimacy.

Thoughts may include:

“Will it hurt?”

“Does my body look attractive?”

“Will I disappoint my partner?”

“Why am I not becoming aroused?”

The woman begins evaluating rather than experiencing intimacy.

That cognitive pressure may further inhibit arousal.

Chronic Stress

Sexual desire usually does not exist independently of life.

A woman managing:

- employment;
- financial pressure;
- household responsibilities;
- childcare;
- elder care;
- sleep deprivation

may have limited physical and psychological energy for intimacy.

Sometimes a woman asking for a libido medicine actually needs help reducing chronic overload.

Trauma

A history of sexual or physical trauma can affect sexual desire, trust and arousal.

Treatment should be **trauma-informed**.

A woman should never be told:

“Just relax and try harder.”

Professional psychological or psychosexual support may be necessary, and sexual activity should always remain voluntary.

Body Image

Body image can change after:

- childbirth;
- surgery;
- weight change;
- menopause;
- ageing;
- illness.

Feeling watched, judged or ashamed of one's body can reduce the ability to focus on pleasurable sensation.

Body-image distress deserves compassionate care rather than reassurance alone.

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3. Physical Illness and Fatigue

Low sexual desire may accompany chronic health problems.

Examples include:

- diabetes;
- cardiovascular disease;
- thyroid disease;
- neurological illness;
- anaemia;

- chronic pain;
- endometriosis;
- pelvic disease.

The supplied material similarly emphasizes medical, neurological and gynaecological contributors to loss of sexual interest.

In these situations, the treatment should address the underlying disease—not only libido.

Sexual Pain Is a Powerful Libido Suppressor

If intercourse repeatedly hurts, the body learns to expect pain.

A cycle develops:

pain → fear → muscle tightening → reduced arousal → more pain → avoidance.

Potential causes include:

- vaginal dryness;
- vulvodynia;
- vaginismus/pelvic-floor overactivity;
- infection;
- endometriosis;
- menopausal tissue changes;
- childbirth-related scars;
- other pelvic conditions.

Pain should be diagnosed and treated.

A woman should not be pressured to increase sexual frequency while the activity remains physically uncomfortable.

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4. Relationship Factors

Female sexual desire often exists within a relationship context.

Important contributors can include:

- unresolved conflict;
- loss of trust;

- emotional distance;
- resentment;
- poor communication;
- coercion;
- mismatched sexual expectations.

The supplied source correctly identifies relationship discord and partner sexual dysfunction as potential contributors to acquired low desire.

A medication cannot fully repair unresolved relationship distress.

Partner Erectile Dysfunction or Premature Ejaculation

This is sometimes overlooked.

If intercourse repeatedly involves untreated erectile dysfunction or premature ejaculation, the female partner may gradually stop anticipating sexual activity positively.

Her reduced interest may therefore be **secondary to an unsatisfying or anxiety-provoking sexual pattern**.

Treating the partner's sexual disorder may improve intimacy for both.

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5. Medication-Related Sexual Dysfunction

Several medicines can affect sexual function.

ACOG specifically identifies categories including:

- SSRIs;
- anticholinergic medicines;
- hormonal medicines;
- some cardiovascular drugs;
- opioids.

Medication review is therefore an important component of diagnosis.

Do not stop medicine without professional advice.

How I Evaluate Low Female Sexual Desire

When a woman consults me at Saira Health Care, I do not begin by asking:

“Which aphrodisiac should we give?”

I begin with a careful history.

I want to understand:

Was sexual desire previously normal?

Did the change happen suddenly or gradually?

Does it occur in every situation?

Is she distressed by it?

Is sex painful?

Is lubrication reduced?

Can she become aroused?

Can she experience orgasm?

Has menopause begun?

Has she recently given birth?

Is she breastfeeding?

Has a new medicine been started?

Is depression or anxiety present?

Is there major relationship conflict?

Is her partner experiencing sexual dysfunction?

Is infertility also a concern?

The diagnosis becomes much clearer when we stop treating “low libido” as one single disease.

HSDD May Be Lifelong or Acquired

Some women report that they have never experienced much sexual desire.

Others say:

“I previously had normal desire, but it disappeared.”

This distinction matters.

Acquired loss of desire makes me particularly interested in:

- new medication;
- childbirth;
- menopause;
- medical illness;
- relationship change;
- stress;
- depression;
- sexual pain.

HSDD May Be Generalized or Situational

A woman may have little interest in sexual activity in every context.

Or she may experience desire in some situations but not with a particular partner or during a particular type of sexual activity.

That difference provides important diagnostic information.

A generalized problem may suggest a broader biological or psychological contributor.

A situational problem may point more strongly toward relationship, context, pain or specific sexual experiences.

There are no absolute rules, but the distinction is useful.

Validated Clinical Tools

One commonly used tool is the:

Decreased Sexual Desire Screener – DSDS

The DSDS was developed as a brief clinical tool for identifying generalized acquired HSDD.

In its original validation study, it showed good agreement with expert diagnostic interviews and was designed to make assessment practical even for clinicians who are not specialist sexologists.

Another instrument frequently used is the:

Female Sexual Function Index – FSFI

The FSFI assesses several domains including:

- desire;
- arousal;
- lubrication;
- orgasm;
- satisfaction;
- pain.

These tools support—but do not replace—a thoughtful clinical interview.

Are Blood Tests Required?

Not always.

There is no universal "female libido blood-test panel."

Testing depends on symptoms.

Possible investigations may include, when appropriate:

- thyroid tests;
- prolactin;
- glucose/HbA1c;
- blood count where anaemia is suspected;
- liver or kidney testing;
- other endocrine tests according to clinical findings.

Routine testosterone measurement alone should **not** be used to diagnose HSDD.

This corrects a common misconception in which every low-libido patient is automatically sold an expensive hormone package.

Pelvic Examination

A pelvic examination may be useful when symptoms suggest:

- vaginal dryness;
- painful intercourse;

- vulvar skin disease;
- pelvic-floor dysfunction;
- menopausal tissue changes;
- infection;
- structural abnormality.

A woman whose only symptom is uncomplicated low desire does not automatically require an invasive examination.

Clinical assessment should be individualized.

Treatment Begins With the Cause

There is no universal female-libido treatment.

A woman whose desire has fallen because of painful menopause-related dryness needs different treatment from a woman whose problem developed after starting an SSRI.

A woman with severe relationship conflict needs a different approach from a woman with generalized acquired HSDD without obvious reversible causes.

I therefore follow the principle:

identify the dominant cause → treat reversible factors → address distress → use specific therapy when appropriate.

Psychoeducation

One of the most useful treatments is sometimes simply understanding normal female sexual response.

Patients may need reassurance that:

- desire can be responsive rather than spontaneous;
- libido naturally changes;
- orgasm does not have to occur every time;
- lubrication and desire are not identical;
- relationship context matters;
- lower desire than a partner does not automatically mean disease.

Education reduces fear and performance pressure.

Cognitive Behavioural Therapy and Mindfulness

Psychological treatment has increasingly strong evidence for female desire and arousal disorders.

A 2025 systematic review and meta-analysis found that **mindfulness-based CBT improved overall female sexual-function scores as well as desire, arousal and orgasm**, while pharmacological treatments also showed benefits in selected patients.

A controlled study involving women with sexual interest/arousal disorder also found positive changes after mindfulness-based cognitive therapy, with effects maintained through follow-up.

These interventions can help reduce:

- distracting thoughts;
- body-image anxiety;
- performance monitoring;
- negative sexual beliefs;
- stress.

They are particularly valuable when psychological “brakes” are strong.

Couple and Sex Therapy

If low desire is strongly influenced by:

- relationship conflict;
- mismatched libido;
- poor sexual communication;
- partner sexual dysfunction

then treating only the woman may be incomplete.

Couple-based treatment can help partners understand differences in:

- desire;
- initiation;

- boundaries;
- expectations;
- emotional needs.

The aim should not be:

“Make the woman want sex more.”

The aim is:

“Understand what has disrupted desire and improve sexual and relationship functioning for both partners.”

Treat Sexual Pain Before Trying to Increase Libido

This is one of my strongest clinical recommendations.

If intercourse is painful, do not begin by trying to stimulate desire.

Treat the pain.

Depending on cause, management may include:

- lubricants;
- vaginal moisturizers;
- menopause-related local treatment;
- pelvic-floor physiotherapy;
- infection treatment;
- endometriosis management;
- vulvar treatment;
- counselling.

Removing pain may naturally allow sexual interest to return.

Modern Prescription Treatment for HSDD

Prescription treatments are appropriate only for selected women after appropriate assessment.

They are not general “female sexual-power medicines.”

Flibanserin

Flibanserin is an oral centrally acting medication used for acquired generalized HSDD.

There has been an important recent regulatory change.

As of the current U.S. prescribing information updated in **December 2025**, flibanserin is indicated for **women younger than 65 years** with acquired generalized HSDD that causes significant distress and is not primarily due to another medical/psychiatric condition, relationship problems or another drug.

This means older descriptions saying it is approved **only for premenopausal women** are now outdated in the United States.

It is taken at bedtime rather than "as needed."

Important adverse effects include:

- dizziness;
- sleepiness;
- nausea;
- fatigue;
- low blood pressure;
- fainting.

The current label also contains important precautions concerning alcohol, interacting CYP3A4 medications and liver impairment.

It is **not intended to enhance sexual performance in women who do not have HSDD**.

How Effective Is Flibanserin?

The benefit is statistically significant but generally modest.

A 2024 meta-analysis of eight randomized trials involving **7,906 women** found improvements in satisfying sexual events, sexual-desire measures and sexual distress compared with placebo, while adverse effects such as dizziness, fatigue, nausea and somnolence occurred more often.

The decision to use treatment should therefore involve realistic expectations and discussion of benefits and risks.

Bremelanotide

Bremelanotide is an injectable melanocortin receptor agonist.

Its current U.S. indication remains for **premenopausal women with acquired generalized HSDD** that is not due primarily to another disease, relationship problem or medication.

Unlike flibanserin, bremelanotide is used **as needed before anticipated sexual activity**.

It can cause:

- nausea;
- flushing;
- headache;
- temporary blood-pressure changes.

It is not a general sexual-performance enhancer.

Latest Evidence Comparing Treatments

A 2025 systematic review of 36 treatment studies found that:

- mindfulness-based CBT improved desire, arousal and orgasm;
- flibanserin improved overall sexual function and desire;
- bremelanotide improved overall sexual function, desire and arousal;
- all three approaches reduced distress in the populations studied.

This reinforces a very important principle:

female sexual desire problems can be treated through more than one pathway.

Medication is only one component.

Testosterone Therapy in Women

Testosterone receives considerable attention online.

The current evidence needs careful interpretation.

ISSWSH supports **systemic transdermal testosterone** for appropriately selected women with HSDD when the condition is not primarily explained by modifiable relationship, mental-health or other medical factors.

The evidence is strongest for postmenopausal women, with **moderate average benefit**. Long-term safety data remain incomplete.

A 2025 Mayo Clinic review similarly concluded that testosterone can provide modest benefit for appropriately selected peri- and postmenopausal women with distressing low desire, but there is currently **no FDA-approved testosterone formulation specifically for women in the United States**.

Testosterone Should Not Be Used to "Correct a Low Number"

This is especially important.

ISSWSH states:

testosterone levels should not be used to diagnose HSDD.

Where testosterone is used, levels help clinicians:

- establish a baseline;
- prevent excessive dosing;
- monitor for androgen excess.

Possible androgenic effects can include:

- acne;
- increased facial/body hair;
- scalp-hair changes.

Treatment requires medical supervision.

The Unani Perspective on Reduced Female Sexual Desire

As a physician trained in Unani medicine, I consider its greatest strength in this area to be its **holistic approach**.

Classical Unani medicine does not look only at one symptom.

It considers:

- **Mizaj** – temperament;
- **Akhlat** – the traditional humours;
- diet;
- sleep;
- movement;

- mental state;
- general strength;
- other bodily functions.

Official Ministry of Ayush material describes the four classical humours and the importance of their balance within traditional Unani theory. It also emphasizes the **Six Essential Factors—Asbab-e-Sitta Zarooriya—**as a foundation for health promotion.

These concepts are part of a traditional theoretical framework and should **not** be presented as direct biochemical equivalents of estrogen, dopamine, testosterone or laboratory values.

What Is Zauf-e-Bah?

CCRUM describes **Zuf-i-Bah/Zauf-e-Bah** as sexual debility associated with reduced sexual desire and capability.

Its official guideline also includes **Umūr Wahmiyya—psychological factors—**among traditional contributors.

This is important because it shows that traditional Unani sexual-health thinking is not entirely limited to anatomy or "sexual power."

Psychological health is also recognized.

However, the currently published CCRUM guideline is largely framed around **male sexual debility**, including low semen volume and penile flaccidity. Therefore, I would not simply apply every part of that guideline directly to female HSDD.

Female low desire requires its own individualized assessment.

Mizaj and Female Sexual Health

The supplied source discusses Unani concepts of Mizaj, Sard Mizaji, Hararat-e-Ghareeziya and sexual debility in considerable detail.

These concepts may be useful within traditional Unani case formulation.

But I do not consider it scientifically appropriate to say:

"Sard Mizaji equals hypoestrogenism"

or

"Hararat-e-Ghareeziya equals dopamine signalling."

These are concepts from different medical frameworks.

They can be discussed alongside one another, but they should not be falsely treated as identical.

Asbab-e-Sitta Zarooriya: A Valuable Unani Lifestyle Framework

The Six Essential Factors traditionally include:

- air/environment;
- food and drink;
- physical movement and rest;
- psychological activity and repose;
- sleep and wakefulness;
- retention and elimination.

Official Ayush documentation confirms these as important health-promoting principles in Unani medicine.

For a woman with low sexual desire, these factors allow us to consider questions such as:

Is she sleeping enough?

Is she chronically stressed?

Is she physically inactive?

Is her diet appropriate?

Is she emotionally exhausted?

This is where Unani care can make a particularly valuable contribution.

Ilaj bil Ghiza – Dietotherapy

Good nutrition supports overall health.

But I do not advise patients to believe that one food will “switch on” libido.

Traditional Unani diets may include:

- nuts;
- selected fruits;
- nutritious protein sources;
- spices;

- other strengthening foods.

These can contribute to a healthy diet.

However, a woman with:

- diabetes;
- obesity;
- PCOS;
- fatty liver

may require a very different dietary plan from an underweight woman with poor nutrition.

Traditional aphrodisiac foods should therefore be adapted to the individual's metabolic condition.

Dates, Honey, Nuts and Other "Aphrodisiac Foods"

Foods such as:

- almonds;
- walnuts;
- dates;
- figs;
- honey;
- pomegranate;
- saffron

have longstanding cultural associations with sexual vitality.

Many are nutritious.

But evidence does not support promising that they will directly cure HSDD.

I consider them **dietary components**, not replacements for diagnosis.

Ilaj bit Tadbir – Regimenal and Lifestyle Therapy

Unani regimenal principles can support:

- regular physical activity;

- appropriate rest;
- sleep;
- stress management;
- healthy routine.

These interventions have particular relevance to low desire because fatigue and chronic stress are major sexual inhibitors.

A woman who is chronically exhausted may benefit far more from restoring sleep and reducing psychological overload than from adding another tonic.

Psychological Balance in Unani Care

The traditional principle of **Harkat-o-Sukoon-e-Nafsani**, psychological activity and repose, has obvious relevance to contemporary sexual-health care.

It creates a culturally familiar way of discussing:

- anxiety;
- grief;
- anger;
- depression;
- stress;
- emotional exhaustion.

This fits well with modern biopsychosocial sexual medicine.

Unani Pharmacotherapy: Where It May Fit

Traditional Unani pharmacotherapy may be considered after proper assessment.

But the goal should not be:

“Give every woman with low desire a Muqawwi-e-Bah.”

The patient should first be evaluated for:

- depression;
- sexual pain;
- menopause;

- medication effects;
- relationship problems;
- endocrine disease;
- chronic illness.

A traditional formulation may have a complementary role in selected patients, but evidence for specific Unani compound formulations in rigorously diagnosed female HSDD remains limited.

Tribulus terrestris – Gokhru/Khare Khasak

The supplied material describes **Tribulus terrestris** as having clinical evidence in female HSDD.

There is indeed some human research.

A randomized double-blind placebo-controlled trial of **67 women** with HSDD found improvement in overall FSFI and several sexual-function domains after four weeks, with similar reported side-effect frequency to placebo.

Another randomized trial involving **40 premenopausal women** reported improvements in desire, arousal, lubrication, orgasm, pain and satisfaction.

A small postmenopausal trial also reported improvement in several sexual-function measures.

These results are interesting.

But the trials are:

- relatively small;
- short;
- based on specific extracts and dosing protocols.

Therefore I would describe Tribulus as **promising but not proven as a universal treatment for HSDD**.

Ashwagandha – Withania somnifera

Ashwagandha has been studied for female sexual function.

A randomized placebo-controlled study involving **80 women aged 18–50** found greater improvement in FSFI and sexual-distress measures after eight weeks of standardized ashwagandha root extract compared with placebo.

An earlier pilot trial of 50 women also reported improvements in arousal, lubrication, orgasm and satisfaction.

These studies are encouraging.

But they are relatively small and do not justify saying that Ashwagandha universally corrects hormones, dopamine or HPA-axis dysfunction.

Product quality also matters.

Saffron – Crocus sativus

Saffron is particularly interesting because clinical studies have investigated female sexual dysfunction.

A randomized placebo-controlled trial involving women with fluoxetine-associated sexual dysfunction found improvements in overall sexual-function score, arousal, lubrication and pain, although desire itself was not significantly improved in that study.

A separate 2022 randomized multicentre trial involving women with sexual dysfunction reported benefit in overall FSFI and several domains compared with placebo.

A 2024 trial combining saffron and vitamin E also reported improvement in female sexual-function measures.

This provides a reasonable basis for continued study.

It is not evidence of a guaranteed libido cure.

Ginger, Aqar Qarha and Safed Musli

These herbs have traditional reputations in sexual and general vitality formulations.

However, robust human evidence specifically for diagnosed female HSDD is substantially weaker than the evidence available for several established therapies.

I therefore would not make claims such as:

- “directly restores dopamine,”
- “reverses frigidity,”
- “corrects hormone imbalance,”

- or “permanently restores sexual desire”

without strong clinical evidence.

Their use, where considered, should remain individualized and professionally supervised.

Traditional Compound Unani Formulations

The supplied material mentions several traditional formulations such as Majoon Supari Pak and other compounds.

These formulations may have historical indications within Unani practice.

But the evidence currently available does not justify presenting them as **clinically proven treatments for modern diagnostically confirmed HSDD/FSIAD**.

I prefer to say:

traditional use exists, but high-quality female HSDD-specific clinical evidence is limited.

This makes the article more scientifically credible.

Herbal Does Not Mean Risk-Free

Natural medicines can cause:

- allergies;
- digestive effects;
- liver problems;
- interactions with other medicines;
- changes in blood pressure or blood sugar;
- pregnancy-related concerns.

Women who are:

- pregnant;
- breastfeeding;
- taking psychiatric medication;
- taking blood thinners;
- receiving hormonal therapy;
- living with liver or kidney disease

should be especially cautious.

Traditional medicines should be selected under qualified professional supervision.

Physical Exercise and Female Sexual Health

Regular exercise can support:

- mood;
- cardiovascular health;
- energy;
- body confidence;
- stress reduction;
- metabolic health.

Exercise should not be promoted as a guaranteed HSDD cure, but it can be an important part of a comprehensive sexual-wellness programme.

For a woman whose low libido accompanies inactivity, poor sleep, obesity or chronic stress, physical activity may improve several contributing factors simultaneously.

Sleep Is Often an Underestimated Treatment

A woman who is chronically sleep deprived may say:

“I have no libido.”

Sometimes the real issue is that she has **no energy for anything**.

I routinely ask about:

- sleep duration;
- interrupted sleep;
- caring for children;
- shift work;
- insomnia.

Sexual desire is more difficult when the body is exhausted.

This is an area where the Unani emphasis on **Naum-o-Yaqza—sleep and wakefulness—**is particularly relevant.

Relationship Communication

A sexual-health plan should also ask:

Can the woman tell her partner what she likes?

Can she say when something hurts?

Does she feel pressured?

Does she feel emotionally close?

Is sex rushed?

Does her partner understand her arousal pattern?

A woman may not need a libido medicine.

She may need a relationship in which sexual activity feels safer and more satisfying.

Consent and Female Sexual Desire

Desire cannot be sustainably created through pressure.

A woman who repeatedly has unwanted sex may gradually associate intimacy with:

- obligation;
- anxiety;
- resentment;
- fear.

That can further suppress desire.

Healthy sexual treatment therefore requires respect for consent and boundaries.

A medication or traditional tonic should never be used to override a woman's genuine preference or autonomy.

The Role of the Partner

Where appropriate, involving the partner can be very helpful.

A partner should understand that reduced desire does not necessarily mean:

“She does not love me.”

Likewise, the woman should be able to understand her partner's feelings without being pressured.

The couple can work on:

- communication;
- non-demand affection;
- improving sexual stimulation;
- treating partner dysfunction;
- reducing conflict.

Female sexual desire frequently exists within a **relationship system**, not in isolation.

My Specialized Approach at Saira Health Care

When a woman consults me at **Saira Health Care** with reduced desire, I prefer a stepwise approach.

Step 1: Define the Actual Problem

Is it:

- low desire;
- reduced arousal;
- dryness;
- orgasm difficulty;
- pain;
- fear;
- relationship distress?

These should not be mixed together.

Step 2: Identify the Pattern

Is it:

- lifelong;
- acquired;
- generalized;
- situational?

Step 3: Look for Reversible Causes

I consider:

- medications;
- depression;
- anxiety;
- menopause;
- postpartum changes;
- chronic illness;
- pain;
- sleep;
- stress.

Step 4: Assess Relationship Context

Is the problem actually:

- relationship conflict;
- mismatched desire;
- partner ED;
- premature ejaculation;
- poor sexual communication?

Step 5: Use Investigations Selectively

Tests should be based on the clinical picture—not ordered simply because a woman reports low libido.

Step 6: Treat the Dominant Cause

That may mean:

- psychosexual therapy;
- treatment for GSM;
- pelvic-floor therapy;
- medication review;
- modern HSDD medication in an appropriate candidate;

- supervised testosterone treatment in selected postmenopausal women;
- or integrative Unani management.

Step 7: Review Progress

Treatment success should include:

- reduced distress;
- improved desire;
- improved comfort;
- better intimacy;
- improved quality of life.

The objective is not merely to produce a higher questionnaire score.

Special Treatment Philosophy of Dr. Nizamuddin Qasmi

My clinical approach is based on **individualization rather than a universal sexual tonic**.

One woman may need treatment of vaginal dryness.

Another may need counselling.

Another may need medication review.

Another may have HSDD appropriate for evidence-based pharmacological therapy.

Another may benefit from a carefully selected Unani programme focused on sleep, nutrition, stress and general health.

Another may require gynaecological or endocrine referral.

This is why I consider comprehensive sexual-health assessment essential.

About Dr. Nizamuddin Qasmi

Dr. Nizamuddin Qasmi

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Focused Practice in Sexual Disorders & Infertility

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

My focused clinical interest includes sexual disorders and infertility, with an integrative approach that combines appropriate Unani principles with contemporary sexual and reproductive-health assessment.

Saira Health Care's Contribution to Female Sexual and Reproductive Health

Female sexual concerns remain under-discussed.

Many women suffer silently because they have been told:

“A good woman should not talk about sexual desire.”

Others hear:

“If you don't want sex, you must have a hormonal problem.”

Others are told:

“Take a powerful tonic and everything will be normal.”

These oversimplifications can delay appropriate treatment.

At **Saira Health Care**, one important part of our work is therefore:

- patient education;
- reduction of sexual myths;
- confidential discussion;
- distinction between normal desire variation and genuine disorder;
- appropriate identification of pain, menopause and psychological factors;
- responsible use of Unani care;
- referral or investigation where necessary.

Sexual health deserves the same professional attention as any other area of health.

Frequently Asked Questions

Is low sexual desire common in women?

Yes.

Low desire is among the most frequently reported female sexual concerns.

But not every woman with lower desire has a disorder. Personal distress and the wider clinical context are essential.

What is the difference between HSDD and FSIAD?

HSDD focuses primarily on distressing low sexual desire.

DSM-5 combined female desire and arousal symptoms into **Female Sexual Interest/Arousal Disorder**, reflecting the overlap between these experiences in many women.

Both terms remain in clinical use depending on the diagnostic and research context.

How long must low desire continue before it is considered FSIAD?

DSM-style criteria generally require relevant symptoms to persist for approximately **six months** and cause significant personal distress.

This should not be confused with simply having a stressful month or a temporary change in libido.

Does low libido mean low testosterone?

No.

Female sexual desire cannot be diagnosed from testosterone levels.

ISSWSH specifically states that total testosterone should not be used to diagnose HSDD.

Can menopause cause low desire?

It can contribute, but not every postmenopausal woman develops low libido.

Menopause-related dryness and painful intercourse may indirectly reduce desire, while relationship, psychological and general-health factors also matter.

Can depression cause low sexual desire?

Yes.

Depression can reduce motivation and pleasure, while some antidepressant medicines can also cause sexual side effects.

Both possibilities should be considered.

Can stress completely reduce libido?

Severe chronic stress can substantially suppress sexual interest in some people.

When stress is an important contributor, improving sleep, workload, psychological health and relationship environment may be central to treatment.

Can relationship problems cause HSDD?

Relationship distress can certainly reduce sexual desire.

However, current HSDD drug indications specifically exclude cases where the low desire is primarily explained by relationship problems.

This is why diagnosis matters before medication.

Does a woman need spontaneous sexual desire to be healthy?

No.

Some women experience **responsive desire**, where interest emerges after welcomed intimacy has already begun.

ACOG recognizes that it can be normal not to feel desire until sexual activity has started.

Can flibanserin treat low desire?

It can help selected women with acquired generalized HSDD.

As of the updated U.S. prescribing information, it is indicated for women **younger than 65 years** whose HSDD is not due to another medical/psychiatric condition, relationship problem or drug effect.

It has modest average benefit and important safety considerations.

Is flibanserin only for premenopausal women?

That statement is now outdated in the United States.

The current indication, revised in December 2025, includes women **under 65**, including appropriate postmenopausal women.

What is bremelanotide?

Bremelanotide is an injectable prescription treatment used as needed for acquired generalized HSDD in **premenopausal women** in the United States.

It is not indicated for postmenopausal women or as a general sexual-performance enhancer.

Can testosterone treat female low desire?

It can provide moderate benefit in appropriately selected women, with the strongest evidence in postmenopausal HSDD.

It is generally an off-label treatment in many countries and requires careful dosing and monitoring.

Can Tribulus terrestris improve female desire?

Small randomized trials have reported improvements in sexual-function scores in both premenopausal and postmenopausal women.

However, the evidence base remains much smaller than that for established treatments and does not establish universal effectiveness.

Can Ashwagandha improve female sexual function?

Some small randomized trials have found improvements in several sexual-function and distress measures with standardized extracts.

Further independent, larger studies are desirable.

Can saffron help?

Clinical trials have reported potential improvements in female sexual function in selected populations, including women with antidepressant-associated sexual dysfunction.

Again, this should be considered promising evidence rather than proof of a universal cure.

Can Unani medicine help women with low libido?

Unani medicine can make a useful contribution through its **whole-person approach**, particularly:

- diet;
- physical activity;
- sleep;
- stress management;
- psychological balance;
- individualized traditional treatment.

Official Unani guidance emphasizes these lifestyle foundations.

However, specific Unani formulations should not be presented as proven replacements for modern diagnosis or established HSDD therapies without adequate clinical evidence.

Is HSDD related to infertility?

Not directly.

A woman can have low desire and completely normal reproductive function.

However, severe sexual avoidance or painful intercourse may reduce the frequency of intercourse and indirectly complicate conception.

Infertility itself requires its own couple-based evaluation.

When Should a Woman Consult a Healthcare Professional?

Professional assessment is appropriate when reduced desire:

- persists for months;
- represents a significant change;
- causes personal distress;
- affects quality of life;
- is associated with painful intercourse;
- occurs with vaginal dryness;
- begins after medication changes;

- accompanies depression or anxiety;
- develops around menopause;
- is associated with other hormonal symptoms;
- or contributes to fertility difficulties.

Seek appropriate medical care for:

- unexplained postmenopausal bleeding;
- recurrent bleeding after intercourse;
- severe pelvic pain;
- abnormal genital discharge;
- suspected infection;
- genital sores;
- sexual trauma.

A Message From Dr. Nizamuddin Qasmi

When a woman tells me:

“Doctor, I don't feel desire anymore,”

I do not automatically tell her:

“Your hormones are weak.”

I do not assume:

“Your marriage is the problem.”

And I do not immediately prescribe an aphrodisiac.

I first want to understand her story.

Perhaps she is exhausted.

Perhaps sex has become painful.

Perhaps she is going through menopause.

Perhaps an antidepressant has changed her sexual response.

Perhaps she is depressed.

Perhaps her partner has untreated erectile dysfunction.

Perhaps the relationship is strained.

Or perhaps she genuinely has acquired generalized HSDD and may benefit from a specific evidence-based treatment.

Female sexuality is not controlled by one hormone, one herb or one organ.

It is the product of the **brain, body, hormones, health, emotions, relationship and life circumstances working together**.

As a physician trained in Unani medicine, I find its holistic philosophy valuable because it reminds us to examine:

Mizaj, food, movement, rest, sleep and psychological wellbeing.

These areas can genuinely support sexual health.

But traditional medicine becomes more credible when we also respect modern evidence.

I do not consider it appropriate to say that every woman with low desire has “cold temperament,” that one herb will permanently restore libido, or that a traditional concept is exactly equivalent to a modern hormone or neurotransmitter.

Instead, I believe in **integrative and individualized treatment**.

Modern diagnosis when necessary.

Psychological and relationship care when needed.

Evidence-based medicines for appropriate patients.

Unani lifestyle and therapeutic support where suitable.

And referral whenever another specialist can offer better care.

At **Saira Health Care**, the objective is not merely to make a woman have more sex.

The objective is to help her achieve **better sexual health, comfort, confidence, intimacy and overall well-being according to her own needs.**

About the Author

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At **Saira Health Care**, the clinical focus includes confidential and individualized assessment of sexual and reproductive-health concerns, including female low sexual desire, sexual pain, arousal difficulties, relationship-related sexual problems and infertility.

Medical Disclaimer

This article is intended for **patient education and general health information**. It does not replace an individual medical consultation, physical examination, psychological assessment or personalized treatment plan.

Reduced female sexual desire may be related to medical, hormonal, psychological, medication-related or relationship factors. Appropriate diagnosis should precede treatment.

Prescription treatments such as flibanserin, bremelanotide or testosterone require professional assessment and have specific indications, contraindications and monitoring requirements.

Unani medicines and herbal supplements may also produce adverse effects or interact with prescription medicines. Pregnant or breastfeeding women and patients with significant medical conditions should seek qualified advice before using them.