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A psychobiosocial model for assessment, treatment, and relapse prevention for female sexual interest/arousal disorder

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ABSTRACT

With the DSM-5 now recognizing Female Sexual Interest/Arousal Disorder (FSIAD), it is imperative that researchers and clinicians have a comprehensive understanding of FSIAD and how to effectively treat it. As the topic of female sexual desire grows in popularity, researchers and clinicians have deemed it more variable, flexible, complex and individualistic than male desire. Most significantly, many have recognized that female desire is just as important as male desire. FSIAD is the most common female sexual complaint, and has the most negative impact on the couple relationship. This conceptual paper utilizes a case study to explore an integrative, couple psychobiosocial model for assessment, treatment (including therapeutic and medication interventions), and relapse prevention of FSIAD.

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Understanding and treating female sexual desire

This is an exciting and challenging time to address issues of female sexual desire. Basson (2001, 2007) introduced the concept of "responsive female sexual desire," which challenges the traditional male model of hypoactive sexual desire disorder (HSDD). After a great deal of conceptual, empirical, and clinical work, the *Diagnostic and Statistical Manual of Mental Disorders* (5th ed.; DSM–5) recognized a new diagnostic category for Female Sexual Interest/Arousal Disorder (FSIAD) (American Psychiatric Association, 2013). This designation recognizes that female sexual desire is more variable, flexible, complex, and individualistic than male desire. Female desire problems, whether primary or secondary, can represent a range of psychological, biological/medical, and social/relational causes, contrasting with HSDD in males, which is typically secondary to sexual dysfunction (Rosen, Miner, & Wincze, 2014).

This conceptual paper explores a positive, realistic couple example utilizing the psychobiosocial model of assessment, treatment, and relapse prevention (McCarthy & Wald, 2017). The new sex therapy model features the mantra of desire/pleasure/eroticism/satisfaction (Foley, Kope, & Sugrue, 2012). Of these dimensions, desire is the crucial factor. Leiblum (2010) noted that desire problems constitute the most common issue that brings

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couples to sex therapy, as they negatively impact sexual satisfaction, as well as the relationship. The previous belief was that with increased sex function, especially orgasm, desire would not be an issue. Although arousal and orgasm are undoubtedly important, they do not constitute the key factor in FSIAD. Many with desire issues find themselves engaged in a negative cycle featuring anticipatory anxiety, performance-oriented sex (with a focus on intercourse and orgasm as a pass–fail test), frustration, embarrassment, and avoidance. The goal when treating for sexual desire disorders is for the individual and the couple to move into a positive cycle consisting of sexual anticipation, pleasure-oriented sexuality, and a regular rhythm of sexual expression.

FSIAD treatment is an example of the personal responsibility/intimate sexual team approach to sexual function and dysfunction (McCarthy, 2015). It is the woman's responsibility to create her "sexual voice," which includes sexual desire; her partner cannot provide her with desire. However, sexuality is a team sport; thus, the couple challenge is to develop a sexual style that promotes strong, resilient desire.

The goal of therapy is to build desire so that sexuality has a 15%–20% positive role for the woman and relationship (Metz, Epstein, & McCarthy, 2017). Genuine sexual desire is based on the woman taking responsibility for her sexual voice and enlisting her partner as her intimate and erotic ally. The female–male equity model facilitates desire and being an intimate sexual team. Sexual satisfaction is grounded in the Good Enough Sex (GES) model, which recognizes the multiple roles, meanings, and outcomes of couple sexuality rather than demanding perfect individual sex performance (Metz & McCarthy, 2012). The treatment outlined in this paper incorporates themes from these two models to help increase sexual desire and facilitate the development of a couple's sexual style. This paper will also explore the use of a new medication, Flibanserin (Addyi), which is being promoted as the female version of the pro-erection medications, Viagra and Cialis.

Clinically, the four-session assessment model is strongly recommended (McCarthy & Thestrup, 2008). Ideally, the first session is scheduled with the couple, even when the woman identifies the desire problem as solely hers. The powerful, motivating message is that intimacy and sexuality are best approached as a couple-oriented issue. During the next two sessions, the clinician collects individual psychological/relational/sexual histories. If the clinician conducts the history with the partner present, the therapist will get a "sanitized" version, rather than the genuine narrative. The fourth session is scheduled for 90 minutes and bridges the assessment and treatment phases.

The couple feedback session has three areas of focus:

(1) Share a genuine narrative that includes each partner's psychological/relational/sexual strengths and vulnerabilities.
(2) Explore the couple's strengths and vulnerabilities and establish a treatment plan and goals.
(3) Assign the first desire psychosexual skill exercises to be done in the privacy of their home.

In sharing each partner's strengths and vulnerabilities, it is crucial that the woman owns her sexual story, free of guilt or shame. Many women have a contingent sexual self-esteem, mistakenly believing she would not be respected or loved if her partner knew her

genuine sexual narrative. Rather than being ruled by societal-determined male myths and braggadocio, she learns to accept her partner's strengths and vulnerabilities. Each person and every relationship has psychological/relational/sexual strengths as well as vulnerabilities. This allows the woman to share her genuine narrative and to feel accepted and loved for who she is, which is emotionally and sexually validating (Rellini, 2014). From this foundation of acceptance, she is open to growth and change.

The most common therapeutic plan is a six-month "good faith" agreement to create a new couple sexual style with strong, resilient sexual desire. Creating her sexual voice with a focus on desire is the woman's responsibility, while the partner functions as her intimate and erotic ally.

The couple focuses directly on the desire psychosexual skill exercises of comfort, attraction, trust, and the creation of her preferred sexual scenario (McCarthy & McCarthy, 2012). Rather than beginning with the traditional sensate focus exercise with a prohibition on intercourse, the desire exercises demonstrate an anti-avoidance approach to touching while helping to facilitate the key psychological dimensions of desire: positive anticipation, sense of deserving pleasure, freedom and choice, and unpredictable sexual scenarios. Sexual desire is surprisingly easy to subvert and kill. It is crucial for clinicians, women, and couples to be aware that desire can be rekindled and be resilient.

The desire psychosexual skill exercises involve reading for cognitive change, emotional processing to change feelings, and, most importantly, enacting the psychosexual skill exercises to build sexual comfort and confidence. The traditional trap for women is to feel sexually inferior and pressured to "catch up" to male arousal. In the new model, the message is that female sexuality, especially sexual desire, is first class and not inferior to male sexuality (McCarthy & Wald, 2016). Female desire is variable, flexible, complex, individualistic, and, most significantly, valued by the couple. The male desire model of spontaneous erection, erotic fantasy, and predictable intercourse and orgasm is not superior, and, in fact, can subvert desire as the man ages. When couples stop being sexual – whether at 40, 60, or 80 – it is almost always the man's choice because he has lost confidence with maintaining an erection, intercourse, and orgasm (Lindau et al., 2007). With the aging of the male and the relationship, "responsive male sexual desire" is an empowering concept for him and the couple. Rather than the traditional male model of autonomous sex function, the female model of intimate, interactive, variable, flexible couple sexuality promotes desire, especially after age 50.

After the couple feedback session, sex therapy begins on a weekly basis with the goal of transitioning to every other week, ideally after 4–6 sessions. The couple is urged to maintain that schedule opening and allot the time for themselves. The couple time can be used to practice psychosexual skill exercises, discuss practical or emotional issues, problem-solve a relational difficulty, discuss and process a sensitive issue from the past, or simply go for a walk and share enjoyable time.

Typically, couples engage in 2–4 exercises between therapy sessions. A valuable concept is that while half of the therapy occurs in the clinician's office, the other half occurs in the couple's home, especially while practicing the psychosexual skill exercises. One function of the exercises is to identify inhibitions, anxieties, and lack of sexual skill. Thus, the psychosexual skill exercises serve as an ongoing assessment process. The second function is to promote sexual anticipation and skill, which enhances desire and satisfaction.

Realistic expectations of Addyi

The introduction of a new medication, Flibanserin (Addyi), which is being promoted as the female version of the pro-erection medications, Viagra and Cialis, has opened a new line of research into the study of FSIAD. As with erectile dysfunction (ED) medications, Flibanserin is promoted as a stand-alone medication that will provide a boost to female libido. There are significant problems with the role of the pharmaceutical industry and its use of public relations and marketing approaches, as opposed to scientifically validated data and interventions. The drug marketing campaign misrepresents the clinical implications of Addyi (Tiefer, 2002). This paper will address using Addyi in a psychobiosocial approach to addressing female desire.

General physicians and gynecologists will likely use (and thus misuse) Addyi as the first-line intervention for FSIAD in the same manner that Viagra has been misused as a stand-alone medication for ED (Leiblum, 2002). Although medication can be an invaluable resource, there are negative consequences as a stand-alone intervention. Rather than motivating the woman and couple, women feel intimidated and demoralized if they do not experience dramatic results and thus "fail" with Addyi. This has occurred with Viagra, leading men to cease taking the medication and stop engaging in couple sex (Metz & McCarthy, 2004).

It is important to convey to the woman (and the couple) that while Addyi is a positive resource to rebuild sexual desire, it does not serve as a cure-all. The medication should not be referred to as a "placebo," but it is important to understand the positive role that medication can play in promoting optimism about sexual desire. Addyi's purpose is to increase openness and enthusiasm about sexuality. However, it is not a "magic pill," nor can it do it all sexually. The analogy many clients have found motivating is that in rebuilding desire, Addyi contributes 1/3, the woman's renewed sexual voice contributes 1/3, and the couple's new sexual style of intimacy and eroticism contributes the final third. Addyi alone will not cure desire problems. If thought of as the sole antidote to the issue of desire, it runs the risk of making the woman feel she is hopeless and helpless because she is an "Addyi failure." Using the criterion of a dramatic increase in sexual desire due to the medication, the majority of women would be classified as "failures." The core therapeutic issue is how to integrate Addyi into the therapeutic regimen to promote significant change (Brotto, 2015). The clinical trial research indicated a modest change in desire, specifically an increase of one positive sexual experience per month (Jaspers et al., 2016).

The integrative psychobiosocial model is a good fit to study the efficacy of Addyi. The medication can promote sexual optimism, as well as have a modest biophysiological effect on desire. The clinician encourages the woman (with the support of her partner) to remain motivated and disciplined to take the medication daily for three months. The medication may become more effective over time. The FDA recommends women refrain from alcohol use while on the medication. However, many women find that alcohol serves to reduce sexual self-consciousness and consequently facilitates sexual desire. This can be achieved by one drink, rather than 3–4. This could strengthen the placebo effect of Addyi since self-consciousness subverts sexual anticipation. The psychobiosocial approach to sexual desire and function involves utilizing resources that create positive anticipation, a sense of deserving pleasure, and the freedom to be sexual.

Sylvia and Conrad

Like many adult women with careers, children, family responsibilities, household chores, and community commitments, Sylvia had lost her sexual voice and resented the perceived pressure from Conrad, her husband of 14 years, to be as sexual as he. During the romantic love/passionate sex/idealization phase (limerence), Sylvia had valued sexuality and frequent intercourse. The limerence phase lasted more than a year, but was gone by the time they were married. Sylvia was sexual once or twice a week – sex was functional, but not special or energizing. Two years later, Sylvia found sex with the goal of pregnancy an aphrodisiac. She became pregnant within three months, which was gratifying, but sex during the pregnancy resulted in a great deal of conflict with Conrad as she felt pressured for intercourse. During the pregnancy, he preferred rear-entry intercourse, which was fine in terms of her growing uterus, but emotionally off-putting to Sylvia. They had conflict over sex during the last trimester. They resumed intercourse five weeks after their daughter was born. Sylvia offered to manually pleasure Conrad to orgasm, but he would not give up his definition of sex as intercourse. Sylvia felt oppressed by Conrad's sexual agenda, and disowned her pro-sexual stance. Over the next nine years, which included the birth of their second daughter, Sylvia and Conrad remained stuck in the traditional power struggle where he would initiate intercourse 3–4 times a week, she would say no, he would persist, and intercourse would occur 2–4 times a month. Conrad complained about Sylvia's lack of sexual enthusiasm and their low sex frequency. Conrad saw himself as providing foreplay to make sex better for Sylvia, but she saw this as pressure and a hassle. She would hurriedly transition to intercourse, to end the encounter as quickly as possible.

When Addyi entered the market, Conrad strongly urged Sylvia to make an appointment to see if the medication would increase sexual desire. Sylvia did not particularly like her gynecologist, but did respect and like the family medicine practitioner. Sylvia waited until her scheduled physical to ask questions about Addyi. The family practitioner emphasized a holistic approach to medical care, and was not swayed by drug company overpromises and marketing. He conducted a short, focused sexual history and asked Sylvia about her sexual motivation. That was an eye-opening question to which Sylvia had no answer. The physician suggested a referral to a couple therapist with a sub-specialty in sex therapy. Sylvia was ambivalent because she felt she had a good marriage and family life. She did not want to destabilize Conrad or the marriage, and especially not the children. Sylvia wanted to be sure the therapist was pro-marriage before setting up an appointment. During their initial phone conversation, the therapist described the four-session assessment process, and reassured her this was not a "cookie cutter" approach.

Sylvia was quite surprised that Conrad was reluctant to attend couple therapy given how frequently he complained about their sex life. As they were driving to the initial session, Conrad said he loved her, but was afraid she would leave him. Sylvia was both surprised and touched; it was she who worried that Conrad would leave because of the sex problem. Conrad was committed to the marriage and family. He felt this was a typical male–female sex argument and did not want it to become destructive for their marriage.

The initial couple session was less threatening than Sylvia expected. What she remembered most was the therapist's comment that sexuality was not having a positive role, and this was a loss for her, Conrad, the marriage, and their family. Rather than blaming or shaming Sylvia, the therapist emphasized that rekindling desire was a challenge for her

and them as a couple. In answer to the question, "When was desire/pleasure/eroticism/satisfaction best for you?" Sylvia and Conrad agreed it was wonderful when they began as a couple. That brought back good sexual memories that Sylvia had forgotten. The therapist said they could not go back to the romantic love/passionate sex phase, but could develop a new couple sexual style with resilient sexual desire. The therapist cautioned them to not engage in the counterproductive blame-counter blame power struggle about intercourse. Sylvia was surprised that Conrad agreed they needed to end the power struggle. When the therapist asked Conrad what his core feelings about the desire problem were, he identified confusion and sadness. This was a softer part of Conrad than Sylvia had witnessed in the past years.

The therapist asked them to sign a release of information form so he could communicate with the family physician. They were sent home with the chapter "Whose problem is it: His, hers or ours" from *Rekindling Desire* (McCarthy & McCarthy, 2014). This introduced the personal responsibility/intimate team model for appraisal of desire problems. Sylvia found the de-stigmatization of the desire deficiency to be helpful. Knowing it is a common problem made her feel less lonely and negative. She realized that over the years she had demonized Conrad about sex and felt demonized by him. The concept of being intimate and erotic friends was a healthy challenge.

Sylvia felt apprehensive about her individual psychological/relational/sexual history appointment. However, she was reassured by the clinician's respectful manner and felt that he genuinely wanted to understand her strengths and vulnerabilities. The exploration of Sylvia's narrative illuminated how sexual enthusiasm had turned to disappointment and frustration, which then led to sexual avoidance. Previously, she had placed all the blame on Conrad; she now realized she had a role in negating sexuality. Awareness of the ways in which blaming and shaming reinforce the self-defeating cycle was powerful for her.

Sylvia enjoyed affectionate touch, but Conrad's sexual touch was alienating. This was worsened by their struggle over intercourse. When the therapist asked about change goals, Sylvia admitted she felt adrift. This awareness made her feel vulnerable. All of her energy had gone toward pushing back against Conrad's sexual approach; she did not have a positive sexual agenda or goals.

When the therapist asked whether there was anything Sylvia had told him that she did not want shared with Conrad, she said it was that she masturbated using a vibrator 1–2 times a month. The follow-up question was, "What are the positive reasons you want to keep this a secret?" Like most clients, Sylvia did not have a positive motivation; it was driven by embarrassment and guilt. The therapist noted that her body enjoying touch and orgasm was a positive prognostic sign. The fact that she responded to touch was part of her new sexual narrative. Sylvia gave the therapist permission to share this information during the couple feedback session.

For Sylvia and Conrad, as with many clients, the couple feedback session was a turning point. The therapist began by focusing on Conrad's genuine psychological and sexual strengths, as well as vulnerabilities. Much of this narrative was new to Sylvia, including how frequently Conrad masturbated; how he felt loved as a husband and father, but not as a sexual partner; how attracted he was to Sylvia; his fears that Sylvia would be attracted to a physically fit man; and fear that the reason she was not attracted to him was that he had a small penis and was not fit. She also learned that Conrad went to strip clubs and

paid for lap dances, and that he believes Sylvia punishes him for not being financially successful. Sylvia had no idea of the fears, guilt, and misunderstandings that weighed on Conrad. She had viewed him as a sexually assured and blaming partner and had not understood the complexity of his genuine narrative.

The narrative that the therapist conveyed about Sylvia was not only new for Conrad; it was new for Sylvia. She had viewed herself and sexuality in stark, simplistic, black–white terms. The therapist began by emphasizing Sylvia's genuine strengths: she was well-intentioned in terms of the marriage and family, committed to Conrad, had her sexual voice during the limerence phase, was orgasmic during masturbation, valued affectionate touch, and respected Conrad as a husband and father. Sylvia's vulnerabilities included that she had de-eroticized herself and their relationship, resented Conrad's intercourse demands, lost her sexual voice, and was a poor sexual model for her children. Sylvia had compartmentalized sex from the rest of life. Resentment and negativity dominated her view of sex.

Sylvia felt the therapist understood her. She was embarrassed about the role of sexuality in her life. Sylvia was reassured when the therapist said this is a changeable problem, but would require a good deal of effort. By taking personal responsibility for sexuality, turning toward Conrad as her intimate and erotic ally, and using all the psychobiosocial resources available to her, including Addyi, she could find her sexual voice and rekindle desire.

The therapist's emphasis on sexual desire as a positive challenge was a welcome approach, especially labeling the "intercourse or nothing" power struggle as a "poison." Conrad accepted Sylvia's narrative and committed to the therapy contract of a six-month good faith effort to build a new couple sexual style with strong, resilient sexual desire. Their motivation was enhanced by the therapist saying, "You can be among the three of four couples who successfully develop healthy marital sexuality."

The first psychosexual skill exercise assigned at home was to build comfort and anticipation regarding touching. The therapist recommended the "ping-pong" system of initiating, with Sylvia taking the first "ping." They committed to at least two exercises per week between therapy sessions, with the recommendation of four each week to reinforce the anti-avoidance approach of non-demand pleasuring. In Sylvia's initiations, the focus was on pleasure-oriented touch – whether clothed or unclothed, sensual or playful, verbal or non-verbal, taking turns (self-entrancement arousal) or mutual (partner interaction arousal). Sylvia focused on what was enjoyable for her rather than trying to second-guess Conrad. On his initiation, Conrad was instructed to touch for himself, not to arouse Sylvia. He identified positive sensations/feelings in the 1–5 range of subjective arousal and learned to value that for itself rather than a means to intercourse. Intercourse was prohibited during Conrad's initiations, but not with Sylvia's. There was no pressure or expectation that Sylvia would transition to intercourse, it was her choice.

At the next therapy session, they reported each had initiated twice. This was more touching than they had had in years. Conrad experienced erections, which was accepted as an acknowledgement of pleasurable sensations/feelings, not as pressure for intercourse. Sylvia found it challenging to differentiate sensual and playful feelings, as well as identify their value for her "sexual voice." The therapist explored the meaning of "responsive sexual desire" and reinforced that this is a common female sexual response pattern (Basson, 2007). Sylvia began taking Addyi daily, increasing her optimism about exchanging intimate touch with Conrad.

The attraction psychosexual skill exercise was the focus in the second week. This exercise acknowledges the psychological, emotional, physical, and sexual factors that enhance attraction. Acceptance serves as the foundation for change and growth. This was particularly important for Sylvia, who had felt Conrad's acceptance was contingent on her willingness to have intercourse. Realizing that Conrad valued her and found her attractive was empowering. Even more important was Sylvia's ability to make requests and that she had a positive influence on Conrad. She made three requests: (1) Conrad expand his definition of sexuality, (2) when sex did not flow to intercourse that he not call her names or punish her, and (3) he use mouth wash before a sexual encounter. He agreed to all of her requests.

At the next therapy session, Sylvia reported that on her initiation they engaged in intercourse. She enjoyed it, although not as much as Conrad. This led to a discussion about synchronous and asynchronous sex; both are healthy for couple sexuality. However, their pattern had been that almost all sex was asynchronous, and at Sylvia's expense. That had not been Conrad's intention, and he apologized for this unintended pattern. Sylvia accepted this as a genuine apology, and now felt she had the power to say no to asynchronous sex that was at her expense.

This led to a discussion about how to utilize the third desire psychosexual skill exercise – creating a trust position. Rather than the traditional lay and hold position, Sylvia preferred an active trust position of standing, holding hands, and swaying together. She knew that if something negative happened sexually, she could use this trust position to feel safe and connected, rather than feel passive and resentful. They practiced the trust position three times during the week. Although they did not need to use it in subsequent weeks, knowing it was available was important for Sylvia.

The female–male equity model facilitates marital sexuality based on trust, equity, respect, and intimacy (McCarthy & Bodnar, 2005). The psychosexual skills that Sylvia and Conrad learned strengthened their marriage, aiding the renewal of Sylvia's sexual desire.

The most challenging and meaningful psychosexual skill exercise for Sylvia and Conrad, as with many couples, was each partner creating a preferred sexual scenario. It was clear to Sylvia that, like one in three women, her receptivity/ responsivity pattern was during erotic non-intercourse encounters (Graham, 2014). In the past, Conrad had used foreplay to heighten her arousal before intercourse, using both manual and oral stimulation. Sylvia had a very different preference. She valued playful touch during non-demand pleasuring, then rubbing her body against his thigh, resulting in vulva/clitoral stimulation; finally, when her subjective arousal level was a 7–8, she wanted Conrad to engage in indirect manual clitoral stimulation to her orgasm. Conrad understood that Sylvia enjoyed intercourse much more when she was subjectively aroused or had already experienced orgasm. Erotic sexuality rather than intercourse was her "orgasmic voice." As the GES model emphasizes, there are a myriad of approaches to experiencing sexual satisfaction and pleasure outside of vaginal intercourse (Metz & McCarthy, 2012). Instead of being judgmental or disappointed, Conrad was enthusiastic about Sylvia's orgasmic pattern. He very much wanted to be her erotic ally, and accepted that her sexual preferences were different from his. Conrad adopted her non-demand pleasuring preferences, and dropped the traditional foreplay scenario. Rather than shun the variability of sex, they accepted that it was an integral part of their couple sexual style.

Sylvia continued taking Addyi daily. She felt free to have a glass of wine before a sexual encounter to reduce self-consciousness and enhance sexual anticipation. Sexuality now had a positive role of energizing their couple bond with Sylvia feeling desire and desirability. It was difficult, if not impossible, to determine whether enhanced sexual desire was a result of psychological changes (especially Sylvia's new sexual voice), the biophysiological impact of the medication, or their new complementary couple sexual style, which emphasized both partners valuing intimacy and eroticism (McCarthy & McCarthy, 2009).

At the termination of formal couple sex therapy, Sylvia and Conrad designed an individualized relapse prevention program that included six-month follow-up sessions for two years. This ensured they would maintain treatment gains and set a new goal for the next six months to enhance desire/pleasure/eroticism/satisfaction. If there were a problem or regression, Sylvia agreed to call for a "booster session." They had come too far to allow a relapse. Sylvia was especially proud that they were now a positive sexual model for their children.

A comprehensive, integrated approach to FSIAD

No treatment will work for all women, but for the majority, the couple psychobiosocial approach to assessment, treatment, and relapse prevention offers genuine hope to treating FSIAD. There is a great need, empirically and clinically, for careful exploration of the integrative approach and its components to provide women and couples with viable treatment strategies for this common problem. Desire has more impact on the couple than any other sexual component (Leiblum, 2010).

It is crucial to guard against the medicalization of female sexuality, based on drug-company marketing and overpromising. With the uncertainty of Addyi's efficacy, it should only be used as part of a comprehensive treatment plan and not as a stand-alone intervention. This approach is likely to subvert female desire and cause women to feel sexually helpless and hopeless.

The struggle between traditional marital therapists who advocate for increased communication, intimacy, and attachment as compared to sex therapists who advocate for eroticism, sexual vitality, and role enactment arousal is not in the best interest of the field nor its subjects. The new mantra of desire/pleasure/eroticism/satisfaction with the goal of a satisfying, secure, and sexual relationship is a better fit for the majority of women and couples (Metz et al., 2017). The clinician asks the couple, "Are each of you committed to a satisfying, secure, and sexual relationship?" The therapist should not assume; rather, clarify the values and goals of the woman, partner, and couple, remembering that their values and goals are more important than the clinician's. In establishing a therapeutic contract, the clinician ensures it is genuine, not based on "social desirability" or coercion by the partner. Sexual desire is promoted by anticipation, feeling deserving, freedom, and choice. Desire is subverted by performance anxiety, anger, coercion, manipulation, and entirely predictable intercourse (Meana, 2010).

Therapy strives to increase desire so that sexuality plays a 15%–20% positive role in the woman and couple's lives, rather than negatively impacting the relationship. The therapeutic model used in this case study incorporated elements of the female–male equity model, helping Sylvia to better understand and take control of her sexual voice, helped by Conrad serving as her intimate and erotic ally. As previously mentioned, sexual

satisfaction is grounded in the GES model, which recognizes the variability of couple sexuality rather than demanding perfect individual sex performance (Metz & McCarthy, 2012). This sort of flexibility in erotic encounters was important for Sylvia and Conrad, teaching them that sex is more than just intercourse. This approach increased the desire, strengthened their erotic partnership, and expanded the definition of sexuality.

A comprehensive couple approach, featuring psychological and medication interventions, is effective in the treatment of FSIAD. An individualized relapse prevention program is crucial to ensure gains are maintained. This psychobiosocial approach encourages the couple to value and remain engaged in their sexual relationship.

Disclosure statement

No potential conflict of interest was reported by the authors.

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Candace A. Koman is a doctoral student int he Clinical Psychology program at American University, where she also received her master's degree. As a member of the Anxiety Disorders Research Lab, Candace studies race-based mental health disparities and the psychological impact of colorism.

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