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Sexual Disorders in Women: Causes and their Correction

Trastornos Sexuales en la Mujer: Causas y su Corrección

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SUMMARY

Introduction: *Difficulties caused by sexual disorders can lead to psychological problems in women associated with feelings of loneliness, shame, alienation, conflicts, and physical and psychological violence, therefore this issue needs detailed consideration. This research was conducted since sexual health is an integral part of a woman's life and inextricably affects psychological well-being, a sense of happiness, and quality of life.* **Objectives:** *The research aimed to identify the prerequisites for the occurrence of sexual disorders and to select methods for effective psychocorrection.* **Methods:** *Several research methods were used in the work, such as dialectical, interpretive, synthesis and analysis, and questionnaire. The causes of sexual dysfunctions in women were analyzed, the relationship with psychological, physiological, and interpersonal factors was described, and the diagnostic criteria of certain types of disorders and their prevalence were given. The consequences of sexual disorders on the general psychological state of women and their relationships with partners are emphasized. An empirical study was conducted among women with sexual disorders of different age categories to determine the relationship between their psychological state mechanisms, strategies for coping with stressful situations, and the development of sexual dysfunctions.* **Results:** *The results showed that women with sexual disorders have pronounced psychological protection mechanisms such as compensation and substitution, and as a strategy for overcoming difficulties, they mainly choose distancing. This indicates the occurrence of sexual dysfunctions, mainly due to the inability to deal with stressful situations and avoid their resolution. Based on the obtained data, the main elements, and stages of psychological correction of disorders were determined. The practical significance of the research lies in the development of effective criteria for the diagnosis and successful treatment of sexual dysfunctions in women.*

Keywords: *Sexual life, psychocorrection, sexual dysfunction, preventive care, women's health, FSD.*

RESUMEN

Introducción: *Las dificultades provocadas por los trastornos sexuales pueden derivar en problemas psicológicos en las mujeres asociados a sentimientos de soledad, vergüenza, alienación, conflictos y violencia física y psicológica, por lo que este tema necesita una consideración detallada. Se realiza esta investigación ya que la salud sexual es una parte integral de la vida de una mujer y afecta inextricablemente el bienestar psicológico, la sensación de felicidad y la calidad de vida.* **Objetivos:** *La investigación tuvo como objetivo identificar los requisitos previos para la aparición de trastornos sexuales y seleccionar métodos para una psicocorrección eficaz.* **Métodos:**

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Se utilizaron varios métodos de investigación, como el dialéctico, el interpretativo, el de síntesis y análisis y el cuestionario. Se analizaron las causas de las disfunciones sexuales en la mujer, se describió la relación con factores psicológicos, fisiológicos e interpersonales y se dieron los criterios diagnósticos de determinados tipos de trastornos y su prevalencia. Se destacan las consecuencias de los trastornos sexuales sobre el estado psicológico general de la mujer y sus relaciones con la pareja. Se realizó un estudio empírico entre mujeres con trastornos sexuales de diferentes categorías de edad para determinar la relación entre los mecanismos de su estado psicológico, las estrategias para afrontar situaciones estresantes y el desarrollo de disfunciones sexuales. **Resultados:** *Los resultados mostraron que las mujeres con trastornos sexuales tienen pronunciados mecanismos de protección psicológica como la compensación y la sustitución, y como estrategia para superar las dificultades eligen principalmente el distanciamiento. Esto indica la aparición de disfunciones sexuales, principalmente por la incapacidad de afrontar situaciones estresantes y evitar su resolución. A partir de los datos obtenidos se determinaron los principales elementos y etapas de la corrección psicológica de los trastornos. La importancia práctica de la investigación radica en el desarrollo de criterios eficaces para el diagnóstico y tratamiento exitoso de las disfunciones sexuales en las mujeres.*

Palabras clave: *Vida sexual, psicocorrección, disfunción sexual, cuidados preventivos, salud de la mujer, DSF.*

INTRODUCTION

Sexual desire is defined as an urge to engage in sexual activity or an interest in a partner. It can be dyadic, that is, there is an interest in actions with another person, or solitary (1). Sexual disorders in women are a common form of pathology and are a serious public health problem, as they occur in about 41.5 % of premenopausal women (2). Sexual function is an important part of life, so it has a direct impact on a woman's well-being. Sexual dysfunctions are a heterogeneous group of disorders, the characteristic features of which are significant impairment of a woman's ability to feel sexual pleasure or to respond sexually. Sexual reactions have a biological basis, so they interact with intrapersonal, interpersonal, and cultural aspects of life and sexual disorders are formed because of somatic and mental factors. Female sexuality is a combination of sexual function, sexual identity, and sexual relations. It is formed throughout life under the influence of several factors: interpersonal communication, age characteristics, sexual and reproductive health, and social factors. A complex of emotional, somatic, social, and intellectual aspects forms sexual health, which affects the enrichment of the personality, the development of sociability, and general psycho-emotional well-being.

World Health Organization (WHO) distinguishes the following components of sexual health: general well-being; security, respect, and freedom from violence and discrimination, respect for human rights; relevance of sexual health throughout life, not only during the reproductive period; a variety of forms of sexual self-expression and sexuality (3). Sexual health depends on the availability of reliable information about sex, risks and consequences, access to services related to sexual health, and living in a supportive environment. According to the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders (4), there are the following types of sexual disorders in women: sexual interest disorder (arousal), orgasm disorder, and genital-pelvic pain disorder (penetration). The formation of sexuality is a complex process in psychosexual and somatosexual directions, which begins in the embryonic period of ontogenesis and ends with puberty. Since the birth of a child, his psychosexual development is influenced by psychological factors, such as sexual orientation, gender-role behavior, sexual self-awareness, as well as social norms of behavior, school, family, children's and youth groups, and mass media. Gross deformations can occur when the early stages of psychosexual development are disturbed (5).

Several modern researchers have studied the issue of female sexual dysfunction and its impact on the general well-being of women. Falyova (6) analyzed approaches to the study of sexual disorders and their impact on psychosomatic health, emphasizing the need for preventive measures, psycho-correction of emotional states such as anxiety, stress, and depression, correction of attitudes about sex, as they increase the likelihood of developing psychosomatic diseases. Kocharyan (7) identified

a number of psychoemotional factors that are the cause of hypoactive sex drive in women, and also compared data on hyposexual behavior in different ethnic regions and found that East Asian women have lower sex drive compared to women of Canadian origin. Gerasimenko (8) studied the impact of post-traumatic stress disorder (PTSD) on the sexual sphere of the personality it was determined that 95.4 % of women with PTSD have an insufficient level of sexual communication, which was the result of a constellation of pathopsychological and negative socio-psychological factors. In their research, Grigorenko et al. (9) studied sexual dysfunctions in women of different ages, where also analysed the classification of female sexual dysfunction (FSD) and the causes of its occurrence, as well as emphasized the importance of taking an interdisciplinary approach when evaluating and treating sexual dysfunctions in women. It was stated that a collaborative effort between multiple specialties is necessary to make accurate diagnoses and choose personalized, targeted treatments for each woman. Kowalewska et al. (10) conducted an online-based survey, aimed at examining the correlates of compulsive sexual behaviors (CSB) with sociodemographic and sexual history characteristics in Polish women. The obtained results showed that excessive pornography use was the strongest predictor of CSB symptoms, and divorced or separated women and those who were single exhibited higher CSB symptom severity in contrast to their married or informally involved counterparts. A study conducted by Efrati et al. (11) showed that young women with substance use disorders displayed higher levels of compulsive sexual behavior disorder symptoms and engaged in more risky sexual behaviors compared to women without substance use disorders. The compulsive sexual behaviors explain the relationship between substance use and risky sex in these women. All the addictive behaviors were associated with a history of childhood emotional abuse.

Contemporary research on FSD takes a comprehensive view, considering biological, psychological, and sociocultural factors. Studies explore the role of neurobiology, psychological elements such as body image and mental health, relationship dynamics, cultural impacts, and varied treatment strategies. Inclusivity, technology-based interventions, and the enduring effects of FSD on women's holistic wellness are focal points, revealing a nuanced and progressive comprehension of this intricate matter. However, discrepancies exist in the classification of FSD, with variations in definitions and diagnostic criteria. Moreover, cultural differences and societal norms lead to divergent perspectives on what constitutes normal sexual function, adding to the contradictions within this multifaceted field.

While many studies have examined different facets of sexual dysfunction in women, there is still a need for research that comprehensively explores how women's psychological factors, sexual attitudes, and emotional states all interact together to impact the development and worsening of sexual disorders. Developing tailored psychotherapy approaches that address these diverse interacting influences is also needed.

This study aimed to determine the factors causing sexual disorders and to identify methods for their correction. Several tasks were performed: approaches to the study of sexual problems on women's psychosomatic health were analyzed; the importance of the study of sexual dysfunctions was emphasized; the relationship between attitudes towards sex and the current psycho-emotional state was established; determined intrapsychological factors that influence the occurrence of sexual disorders; methods of psychocorrection of female sexual dysfunction were given.

MATERIALS AND METHODS

To achieve the goals of the research several methods were used, which made it possible to analyze the problems of sexual disorders in women, in particular of a psychological nature, as well as to identify methods for the prevention and correction of sexual dysfunctions. Through synthesis and analysis, scientific and theoretical concepts were studied, which revealed the essence of female sexual dysfunction and its development, types, and nature of manifestation, causes of occurrence, and concepts of treatment. The theoretical data obtained during the research provided the basis for further study of the problems and factors of the occurrence of female sexual

disorders. 40 women aged 18-45, who had sexual disorders, took part in the study by questionnaire. The participants filled out questionnaires through Google Forms, using only initials to denote themselves to preserve anonymity. Before the questionnaire, the participants were informed about the objectives of the study and gave their consent to data processing. The average time to fill out the questionnaire was 30 minutes.

Since sexual dysfunctions often arise due to depression and psycho-emotional factors, the first method for the study was the questionnaire "Index of lifestyles" by Plutchik–Kellerman (12) to identify the dominant mechanisms of mental protection in women, study the hierarchy of the psychological protection system and assess the overall intensity of all mechanisms. The methodology was developed based on the generated characteristics of 16 self-defense mechanisms, which over time were revised and reduced to 8 main mechanisms, namely: displacement, denial, substitution, projection, compensation, reactive formation, regression, and rationalization. At the same time, compensation and rationalization stand out as the most constructive forms of protection, and projection and displacement – as the most destructive. Currently, a version of 92 statements is used, to which it is necessary to answer "Yes" or "No" depending on whether the respondent agrees with them.

In the study, it was also important to determine the behavior of women, their ability, and ways of getting out of crisis situations, one of which is problems of a sexual nature, to rationally select methods for correcting sexual dysfunctions that arose because of psychological problems. For this, the questionnaire "Coping Strategies" by Lazarus and Folkman (13), is designed to identify coping mechanisms and methods of overcoming difficulties in a number of areas of mental activity. The questionnaire consists of 50 statements that must be rated from 0 to 3 depending on how much the respondent agrees with them. The methodology makes it possible to identify behavioral strategies that a person prefers in difficult life situations, among which the following are defined: confrontational coping, self-control, distancing, acceptance of responsibility, search for social support, escape avoidance, positive reappraisal, and problem-solving planning.

The dialectical method made it possible to reveal the relationship between the development of sexual dysfunction and the methods of mental protection that dominate the interviewed women, as well as their ability and methods to overcome stressful situations. The interpretive method helped to combine the received data and data from previous studies to determine the most effective factors contributing to the process of prevention and correction of female sexual dysfunctions.

RESULTS

Female sexual dysfunctions (FSD) are a single diagnosis that denotes the number of sexual disorders in women, which include disorders of desire, disorders of arousal, disorders of achieving orgasm, and the presence of sexual pain. A broad classification of female sexual disorders includes disorders of both physiological and psychological direction (9). These encompass various sexual disorders, such as decreased interest and desire within relationships, aversion to sexual activity, reduced cognitive and genital arousal, unwanted spontaneous genital arousal, female orgasmic issues, and painful intercourse conditions. A separate type of sexual disorder also includes compulsive sexual behavior (CSB), which is currently under-researched in women compared to men (10). It is excessive use of pornographic content, impulsive participation in risky sexual relationships, and uncontrolled use of paid sexual services.

There are different origins of female sexual disorders. One of them is psychogenic factors, which are manifested more often in women due to increased vulnerability, emotionality, and sensitivity, and therefore are more pathogenic than in men, and cause inhibition of sexual manifestations or become a priority in intermediate states. There can be different reasons and conditions for the occurrence of sexual pathology in women: FSD can appear as an independent disease with somatic well-being, not related to a disease of the body; may be the result of external causes and constitutional factors; may be the result of a disease of the body. There is also a narrower term for sexual disorders – hypoactive sex drive disorder (HSDD), which

refers specifically to elements of desire, interest in sex, or libido (14).

Currently, there is no single approach to determining the psychological causes of FSD, but a number of researchers have studied this issue. Based on work with patients, Kocharyan (7) identified factors for women, including negative partner influences (husband's unemployment or dominance), dissatisfaction with partner's appearance, outside romantic interests, loss of sexual allure due to dependency, unmet sexual needs, sexual reproaches, and conflicts with in-laws.

According to the Diagnostic and Statistical Manual of Mental Disorders (4), female sexual disorders can arise from various factors including a partner's health or sexual problems, a woman's history of trauma or negative body image, mismatched libidos, or poor communication within a relationship, and cultural or religious views about sexuality.

Friedmann and Cwikel (1) argued that psychosocial factors that can provoke hyposexual disorders include difficulties in communication, destructive previous or current relationships, deficiencies in sexual education, and sexual misinformation. Negative and emotional factors are also distinguished, which include distracting thoughts about appearance, memories of previous unsuccessful attempts at intimacy, and anxiety about sexual activity. Since the emotional and interpersonal component of emotional closeness is more important for women than for men, the above factors hinder their sexual arousal and satisfaction. For women, sexual response is more important in psycho-emotional terms than in physical terms, in particular, because of the need for a relationship with a partner. Therefore, for them, sexual games, and signs of attention from a partner play an important role as stimuli in arousal, which, as a result, strengthens the feeling of unity and responsibility in the relationship. Women's sex drive depends on the emotions associated with sexual relations, so they are more likely to be satisfied if they have a close relationship with their partner.

The opposite of reduced sex drive is hypersexuality in women, which has only recently begun to receive due attention and discussion. According to studies (10), only 31 % of women seek help for hypersexual behavior. The strongest predictor among symptoms of hypersexuality was problematic viewing of pornography. This problem was observed more among single women, divorced, and those who live apart from their partner than among those who are married or in informal relationships. The severity of hypersexual behavior directly depends on the number of sexual contacts but does not depend on the age of the first sexual relationship. From the above, it can be concluded that the aetiology of FSD includes many factors, such as psychological, interpersonal, psychological, and sociocultural.

When investigating the causes of sexual disorders and choosing rational methods of treatment, it is important to study the general psychological state of women. Since FSDs are inextricably linked to psychological factors, particularly those related to stress and depression (15), it was decided to study the mechanisms of psychological protection in women. The study was conducted among 40 women with diagnosed sexual behavior disorders aged 18-45. For this, the "Index of lifestyles" method by Plutchika–Kellerman (12) was used (Figure 1).

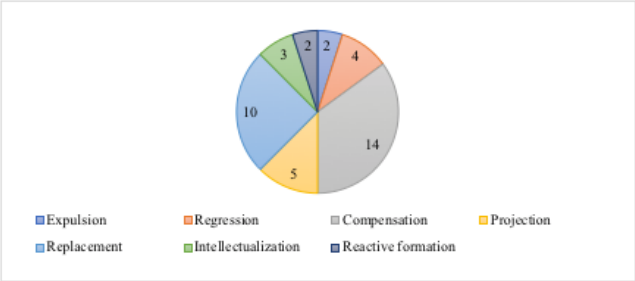

Figure 1. The results of the "Index of lifestyles" method by Plutchika –Kellerman (12).

As can be seen from the results, compensation, and substitution are dominant mechanisms of psychological protection in most women, and regression and projection are used to a lesser extent. Compensation manifests itself in finding a replacement for a real or unreal defect, hiding the shortcomings of an intolerable feeling with other qualities through fantasies, and "putting on" the characteristics, behavior, and values of another person. Compensation can act as a form of protection against the feeling of inferiority, which is typical for women with sexual disorders that arise because of dissatisfaction with their external qualities. Substitution manifests itself in the release of oppression, most often through anger, which is directed at people or objects that are less dangerous or more accessible than those that cause negative feelings.

In this way, women can use the sexual energy that they cannot release in their sexual life in useful affairs, and hobbies. Although this does not save them from the problem of FSD, but only allows them to divert attention from it. Violation of sexual function for a woman's personality has a negative character, as it increases the feeling of inferiority and can lead to a violation of interpersonal relations with a partner. What methods women choose to overcome difficulties in their lives can also show strategies for further therapy of sexual dysfunctions. This led to the implementation of the "Coping strategy" by Lazarus and Folkman (13), a technique to determine which coping mechanisms women with FSD prefer.

As can be seen from the results, the prevailing strategies in women are equally distancing, acceptance of responsibility, and planning to solve the problem (Figure 2). Thus, considering the results of both methods, it is possible to confirm once again that a large part of women with sexual dysfunctions, when aware of the problem, have the desire to switch to another type of activity, which can only deepen the problem if ignored. However, a significant part is still ready to take responsibility and look for ways to solve it.

A Pearson correlation analysis showed a 0.2 coefficient between coping strategies and defense mechanisms, indicating unconscious influences of defenses on behavior, reasoning, and situation acceptance. For example, compensation and substitution as protection combined with distancing as a coping method explain the prevailing desire of women to avoid the issue of sexual problems, which in the future may lead to worse consequences for their psycho-emotional state. Therefore, psychotherapeutic measures occupy a special place in the system of treatment of various forms of sexual pathologies in women, and they should have a systematic therapeutic effect.

Given women's emotional sensitivity and vulnerability, treating FSD should involve principles like addressing their personality, active participation, cooperation with professionals, holistic life focus, combining biological and psychological approaches, shifting self-perception, and following a sequenced treatment process. In the therapy of sexual disorders, the key task is to normalize emotional reactions, eliminate functional disorders, and increase endurance in relation to the mental effects of stressful situations on a woman's life. Rational therapy should consider both the physical features of the body and the personality itself with its individual characteristics, as they affect a woman's ability to focus on therapy, to be

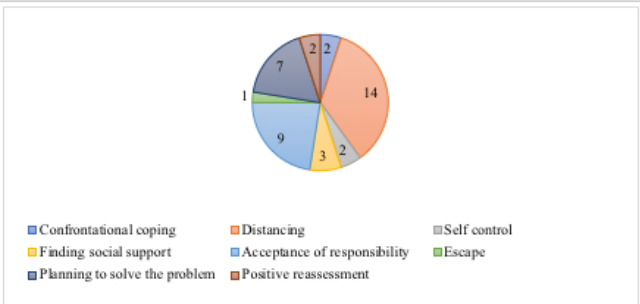

Figure 2. Results of the "Coping strategy" by Lazarus and Folkman (13) technique.

influenced by it. Therefore, it is important to identify the causes of suffering and to study the influence of unconscious and conscious mental reactions on them.

There are a number of methods of therapeutic interventions in the treatment of FSD (5):

- Drug therapy, which is effective in cases where disorders arise on an organic basis.
- Physiotherapy, which is used to treat disorders of an organic and functional nature.
- Training methods that are particularly effective for the treatment of sexual disorders of the functional type and when working with couples (relaxation training, the program of Masters and Johnson, systematic desensitization, emotional training, aversion treatment);
- Hypnotherapy and autogenic training.
- Psychotherapy, which sometimes becomes the only form of treatment for FSD or plays the most significant role in a systemic approach (non-hypnotic suggestive psychotherapy, meditation methods, rational psychotherapy methods).
- Partner and group psychotherapy.

A separate method is the use of cognitive behavioral therapy (CBT), which can be effective both under the supervision of a psychotherapist and when working independently (16). CBT can be delivered in an individual, group, or couples format, with the involvement of all participants being an important prerequisite for successful treatment. Behavioral, cognitive, and emotional aspects are the main components of cognitive-behavioral therapy. Negative thoughts about sexual intimacy increase anxiety, negatively affect a woman's psychological and emotional state and lead to avoidance and tension, which provokes even more negative thoughts, as if in a closed circle.

Therapy aimed at cognition should include a reinterpretation, psychoeducation, cognitive restructuring, validation of taking responsibility for one's pleasure, non-evaluative awareness, and distancing from thoughts. For the development of emotional perception, and management of anxieties that may arise as a cause or consequence of sexual disorders, important components are relaxation training and stress reduction methods. Step-by-step exposure and communication skills training are effective for correcting behavioral aspects. Psychotherapy for FSD will be effective if it consists of the main mandatory steps: formation of healthy psychological attitudes through psychotherapeutic conversations, elimination of neurotic reactions caused by the personal reaction of women with disorders to their own sexual inferiority; and restoration of sexual function. Thus, the effective treatment of women's sexual disorders is inextricably linked to the psychological aspects of their personality and must consider the general psycho-emotional state of a woman when selecting therapy methods.

DISCUSSION

Sexual disorders in women can have both a psychological and a physiological nature, as well as be complex. It is important to have clear diagnostic criteria by which to determine the presence of dysfunctions in sexual health in a case. The causes of psychological or interpersonal dysfunctions are low self-esteem and negative body image, inaccurate or unrealistic sexual desires, false expectations, unrealistic standards and assumptions, partner monitoring and self-monitoring, inadequate skills and knowledge for emotional and physical relaxation, lack of deep sexual knowledge, insufficient skills for self-pleasure, experience of violence and abuse, mistrust, and alienation of a partner.

Inadequate strategies for managing life stress can be identified as a separate reason. As the results of "Coping Strategies" by Lazarus and Folkman (13) showed, most women in their lives choose strategies related to distancing themselves from problems. This applies not only to sexual dysfunctions, but also to other stressful situations that arise in life: conflicts, mistrust, alienation, weak communication skills, and previous relationship experience. It is especially critical when it concerns the relationship with the partner and directly affects the sexual relationship with him. According to the biopsychological model of understanding the sexual response of a person, which was presented by Rosen and Barsky (17), it combines many aetiological

factors: interpersonal, such as the quality of past and present relationships, psychological, which includes anxiety and depression, physiological and biological, related to physical health, neurobiology, endocrine functions, sociocultural factors that depend on upbringing, cultural norms, and expectations. Combined, all of this affects a woman's sexual response.

The circular model by Basson (18) shows that emotional closeness and relationship satisfaction are important components of sexual relationships in women, and the need for closeness is an integral motive for accepting sexual stimuli. Orgasm is not necessarily the goal of sexual intercourse for women, but rather the emotional satisfaction of feeling close and connected with a partner. Several reasons encourage women to have sex: physical pleasure, the desire to please a partner and express their affection for him, to raise their self-esteem, to feel wanted, and to distract themselves from negative thoughts. As for the latter, this echoes the results of the "Index of Lifestyles" method by Plutchik–Kellerman (12), according to which women tend to use the compensation mechanism for psychological protection. In many cases, sex for them acts to "block" stressful life situations or anxiety. In the case when sexual relations themselves become the cause of anxiety and depression, women compensate or replace them with other types of activities, often ignoring the existence of a problem and not paying much attention to it. This complicates the diagnosis of sexual disorders and their subsequent treatment, which has a negative impact on the general psycho-emotional state of women.

The reason for this negative phenomenon can be the taboo of the subject of sex and its concealment from society until recently, since for many centuries it was perceived only as a means of procreation, while other types of sexual stimulation were considered sinful, and in some places became a reason for imprisonment (19). Nowadays, the view of sex and sexuality has changed, although in some cultures it is still a matter of shame. This is demonstrated in the study of scientists from Bahrain, Alselaiti et al. (20), who studied the extent to which the male-oriented Arab culture affects the quality of Arab women's sexual lives, the prevalence of sexual dysfunctions among them, and the frequency of seeking medical attention with this problem. Thus, it was determined that 43 % of the 360 surveyed women had problems with sexual contact. In particular, 37 % of women with disorders noted difficulties with sexual desire. The reasons for the high level of FSD were the polygamous relationships of men, the lack of gender equality, and the directly proportional dependence of the number of detected disorders on the age of women. The worst thing is that 96 % of women did not ask doctors about sexual difficulties, and 87 % did not dare to discuss their problems with doctors. This again confirms the results obtained during the study cited in the article that numerous modern women still prefer to distance themselves from the problem of FSD in case of their occurrence. However, the frequency of manifestation of certain mechanisms of psychological protection and strategies for overcoming stressful situations also depends on aspects of the cultural environment in which women are located (21,22).

A study of sexual dysfunction among middle-aged and elderly Chinese women by Zhu et al. (23), confirmed the relationship between the increasing age of women and the risk of developing sexual disorders. In particular, 58 % of women had certain sexual difficulties related to both physical factors (dyspareunia, dysphoria, other diseases of the body not related to sexual function) and the presence of sexual dysfunction of the partner, due to which 39 % of the surveyed women completely stopped sex life (24). Lammerink et al. (25) also noted the decrease in sexual desire with age, they studied the sexual functioning of Dutch women. According to their results, one in four women between the ages of 20 and 80 had some problems in their sex lives, but despite a decline in sexual activity and functioning with age, sexual satisfaction showed a slight decline.

The presence of other diseases of the body and drug therapy also have a significant impact on FSD. Camara et al. (26) investigated the risk of sexual dysfunction in HIV-infected women from Conakry. They found the connection of disorders not only with the adoption of antiretroviral therapy, but also with other factors, such as the absence of marriage, and the age of 35 years and older, which were associated with hormonal changes in the aging process. The work also noted the importance of sensitizing doctors

and people supervising HIV-infected women to assess possible sexual disorders in their patients during routine consultations and as part of HIV treatment programs.

The issue of compulsive sexual behavior disorder was raised by Efrati et al. (11), who studied this question among women who were dependent on the use of psychoactive substances and who had experienced early psychological trauma. It has been determined that chemical dependencies are often combined with other mental disorders and addictive behaviors, one of the main types of which is compulsive sexual behavior disorder. This was because the precursors of this disorder and addictions have the same nature of occurrence. And the main ones are children's injuries, and the accumulation of negative life events over time. This once again confirms the need for psychological therapy and correction, firstly, of women's depressive and anxious states to overcome various manifestations of female sexual disorders (27,28).

As emphasized by McCool-Myers et al. (29), in treatment and correctional work with women with sexual dysfunctions, health workers should be aware of risk factors for women of reproductive age, and prevention strategies should have an impact on factors such as physical activity, access to sex education, empowerment of women regardless of age and cultural background. Among the significant risk factors for the appearance of FSD, poor physical and psychological health, stress, traumatic operations on the genitals, dissatisfaction with relationships, religiosity, and violence were highlighted. At the same time, among the factors that could have a preventive effect, physical exercises, established intimate communication, sexual education, and older age at marriage were emphasized (30).

Female sexual dysfunction has a strong impact on women's reproductive and sexual lives, where social, psychological, and biological factors play a role (31). The conducted research and analysis of the works of other scientists showed the interdependence of the psycho-emotional state of women and the development of sexual disorders, as well as the influence of psychological protection mechanisms and strategies for overcoming stress on the effectiveness of corrective and therapeutic therapy.

CONCLUSIONS

Sexual health is an integral complex of interacting elements of sexuality: biological, psychological, social, and socio-psychological, which ensure adequate sexual behavior and relationships, sexual harmony, and adaptation to a partner. The reasons for the development of sexual disorders in women can be different. Among the main ones, psychogenic factors that negatively affect sexual manifestations can be distinguished, and in women who are more emotional, sensitive, and vulnerable, they take on more threatening forms. Although there is currently no single approach to determining the psychological causes of FSD, some researchers have singled out the following: partner factors related to the partner's health and sexuality; individual vulnerability; negative attitude towards one's own body and appearance in general; stress, psychological exhaustion and burnout; strained relations with a partner, sexual disharmony in activities and desires; violation of interpersonal communication; cultural and religious factors; early trauma and trauma related to violence. Women's sexual desire depends on emotions, so the important role for them is not so much physical pleasure from sexual intercourse as the feeling of closeness with their partner, which they seek to get through sexual games and signs of attention from their partner.

The aetiology of FSD includes many factors, such as psychological, physical, interpersonal, psychological, and sociocultural. The study described in the article demonstrated that women with sexual disorders tend to use compensation and substitution as a psychological defense mechanism, and distancing as a coping strategy. This makes it difficult to diagnose and treat the problem, as women still often avoid it. Psychotherapeutic measures in the treatment of sexual disorders in women should be aimed at correcting personal reactions when pathology is detected and preventing the emergence of an inferiority complex, considering the individual and general emotional characteristics of each woman. At the same time, it is important to observe the principles of phasing, consistency, and ethics. Correction should consist of three important steps: formation of healthy psychological attitudes,

elimination of neurotic reactions, restoration, and activation of sexual functions. The sample of this research only included women aged 18-45 with diagnosed sexual disorders, which are a specific subset of the female population. The findings may not apply to women outside this age range or women without sexual disorders. However, the exploration of coping mechanisms and defense mechanisms employed by women with sexual disorders offers insights into how these strategies influence their responses and common emotional states. The article's integration of diverse therapeutic approaches like drug therapy, physiotherapy, cognitive-behavioral therapy (CBT), and psychotherapy underscores the complexity of addressing FSD and offers a more holistic view of potential treatment ways, that can be applied to the larger number of the female population. Further research with larger, more diverse samples would be needed to determine if the patterns observed here generalize robustly to the overall female population. This article expanded the knowledge of women's sexual psychology. It provided a foundation for future research and clinical practice in this area, guiding the development of more effective strategies for addressing the complex challenges faced by women with sexual disorders.

REFERENCES

1. Friedmann E, Cwikel J. Women and men's perspectives on the factors related to women's dyadic sexual desire, and on the treatment of hypoactive sexual desire disorder. J Clin Med. 2021;10(22):5321.
2. McCool ME, Zuelke A, Theurich MA, Knuettel H, Ricci C, Apfelbacher C. Prevalence of female sexual dysfunction among premenopausal women: A systematic review and meta-analysis of observational studies. Sexual Med Rev. 2016;4(3):197-212.
3. Sexual health. 2023. https://cutt.ly/q7B1gEj.
4. American Psychiatric Association. Diagnostic and Statistical Manual of Mental Disorders. Washington: American Psychiatric Publishing, 2013.
5. Dronova VL, Kornienko SM. Clinical-anamnestic features and quality of life in women with endometrial pathology on the background of uterine myoma. Med Perspektivi. 2017;22(1):81-88.
6. Falyova OE. The relationship between attitudes towards sex and the current psycho-emotional state of women with different family status. Med Psychol. 2015;4(40):10-14.
7. Kocharyan G. Hypoactive sexual desire due to physiological conditions, influences of social and psychological factors, disregard for sexual needs of a woman. Health of Man. 2022;3:56-65.
8. Gerasimenko LO. Motivational aspects of sexual behavior in women with post-traumatic stress disorders. Herald Prob Biol Med. 2014;2(4):107-111.
9. Grigorenko VM, Romashchenko OV, Melnikov SM, Bilogolovka VV, Myronenko NO, Dzuraeva LS. Sexual dysfunctions in women of different ages. Men's Health, Gender and Psychosomatic Medicine. 2023;1-2(14-15):68-75.
10. Kowalewska E, Gola M, Lew-Starowicz M, Kraus SW. Predictors of compulsive sexual behavior among treatment-seeking women. Sexual Med. 2022;10(4):100525.
11. Efrati Y, Goldman K, Levin K, Rosca P. Early-life trauma, negative and positive life events, compulsive sexual behavior disorder and risky sexual action tendencies among young women with substance use disorder. Addictive Behaviors. 2022;133:107379.
12. Plutchik R, Kellerman H, Conte HR. A structural theory of ego defenses and emotions. New York: Plenum; 1979.
13. Lazarus R, Folkman S. Stress, appraisal, and coping. New York: Springer Publishing Co.; 1984.
14. Pyke RE. Decisions on measures of hypoactive sexual desire disorder in women: A history, with grounds to consider clinical judgment. Sexual Med Rev. 2021;9(2):186-193.
15. Alidost F, Pakzad R, Dolatian M, Abdi F. Sexual dysfunction among women of reproductive age: A systematic review and meta-analysis. Internat J Reprod BioMed (IJRM). 2021;19(5):421-432.
16. Stephenson KR, Zippan N, Brotto LA. Feasibility of a cognitive behavioral online intervention for women with Sexual Interest/Arousal Disorder. Clin Psychol. 2021;77(9):1877-1893.
17. Rosen RC, Barsky JL. Normal sexual response in women. Obstet Gynecol Clin North Am. 2006;33(4):515-526.
18. Basson R. The female sexual response: A different model. J Sex Marital Therapy. 2020;26(1):51-65.
19. Poslavska OV, Shponka IS, Babiy HS. The diagnostic value of the p16ink marker for verification of tumors of unknown primary site in women with isolated lesion of inguinal lymph nodes. Med Perspektivi. 2019;24(2):13-19.
20. Alselaiti M, Saleh MA, Muhammed H, Attallah E, Dayoub N. Prevalence of female sexual dysfunction and barriers to seeking primary health care treatment

in an Arab male-centered regime. Open Access Macedonian J Med Scienc. 2022;10(E):493-497.

21. Chorna VV, Makhniuk VM, Khliestova SS, Gumeniuk NI, Chaika HV. Attitude of health care workers in the field of mental health to their health. Med Perspektivi. 2021;26(2):188-196.
22. Orupabo CD, Odoya CG. Anthropometric variables in breast lesions of women of reproductive age in University of Port Harcourt Teaching Hospital. Internat J Med Medical Res. 2023;8(2):18-23.
23. Zhu Y, Yang X, Fan X, Sun Y, Tan C, Wang Y, et al. Decreased sexual desire among middle-aged and old women in China and factors influencing it: A questionnaire-based study. Evidence-Based Complemen Alternat Med. 2021;1:6649242.
24. Astakhov VM, Batsylyeva OV, Puz IV, Shudrikova NV. Features of the organization of medical and psychological assistance in the situation of perinatal losses (literature review). Med Perspektivi. 2022;27(3):44-50.
25. Lammerink EAG, de Bock GH, Pascal A, van Beek AP, van den Bergh ACM, Sattler MGA, et al. A survey of female sexual functioning in the general Dutch population. J Sexual Med. 2017;14(7):937-949.
26. Camara A, Tounkara TM, Delamou A, Baldé R, Leno NN, Kuotu GC, et al. Prevalence and risk factors of female sexual dysfunction among women infected with HIV in Conakry. Clin Epidemiol Global Health. 2021;12:100828.
27. Beniuk VO, Ginzburg VG, Vygivska LM, Maidannyk IV, Chorna OO, Oleshko VF, et al. Assessment of correction effectiveness of psychoemotional state in pregnant women after application of assisted reproductive technologies. Med Perspektivi. 2021;26(4):131-138.
28. Kulyk II, Khmil SV. Endometriosis-associated infertility: the role of hormones and its correction. Internat J Med Medical Res. 2021;6(2):5-10.
29. McCool-Myers M, Theurich M, Zuelke A, Knuettel H, Apfelbacher C. Predictors of female sexual dysfunction: A systematic review and qualitative analysis through gender inequality paradigms. BMC Women's Health. 2018;18:108.
30. Heryak SM, Humenna IY. Instrumental and diagnostic criteria of hemodynamic disorders and endothelial dysfunction correction in pregnant with arterial hypertension. Internat J Med Medical Res. 2015;1(1):30-34.
31. Slyva AF, Selskyy PR, Kuziv OY, Slyva VV. The state of cellular immunity in pre- and menopausal women with hyperplastic endometrial processes. J Med Biol Res. 2020;2:29-36.