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Why does passion wane? A qualitative study of Hypoactive Sexual Desire Disorder in married women

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WHY DOES PASSION WANE? A QUALITATIVE STUDY
OF HYPOACTIVE SEXUAL DESIRE DISORDER
IN MARRIED WOMEN

by

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Bachelor of Arts
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1994

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A dissertation submitted in partial fulfillment
of the requirements for the

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Department of Psychology
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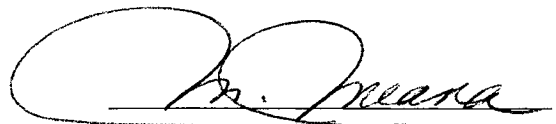
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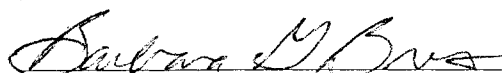
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ABSTRACT

Why Does Passion Wane? A Qualitative Study of Hypoactive Sexual Desire Disorder in Married Women

by

Karen E. Sims

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Hypoactive Sexual Desire Disorder (HSDD) is a prevalent and disabling condition for women and their partners. With one in three women experiencing a significant lack of interest in sexual activity, it is the most common female sexual dysfunction. It is also the most treatment resistant. Despite increased awareness of the problem, we have seen an increase in cases of low sexual desire over the past two decades. There is currently no standard treatment modality recommended for HSDD because of difficulties (1) defining the vague concept and (2) establishing what is “normal.” Recently, clinicians have favored a treatment relational approach because of the importance of interpersonal influences for women. Yet, treatment outcomes have not improved and HSDD remains poorly understood.

Using semi-structured interviews, participants were asked what causal attributions they make and barriers they perceive to their loss of sexual desire. Grounded theory methodology was utilized to identify emergent themes and build a comprehensive theory about loss of desire. Three core themes emerged from the data which appeared to

represent dragging forces on sexual desire. They are (1) *institutionalization* of relationships, (2) *over-familiarity* with one's partner, and (3) the *de-sexualization of roles* within these relationships. Based on these core themes, a model of female sexual desire is presented. It is a model of dilemmas, or paradoxes, that women appear to experience related to sex. On one hand, women work toward and value marriage and the meanings associated with it, such as security and family. Ironically, however, their sexual needs are in direct competition with its very ideals. The extent to which couples navigate these dilemmas may be a determinant in successful treatment for HSDD.

Until now, anger, communication problems and other relationship influences have been stressed in the literature as reasons for loss of desire and the focus of clinical interventions. However, our data suggest that reasons that married women lose desire may have more to do with factors such as physical attraction, lack of sexual novelty, and role incompatibility than relationship factors. Clinical implications are discussed and possibilities for future research explored.

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CHAPTER 1

INTRODUCTION

Hypoactive Sexual Desire Disorder (HSDD), defined as a persistent lack of desire for sexual activity, is a prevalent and disabling problem affecting women (of all ages) and their partners in the United States and other countries (Graziottin, 2007; Trudel et al., 2001). A complex and multidimensional problem, HSDD interacts with the affective, cognitive, and behavioral areas of a woman's functioning and may have a major impact on the quality of her life (Ullery, Millner & Willingham, 2002). At times, the unfortunate result is dissolution of marriage. Not surprisingly, many women experience low sexual desire as physically disconcerting, emotionally distressing, and interpersonally very disruptive (Basson et al., 2001).

Data from the recent National Health and Social Life Survey indicate that a third of women experience a significant lack of interest in sexual activity, making it the most common of the female sexual dysfunctions (Laumann, Paik & Rosen, 1999). Desire was first acknowledged in 1977 to be an important part of the human sexual response cycle, and lack of desire has received significant attention in the literature as perhaps the most treatment resistant sexual dysfunction (e.g., Kaplan, 1979; Levine, 1984; LoPiccolo, 1980; Regas & Sprenkle, 1984; Rosen & Leiblum, 1987; Schover & LoPiccolo, 1982; Schreiner-Engel & Schiavi, 1986). It is also the one that most adversely affects the

treatment of other sexual dysfunctions, making the problem even more far-reaching. Despite this awareness (or perhaps because of it), we have seen an increase in cases of low sexual desire over time (LoPiccolo & Friedman, 1988; Rosen & Leiblum, 1987; Schover & LoPiccolo, 1982). HSDD remains one of the most poorly understood sexual problems with an alarming paucity of both etiologic and treatment outcome studies. In fact, there is currently no standard treatment modality recommended for HSDD, in large part due to difficulties operationalizing and accurately measuring the concept of desire (Beck, 1995; Friedman & Hogan, 1985; Letourneau & O'Donohue, 1993; Rosen & Leiblum, 1987; Trudel, 1991). Because of these and other methodological difficulties, research on sexual desire is sparse (Beck, 1995; Letourneau & O'Donohue, 1993; Regev, Zeiss & Schmidt, 2006; Rosen & Leiblum, 1987; Trudel, 1991). The literature that is available abounds with frustrated clinicians and researchers alike offering treatment strategies from which we can only infer potential etiological theories for the disorder.

With the introduction of desire phase problems in 1977 by Drs. Helen Kaplan and Harold Leif, treatment focused on the individual (woman) and was aimed at alleviating intrapsychic conflict, reflecting deep-rooted psychoanalytic tendencies in the field at that time. Quickly, however, behavioral and cognitive behavioral treatment strategies replaced psychodynamic approaches, as it became increasingly apparent that desire difficulties were likely multicausal. The couple and not just the individual became the focus of treatment (Friedman & Hogan, 1985; McCarthy, 1984). By the 1990's most clinicians and researchers were in agreement that HSDD is a multidimensional problem best considered within the physical, emotional, interpersonal, and other circumstances of the individual (Beck, 1995; Hurlbert, 1993; O'Carroll, 1991; Trudel, 1991). Not surprisingly,

many called for a more systemic approach to the study of sexual desire disorders (e.g., Beck, 1991; O'Carroll, 1991; Trudel, 1991). More recently, a specific call has been made to address the *etiology* of sexual desire disorders in the hope that treatment can be more individualized and guided by specific reasons for the disorder (Basson et al., 2001).

Understandably perhaps, we are still not that much farther along now in our knowledge about female sexual desire than we were in 1977. After all, it is a primarily subjective experience fraught with complexities that make it difficult to study. Self-reports raise the perennial questions of validity and reliability. Objective measures of arousal as indicators of desire are also problematic as there is a low correlation between subjective and physiological measures of women's arousal (Meston, 2000). In addition, we currently do not know the extent to which subjective desire and/or physiological arousal actually influence behavior or whether they do so differentially.

Out of an ever-growing wish to better understand female sexual desire problems, researchers have been proposing and testing new approaches. Some have brought qualitative methodologies to bear upon the question of what sexual desire means to both men and women. Results indicate interesting gender differences in causal attributions for desire (Regan, 1999; Regan & Berscheid, 1995; Regan & Berscheid, 1996). For example, in one study, Regan and Berscheid (1996) asked men and women about the causal antecedents of sexual desire and found that female sexual desire was reported to be dependent upon interpersonal and romantic environmental factors, whereas male sexual desire was perceived as more influenced by intrapersonal and erotic environmental factors. Similarly, Baumeister's (1999) review of the literature on erotic plasticity suggests that, in terms of sexuality, female desire is affected to a great extent by external

factors and is fairly malleable, unlike that of men. He articulately summarizes the results of many studies on the topic as indicating that, sexually, women are creatures of meaning while men are creatures of nature. In other words, women's sexuality appears to be more contextually driven while that of men seems more easily tracked by physiology. More recently, Basson (2001c) has suggested that our very definition of female sexual desire is flawed in its reliance on male models of desire and arousal. She advocates restricting the definition of HSDD to reflect the idea that many women in long-term, monogamous relationships remain *receptive* and interested in sexual advances, despite not having *spontaneous* desire. Each of these ideas has specific implications for the conceptualization and treatment of HSDD and reflects continued efforts to explain the elusive phenomenon of female sexual desire.

Understandably, the urgency of addressing the distress of women with HSDD has resulted in the formulation of treatments in the absence of empirical support for causal pathways. In addition, the current rush to pharmacotherapy for sexual problems has neglected potential psychosocial etiologies that may, in fact, be more relevant for problematic desire in women, particularly in light of empirical support for the importance of meaning and context to women's sexuality (Baumeister, 1999; Heiman, 2002). In an attempt to return to essential questions regarding female sexual desire, the current study asked married women who self-identified as having acquired HSDD within the context of their current marriage about their attributions for their loss or reduction in desire. Using grounded theory methodology, the current study constructed a theory of HSDD as it emerged from the data that accounts for the complexity of the problem while condensing it to its major components. The theory of the psychosocial conditions of desire and,

consequently of HSDD, that emerged now offers a theoretical basis for future quantitative, empirical studies. The systematic investigation of women's own explanations for loss of sexual desire was preceded by a critical review of the available literature on psychological etiologies for Hypoactive Sexual Desire Disorder. To this end, a literature search was conducted using the Psycinfo Abstract from the earliest date to September, 2007. Keywords utilized in this search were Hypoactive Sexual Desire, Inhibited Sexual Desire, and low sexual desire. For the purposes of this study, only articles pertaining to psychological etiologies or treatments were reviewed, including both empirical and data-less theoretical pieces. HSDD may be best conceptualized as a biopsychosocial problem; however, the focus of this study is on the psychosocial correlates and not the biological aspects of the syndrome. By gaining insight directly from women about their perceived etiology of their individual experience of HSDD, a coherent theory emerged, the result of which facilitates ongoing research about the determinants of desire and the development of effective treatment protocols for those who have either never known sexual desire or lost it.

CHAPTER 2

REVIEW OF RELATED LITERATURE

Characteristics of Hypoactive Sexual Desire Disorder

Harold Lief, who in 1977 first classified low sexual desire as a dysfunction, coined the phrase Inhibited Sexual Desire (ISD) to refer to the failure to initiate or respond to sexual cues. At that time, he and other clinicians were becoming increasingly aware of the importance of “readiness” for sexual activity, noting that without such readiness sexual arousal was unlikely to occur (Lief, 1977). At about the same time Helen Kaplan (1977), in a landmark article, recognized that disorders of sexual desire had been neglected in the literature despite being highly prevalent and extremely distressful to patients and their partners. In fact, it was she who introduced the triphasic model of sexual response, consisting of desire, excitement, and orgasm wherein desire is described as an appetite that resides in the brain, excitement as the result of vasodilation of the blood vessels in the genitals, and orgasm as the sensation associated with the involuntary contraction of certain genital muscles. Previously, the literature had emphasized the excitement and orgasm phases (Masters & Johnson, 1970), and Kaplan aptly noted that even she had not mentioned desire phase problems in her own prior writings of sexuality. It was not until it became apparent that sexual desire problems were contributing

significantly to failures of conventional sex therapy techniques that clinicians developed an active interest in the phenomenon (Kaplan, 1977).

Inhibited Sexual Desire (ISD) was first introduced into the psychiatric nomenclature as a formal disorder in 1980, with the publication of the Diagnostic and Statistical Manual of Mental Disorders-III (DSM-III). In a subsequent version, in 1987, ISD was renamed Hypoactive Sexual Desire Disorder (HSDD) (Beck, 1995; Segraves & Segraves, 1991). The most recent version of the manual, the DSM-IV-TR (American Psychiatric Association, 2000), defines HSDD as: a) persistently or recurrently deficient (or absent) sexual fantasies and desire for sexual activity. The judgment of deficiency or absence is made by the clinician, taking into account factors that affect sexual functioning, such as a) age and the context of the person's life; b) the disturbance causes marked distress or interpersonal difficulty, and; c) the sexual dysfunction is not better accounted for by another Axis I disorder (except another sexual dysfunction) and is not due exclusively to the direct physiological effects of a substance (e.g. a drug of abuse, a medication). Beyond these criteria, the clinical presentation of HSDD is quite variable. For example, the disorder may be *lifelong* (developed at the onset of sexual functioning) or *acquired* (developed after a period of normal sexual functioning); *generalized* (not limited to certain types of stimulation, situations, or partners) or *situational* (limited to certain types of stimulation, situations, or partners); and judged to be due to psychological factors or a combination of psychological and physiological factors. To illustrate, low sexual desire may be global and encompass all forms of sexual activity or may be situational and limited to only one sexual partner or one sexual activity. In the latter, an individual may have no desire for intercourse but may masturbate frequently. Or an individual may have

no desire at all for his/her own spouse but feel a great deal of desire for one or more other partners (American Psychiatric Association, 2000).

As a general rule, frequency of sexual activity in those experiencing HSDD is low, as they report little motivation to seek out sexual stimuli. HSDD is also commonly associated with other sexual dysfunctions, such as arousal and orgasm disorders.

Although some individuals retain the capacity for sexual excitement and orgasm in response to sexual stimulation, others do not, even though they may reluctantly engage in sexual activity to appease their partner or for other reasons, such as a desire for intimacy. In these cases, lack of desire can be either the primary or secondary dysfunction. That is, low sexual desire can pre-date the inability to become aroused or orgasmic *or* low desire can be the consequence of one's expectation that he/she will not become aroused or achieve orgasm if they engage in sexual activity (American Psychiatric Association, 2000). This distinction has important treatment implications and requires clinical judgment. In fact, the diagnosis of HSDD, in general, relies to a great extent upon the clinician's judgment because of a lack of appropriate age and gender based normative data (Letourneau & O'Donohue, 1993). Furthermore, clinicians must assess desire levels in *both* partners to determine whether there is simply a discrepancy (rather than a disorder) between two individuals with desire levels within the normal range but at different ends of the continuum (American Psychiatric Association, 2000).

Most frequently, HSDD develops in adulthood, following a period of adequate sexual interest. In some cases of lifelong HSDD, however, it develops as early as puberty (American Psychiatric Association, 2000). Longstanding HSDD is characterized by a consistent absence of sexual thoughts/fantasies, a history of infrequent masturbation, few

sexual experiences with a limited number of sexual partners, and little or no pleasure during the few experiences that were shared (Rosen & Leiblum, 1987). Onset of HSDD may be insidious or acute. When onset is insidious, biological problems may be implicated. In contrast, when its onset is acute and develops in adulthood, it is frequently correlated with psychological distress, stressful life circumstances, or interpersonal difficulties. Not surprisingly, then, Depressive Disorders are also significantly correlated with HSDD (American Psychiatric Association, 2000; Rosen & Leiblum, 1987). Again, clinical judgment is critical in determining whether the depressive symptoms preceded and may be contributing to the low desire or whether depression is a consequence of HSDD. Particularly when HSDD has been longstanding, individuals frequently report a history of relationship problems and marital dissatisfaction. Overall, acute onset HSDD associated with a precipitating event (i.e. loss of a job, death of a family member) indicates a more favorable prognosis (American Psychiatric Association, 2000).

As the diagnostic criteria indicate, it is essential that HSDD, especially with an acute onset, be distinguished from sexual dysfunctions caused by a general medical condition or medication side effects. Sexual functioning can be disrupted by a host of medical explanations that can be ruled out with a thorough medical examination. It is also important to recognize that most people experience fluctuations in libido over time that are not persistent and do not cause interpersonal distress. These fluctuations are normal and do not constitute HSDD (American Psychiatric Association, 2000).

Prevalence estimates suggest that low desire rises to the level of clinical significance in 15% to 20% of the population (Beck, 1995; O'Carroll, 1991; Segraves & Segraves, 1991; Segraves & Woodard, 2006). Many studies have shown HSDD to be more

common in women than men (i.e., Baumeister et al., 2001; Laumann, Paik & Rosen, 1999; LoPiccolo, 1980; Segraves & Segraves, 1991). In fact, research has shown that persistent low desire is the primary complaint of 51% to 65% of all women seeking help for sexual problems (Beck, 1995; O'Carroll, 1991; Segraves & Segraves, 1991). Furthermore, epidemiological data from the National Health and Social Life Survey indicate that a third of women report a lack of interest in sexual activity, making it the most common of the female sexual dysfunctions (Laumann, Paik & Rosen, 1999). These prevalence rates have driven some researchers to speculate that we may be pathologizing what could be normative levels of desire in women (Basson, 2001c, 2002b; Goldmeier, 2001). Furthermore, over time HSDD is increasingly coming to the attention of mental health professionals, which may also explain the rise in prevalence rates (LoPiccolo & Friedman, 1988). Unfortunately, formal prevalence studies are complicated by a number of methodological difficulties inherent to the study of desire (Beck, 1995; O'Carroll, 1991; Rosen & Leiblum, 1987).

An obvious problem studying and defining low sexual desire is its subjective nature. The concept of desire is vague and general. The terms "low," "hypoactive," and "inhibited," for example, mean very little without normative data to indicate what is *normal* versus *abnormal* or *functional* versus *dysfunctional*. To suggest that there is too much or too little of anything necessitates a standard of comparison, and we currently lack standards for sexual desire. Nor are they likely forthcoming. Therefore, the diagnosis of HSDD relies heavily on the clinician's subjective judgment (Beck, 1995; Letourneau & O'Donohue, 1993; Trudel, 1991). There exist few instruments to aid in reliably assessing the various dimensions of sexual desire problems.

The Female Sexual Functioning Index, a measure of global sexual functioning, has been validated on an HSDD population (Meston, 2003; FSFI, Rosen et al., 2000).

Although internal consistency of the FSFI is in the acceptable range for other domains (arousal, lubrication, orgasm, satisfaction, pain), the desire composite was not, which suggests it may not be a reliable indicator of sexual desire. Moreover, the FSFI is a self-report instrument which carries with it added concerns of validity and reliability, as previously noted.

The Index of Sexual Desire (HISD; Apt & , 1992) and the Sexual Desire Inventory (SDI; Spector, Carey & Steinberg, 1996) are two other scales that have been developed to assess clinical symptoms of HSDD. The psychometric properties of these scales have been reported to be good, however these scales are also self-administered and vulnerable to subjective interpretation. Also, because they are designed to be symptom focused, they do not capture other, equally important aspects of desire. More recently, the Sexual Interest and Desire Inventory-Female (SIDI-F), a clinician administered scale, has been designed to address some of the reliability and validity concerns associated with self-report tools. Furthermore, the SIDI-F offers clinicians a means to quantify the severity of women's symptoms. This is important because it may be helpful in measuring treatment outcome gains. This 13-item scale has also demonstrated good reliability and validity (Clayton et al., 2007).

The Derogatis Sexual Functioning Inventory (DSFI; Derogatis & Melisaratos, 1979) is another assessment device that has shown promise and addresses the issue of sexual desire. Unfortunately, it measures desire based on frequency of sexual behavior.

Although ambiguous definitions and criteria have led many researchers to operationalize

the diagnosis of HSDD based on the frequency of sexual activity or sexual fantasies (e.g., Segraves & Segraves, 1991), frequency is *not* a sufficient indicator of desire for several reasons. Both men and women report engaging in sexual behavior when they are not experiencing desire, for reasons such as wanting to please one's partner or as a means to enhance intimacy (Beck, 1991). Behavior may be a particularly faulty operationalization of desire for women as they, unlike men, do not even need to be physiologically aroused to engage in sexual intercourse. Furthermore, it has been widely recognized that a variety of psychological and other factors influence frequency of sexual behavior, such as marital discord (LoPiccolo & Friedman, 1988; Trudel, 1991).

Recognizing the diagnostic and definitional difficulties associated with sexual desire, some authors advocate using a "discrepancy model" as the diagnostic criterion in cases in which sexual desire is causing distress in a relationship (Zilbergeld & Ellison, 1980). According to the "discrepancy model," a desire problem is best understood as a relationship problem, like any other, in which there is a discrepancy between two people's styles or interests. Zilbergeld and Ellison (1980) also note that researchers often fail to distinguish between sexual desire and sexual arousal (a physiological response), using the terms interchangeably and contaminating discussions of sexual desire problems.

Other researchers, including Regan and Berscheid (1999) have commented on the importance of distinguishing sexual *desire* from sexual *arousal*. In fact, it is Regan and Berscheid (1999) who have offered the most widely accepted functional definition of sexual desire currently, which suggests that sexual desire is a subjective, psychological experience that can be understood broadly as an interest in sexual objects or activities, or

as a wish, need, or drive to seek out sexual objects or to engage in sexual activities (presumably pleasurable) that one is not currently engaging in.

Early Proposed Etiologies of Low Sexual Desire

Havelock Ellis, a central figure in the emergence of the modern study of human sexuality, viewed sexuality as a normal part of human function. Unlike his predecessors, he focused on non-pathological sexual phenomena in men and women. For example, he argued that the high incidence of “frigidity” in women during the 19th century was attributable not to a biological deficit but, rather, to the combined result of their partners’ inadequate sexual skills, societal and religious influences, ignorance of sexuality, and inadequate education (Ellis, 1933).

Like Ellis, Sigmund Freud emphasized sex as a normal part of human development. He proposed that libido is the primary motivating force of all human behavior. Within his theory, he conceptualized low sexual desire as a dissociation of the libido, which was the result of excessive defensive inhibition during sexual maturation within the individual. Furthermore, he postulated that low sexual desire would be more likely to occur in women because men possess a greater intensity of innate libido than do women. He also believed that girls tend to be more inhibited and repressed during maturation than boys (Freud, 1938).

In the mid 20th century, the state of affairs began to change when a few courageous individuals began to challenge the unspoken rules that had guided earlier theorizing on human sexuality. Researchers became interested in studying the attitudes and behaviors of the ordinary person. Among them, Alfred Kinsey and his colleagues were the first to

quantify the study of human sexuality. Unlike Freud, Kinsey did not believe that humans possess an innate libido. Rather, he believed that individuals are born with an innate capacity to *respond* to physical or psychologic stimuli and that most aspects of human sexuality are the product of learning and conditioning. However, Kinsey did recognize greater desire in men than in women, which he explained by proposing that men have greater responsiveness to sexual stimuli in the environment, and consequently experience a greater desire for sexual expression. That is, men become aroused by a greater number of things and, therefore, want to behave sexually more often. Furthermore, Kinsey stated that due to biologic, psychologic, and sociologic factors, some individuals are not equipped to respond sexually. Obviously, these individuals would experience little sexual desire (Kinsey, Pomeroy, Martin & Gebhard, 1953).

In the 1950s, William Masters and Virginia Johnson further challenged public opinion when they began studying the physiological responses of men and women as they engaged in sexual behavior in the laboratory. They observed what came to be known as the “human sexual response cycle,” consisting of physiological stages labeled excitement, plateau, orgasm, and resolution. Noticeably absent in the cycle was sexual desire. Although not formally discussed, Masters and Johnson did acknowledge something akin to sexual desire and hypothesized that in cases of orgasm inadequacy, prior negative experiences (psychosocial influences) may interfere with a woman’s ability to respond to sexual stimuli. In other words, they believed that these women were not *permitting* themselves to function sexually. This belief was fundamentally flawed in that not all women experiencing low desire had a history of negative or traumatic experiences. As a result of their inadequate conceptualization, Masters and Johnson

suffered high failure rates for treatment of these cases (LoPiccolo, 1980; Masters & Johnson, 1970; Regan & Berscheid, 1999).

It was the recognition of such treatment failures that prompted Helen Kaplan to eventually revisit the issue of sexual response in 1977 and ultimately propose the triphasic model of sexual response: desire, excitement, and orgasm (Kaplan, 1977). The initial desire phase was a very different way of conceptualizing sexual response. Kaplan's excitement phase encompassed Masters and Johnson's excitement and plateau phases. Only the orgasm phase remained the same.

Psychodynamic Theories

Freud's early conceptualization of sexuality as a developmental process that individuals navigate with varying degrees of success influenced a number of psychodynamic theorists to offer their thoughts on the origins of HSDD. These theorists emphasize intrapsychic conflict as a key etiological factor, specifically focusing on anxiety and early developmental influences, such as what we learn about relationships from our primary caregivers. There are no empirical studies of psychodynamic models of HSDD but several authors have commented on the psychodynamic origins of desire problems based on their own clinical experiences. These psychodynamic theories of HSDD have focused on the role of anxiety, object relations and, more traditionally, fixations at Freudian stages of development.

The first cohesive account of HSDD was Kaplan's (1977) conceptualization of libido as an innately compelling and pervasive force that *inevitably* seeks expression in a sexual or nonsexual outlet. Therefore, the primary goal of sex is to relieve libidinal tension and

return an individual to a state of emotional equilibrium (Beck, 1995; Kaplan, 1979). Sexual dysfunction, according to Kaplan's model, is the result of intrapsychic conflict and, more specifically, anxiety. Numerous subconscious and involuntary variables activate anxiety, including feelings of guilt, performance fears, and fear of intimacy and commitment. The earlier in the sexual response cycle that the dysfunction occurs, the more deep-seated the intrapsychic conflict/anxiety is. In cases of inhibited desire, then, the conflict is very deep since it occurs very early in the cycle. According to Kaplan, this explains poor treatment outcome in these cases (Kaplan, 1977, 1979). In addition to anxiety, she suggests that anger and depression play a role in the development and maintenance of HSDD because in varying intensities, they (much like anxiety) can act as 'turn off' mechanisms, suppressing sexual desire (Beck, 1995). She hypothesizes that, in some cases, there may be diminished activation of brain "centers and circuits" that control sexual functioning. In other instances, depression and subsequent loss of desire can be the result of an individual's reaction to a particular life circumstance or event. The prognosis for these cases is more optimistic than in cases of chronic depression and long-standing, intrapsychic conflicts/anxiety (Kaplan, 1977; Rosen & Leiblum, 1987).

A striking feature of this theory is its emphasis on the individual and intrapsychic determinants of desire and relative neglect of other influences, such as cognitive and relational factors. Problems of desire are seen as residing exclusively within the individual rather than within a marital dyad or family system. This focus on the individual is consistent with classical psychoanalytic theories of conflict but it is difficult to accept considering its dismissal of the necessarily relational aspect of sex.

More recently, Bernard Apfelbaum (1988) proposed an ego-analytic model of sexual desire problems. Like Kaplan, he believes that anxiety plays a central role in HSDD but suggests that many women experience anxiety not about performing but about not feeling aroused, which he refers to as “response anxiety”. This, he suggests, is the basis for most (if not all) cases of inhibited desire. Within Apfelbaum’s model, problems of sexual desire are seen in the context of an over-riding societal expectation that one *should* be sexually desirous and responsive. Ironically, he states, our enthusiasm for sexual expressiveness during the 1960s and 1970s created oppression rather than liberation for some women. He acknowledges that women were provided sexual freedom, but only to say “yes.” The insistence that individuals experience sex as pleasurable and positive has become a psychological burden in some cases. To admit otherwise is socially unacceptable and results in feelings of inadequacy and humiliation.

According to Apfelbaum, sexual apathy is actually a withdrawal from negative reactions created by the societal expectation to respond sexually, a belief exacerbated by the idea that sexual urges are biological and should, therefore, be automatic. This idea is reflected in the maxims ‘sex is beautiful,’ ‘sex is natural,’ and ‘sex is communication.’ To the extent that the idea of sex as automatic is validated, a woman’s ability to say “no” is equally *invalidated*, as evidenced in the notion of frigidity. In fact, women are more inclined to plead the proverbial headache or to lie passively during sex rather than assert their right to say “no” directly (Apfelbaum, 1988).

In Apfelbaum’s theory we again see this psychoanalytic tendency to reduce etiology to one factor- the pressure on women to say yes. Although this may well have some influence, it is not intuitively the most obvious center of a problem as potentially

complex as HSDD. Again, there is almost no consideration of other interpersonal and intrapersonal influences on inhibited sexual desire. The supposed pressure of having to agree to sex might more likely result in anger than anxiety and at least one study has shown that anger rather than anxiety may be the primary mechanism inhibiting desire (Bozman, 1992).

Taking an object relations perspective, Scharff (1988) suggests that early family experiences with caregivers influence sexual desire. Children begin with undifferentiated egos, into which all experiences with primary caregivers are internalized. Problems occur when the child perceives the object(s) of his/her desire (parents) as rejecting or hostile. In this case, the child must repress his/her emotions to defend against experiencing the pain of rejection (Letourneau & O'Donohue, 1993; Scharff, 1988). This, according to Scharff, is at the root of sexual desire problems. As adults, we decode and approach our world, including sexuality, as a function of our past relationships and experiences (Scharff, 1988). In other words, our internal representations, good and bad, subconsciously shape the way we feel and behave (Beck, 1995). Therefore, unhealthy attachments to one or both parents may result in a woman experiencing decreased sexual desire as a means of defending against her subconscious expectation that her spouse will be rejecting of her.

Also taking an objects relations approach to HSDD, Kernberg (1988) and Talmadge and Talmadge (1986) suggest that sexual dysfunction results from an inability to master developmental stages in relationships. Kernberg proposes that inhibition of desire stems from an individual not having passed successfully through one of the necessary stages of sexual development. He believes that HSDD may appear as a symptom of a personality

disorder in which there is severe inability to establish effective relationships, social isolation, and little, if any, sexual involvement. A milder level of pathology may affect individuals who *have* achieved a normal integration of object relations along with the corresponding capacities to fall and remain in love but who have done so the cost of sexual inhibitions. Specifically, Kernberg's clinical experience leads him to theorize that neurotic, hysterical, and obsessive-compulsive personality disorders are highly correlated with inhibited sexual desire.

In contrast, the clinical impressions of Talmadge and Talmadge (1986) point to a *couple's* inability to successfully negotiate stages in their relationship as the cause of HSDD. They suggest that, in our Western culture, marriage is the ultimate attempt to address the need for closeness (intimacy) between two people. However, intimacy is difficult to achieve in marriages because it requires both a sense of personal identity and the capacity for dependence, attributes which are frequently at odds within an individual. Also, our culture emphasizes that our dependence should be confined only to our spouse and children (our nuclear family) and not our extended family. Therefore, we depend to a great extent on our nuclear family to meet all of our human needs and, not surprisingly, we disappoint one another. At the beginning of relationships this is typically not a problem because we regress to an infantile fantasy and see our partner as an "omnipresent, ever-available caretaker." However, once the honeymoon period is over and we are faced with the reality of our partner, we become disillusioned. At this point many couples divorce, while others negotiate this difficult stage successfully and develop an even deeper connection based on a shared reality. Intimacy is enhanced and sexual desire preserved. On the other hand, couples who continue to idealize and suppress all

negative feelings about one another maintain the appearance of a smooth façade but do so at the expense of intimacy and, ultimately, sexual desire. Talmadge and Talmadge (1986) suggest that couples experiencing HSDD have an exaggerated version of this situation and frequently present saying “Everything is fine in the marriage except sex. We never fight. She/he just doesn’t like sex.”

Even today, classic analytic approaches to HSDD are alive and well in psychotherapy. Elise (2000) addressed the question of why women may not want to want and suggested that as infants, girls experience pain and rejection because they cannot have the one thing they want - their mother. They internalize the rejection and are resentful that they received the “wrong” genitalia which are all hidden away unlike men’s organs which are erect and “out there.” A woman’s power is thus to hide herself to prevent castration. In addition, Elise claims that fully recognizing and expressing one’s desire as a woman is threatening to the balance of power in our society and thus not encouraged. Therein lies the secret of HSDD, some combination of genital self-loathing and societal prohibitions (Elise, 2000). As recently as 2006, Firestone, Firestone & Catlett characterized declining sexual desire as unconscious sexual withholding, which stems from a need to defend against genuine closeness and sexual intimacy. Factors that predispose women toward the development of self-denying and sexual withholding are having parents who withheld in relation to her needs as a child, fears of competing because of covert or overt sibling rivalry within the family of origin, and having parents who were themselves unable to express appropriate affection to one another or their children. Essentially, according to these authors, a woman’s childhood experiences with

her caregivers predispose her to engage in a pattern of sexual withholding in order to defend against potential disappointment and to deny herself pleasure.

Overall, the depth aspect of psychoanalytic theories has some appeal and would explain the resistance of HSDD to treatment. However, there are absolutely no empirical studies to support these models, in part because the constructs within them are very difficult to operationalize and study. Also, these models are based on theories that are entirely unsubstantiated. There is, for example, no compelling evidence whatsoever 1) that women with HSDD experience greater levels of intrapsychic conflict; (2) that children are sexually desirous of their parents or; (3) that young girls are resentful that they don't have a penis. Despite the depth of these models, they are overly monolithic and don't offer explanations for inconsistencies

Systems Theories

Many authors believe that HSDD is best conceptualized as a relational problem, wherein low desire is the result of an imbalance within the dyad (Bagarozzi, 1987; Clement, 2002; Gehring, 2003; Hurlbert, Apt, Hurlbert & Paul-Pierce, 2000; Lief, 1988; MacPhee, Johnson & Van DerVeer, 1995; Pietsch, 2001; Regas & Sprenkle, 1984; Schwartz, 2001; Schwartz & Masters, 1998; Stone Fish, Busby & Killian, 1994; Verhulst & Heiman, 1988). In fact, some argue that the failure of HSDD, historically, to respond to treatment has stemmed from inadequate conceptualization of the problem and neglect of the dyadic relationship (Stone Fish, Busby & Killian, 1994; Talmadge & Talmadge, 1986). After all, relationships are at the very core of our existence and sex occurs in the context of our relationships. Despite the fact that most of the current psychological

treatments for HSDD are focused on the couple rather than the individual, many still conceptualize the problem in terms of individual factors, to the neglect of relational influences (Beck, 1995). Lief (1988) points out that even if HSDD stems from other (biologic, intrapsychic) causes, the resulting marital conflict exacerbates and maintains the situation. The Master's & Johnson model of desire problems argues (albeit without empirical support) that sexual desire is a natural function that occurs in non-conflicted and loving relationships in the absence of other roadblocks. Therefore, sexual desire and behavior mirrors the relationship outside of the bedroom (Schwartz & Masters, 1998). In this sense, low sexual desire is seen as a symptom of a larger relationship problem.

Unfortunately, few empirical studies of etiology or treatment effectiveness of HSDD exist to either disconfirm or lend support to the systemic approach of HSDD. In fact, only three empirical studies of the systems approach, one controlled and two uncontrolled, have been conducted to date. Many clinicians, though, have contributed their thoughts on the origins of HSDD by way of recommending treatment strategies for the problem. Across the existing empirical studies *and* data-less theories, several themes emerge from the literature. A number of authors posit that unresolved marital and relational conflict is the primary cause of HSDD (Bagarozzi, 1987; Hurlbert, Apt, Hurlbert & Pierce, 2000; MacPhee, Johnson & Van Der Veer, 1995; Regas & Sprenkle, 1984; Stone-Fish, Busby & Killian, 1994; Verhulst & Heiman, 1988). Some think that HSDD represents a certain homeostatic balance or imbalance within the dyad (Regas & Sprenkle, 1984; Verhulst & Heiman, 1988). Still others argue that issues of separation and dependence affect intimacy levels which, in turn, lead to decreased sexual desire (Lobitz & Lobitz, 1996; Schnarch, 2000).

Regas & Sprenkle (1984) are among those believing that relationship discord is at the heart of HSDD. In the hope of improving relationship quality, they applied Functional Family Therapy (FFT) principles to the treatment of HSDD in a small number of couples (Regas & Sprenkle, 1984). FFT is one of the most empirically-validated family therapies and consists of three components: therapy, assessment, and education. Regas and Sprenkle (1984) note that clients with HSDD are often unmotivated to change, especially if they've been coerced into therapy because their spouse is threatening divorce or infidelity. FFT is based on the assumption that HSDD serves some function in a relationship. Take, for example, a woman whose husband arrives home late each evening, doesn't speak to her very much, and spends most of his time at home watching television or engaging in activities without her. During lovemaking, he is selfish and inattentive. In this case, refusing sex offers negative attention for the woman, as her husband demands to know why she is uninterested and spends time trying to get her interested. Within FFT, education is central and strategies include sensate focus, relaxation, learning optimal means of stimulating one's partner, and bibliotherapy. Based upon initial results with this small, unspecified number of couples in this study, the authors claim that FFT shows promise for the treatment of HSDD (Regas & Sprenkle, 1984). However, they fail to delineate sample characteristics or even results.

Bagarozzi (1987) suggests relationship problems occur as a result of a couple's inability to master a series of stages during their premarital relationship. These stages are: (1) perceiving similarities, (2) achieving pair rapport, (3) inducing mutual self-disclosure, (4) role taking, (5) achieving interpersonal role fit, and (6) achieving dyadic crystallization (couple identity formation). Specifically, Bagarozzi (1987) notes a

tendency for couples in which one or the other experiences low sexual desire to have gotten married without resolving one or more of the last three stages. To illustrate, if the fourth stage (role taking) is not resolved and one partner is dissatisfied because there are discrepancies between his or her ideal spouse and actual spouse, that partner may withhold sex as punishment to make his/her spouse more “ideal.” Overall, within this model of HSDD, sex is seen as an integral part of a much larger system of meaning, rules, and justice within a couple’s relationship (Bargarozzi, 1987).

Based on this shared idea that HSDD stems from marital conflict, MacPhee, Johnson and Van Der Veer (1995) conducted the only controlled treatment outcome study, consisting of 49 couples, in which the woman was experiencing low sexual desire. Couples participated in ten sessions of Emotionally Focused Therapy (EFT), which integrates experiential and systemic traditions in psychotherapy. Couples completed a series of measures before and after treatment, yielding only modest results. Although women reported increased desire and decreased depression, other areas of importance (such as frequency of sexual activity) were not significantly changed. The authors suggest that ten sessions may not have been enough to resolve the relational conflict and result in more significant treatment gains.

On the other hand, Stone-Fish, Busby and Killian (1994) conducted an uncontrolled treatment study of HSDD and reportedly obtained significant results utilizing Structural Couple Therapy (SCT), which incorporates techniques such as probing, challenging, and restructuring the interpersonal dynamics within a couple to alleviate the function of HSDD in the relationship (i.e., a power struggle or lack of intimacy). Within this study, 12 couples in which one of the partners complained of low sexual desire (8 women and 4

men) were administered measures before and after 16 treatment sessions. Post-treatment, women experienced either decreased expectations about the pleasantness of sexual activity or actual increased pleasure. Although results from this preliminary study lend support to the systemic conceptualization of HSDD and the effectiveness of SCT for treating HSDD, it is important to keep in mind that this study had a very small N and no control group.

Hurlbert, Apt, Hurlbert and Pierce (2000) propose that because women emphasize relationship characteristics as precursors to sex, sexual compatibility is likely an indicator that the marriage, on the whole, is satisfying. They differentiate sexual *motivation*, the behavioral process by which one approaches or avoids sexual activity, from sexual *desire*, which they define as a cognitive experience. In an uncontrolled treatment study, they asked 54 women with HSDD to complete daily reports of sexual motivation and desire and concluded that women who self-reported as being sexually compatible with their partners experienced more sexual motivation and desire as well as less depression and more fantasy. So, if two people are compatible outside of the bedroom (as measured by self-reported marital satisfaction), they are more likely to be compatible inside the bedroom and, as a result, a woman will be more inclined to initiate and/or be receptive to sex.

Within another systemic model of HSDD, Verhulst & Heiman (1988) propose, based on their experiences treating individuals (clinical impressions), that HSDD is the result of a lack of synchronicity of sexual rhythms between two partners. That is, each individual has a sexual rhythm that reflects the interaction of his/her physiological arousal, emotional desire, and cognitive sexual scripts. To the extent that one or more of these

factors is out of synchrony, an individual may experience an absence of sexual desire. Furthermore, for couples to maintain a sexual rhythm, they must coordinate their individual rhythms along the levels of “symbolic interactions,” “affect-regulated interactions,” and “sensate exchanges” (Verhulst & Heiman, 1988). *Symbolic interactions* refer to one’s views and beliefs about how the world operates, or one’s “map of the world.” Heritage, language, cultural influences, and even personal memories also play a role. *Affect-regulated interactions* consist of that part of the total communication process that is coordinated by emotional states. Upon initial contact between two people, mixed emotional feelings are elicited in each partner based upon implicit and explicit information such as sexual attraction for one another, depth of the relationship, territorial claims, and social rank. Sometimes there will be an “interactional fit” between the emotional states of the individuals and other times there will not. Finally, *sensate exchange* refers to the physiological responses elicited by partners. Low desire may occur when these are not synchronized such as when partners differ in length of time to reach orgasm or when intercourse is not pleasurable for one partner.

Heiman, Epps and Ellis (1995) subsequently commented on the “feedback loops” inherent in this model and warned therapists to remain flexible when dealing with HSDD because of the level of resistance encountered. Resistance may be the result of desire problems playing an adaptive role in a couple’s interpersonal system. For example, LoPiccolo and Friedman (1988) claim from their experience that, whether couples are consciously aware of it or not, HSDD is often maintaining a balance within the dyad. Similarly, Heiman, Epps and Ellis (1995) theorize about the role of HSDD in maintaining levels of power and control. For many women (and men), having sex is equated to

“giving in” to one’s spouse and losing an effective means of power and control (Heiman, Epps & Ellis, 1995; Pietsch, 2001).

Recently, Hurlbert et al. (2005) have suggested that the amount of stress that a woman experiences related to sex, especially in the context of her relationship with her husband, contributes significantly to her adjustment to and management of HSDD. This may be because men tend to be very sensitive to the sexual aspect of their marital relationship and often make personal attributions about their wives’ lack of interest in sex (Morokoff & Gilliland, 1993; MacPhee et al., 1995). Husbands may be indirectly contributing to their wives’ low desire by placing greater sexual stress on them, and therefore, creating greater sexual tensions (Hurlbert et al., 2005).

David Schnarch (2000) and Lobitz and Lobitz (1996) advocate a different approach to conceptualizing and treating low sexual desire. They, too, argue from a systemic perspective but focus on the importance of separation and dependence in relationships. According to Schnarch, a practicing clinician who has written extensively and been well-received by the lay public, differentiation between partners and self-validation enhances intimacy and desire. *Differentiation*, he explains, is the “central drive wheel” in human relationships and involves the ability to distinguish, develop, and balance one’s desire for communication and contact with others along with the need to be unique (Schnarch, 2000). Lack of differentiation is emotional fusion. Although Schnarch suggests there is nothing *wrong* with emotional fusion, he believes it negatively impacts sexual desire by promoting borrowed functioning (enhancing the function of the recipient but suppressing that of the donor). Greater differentiation, on the other hand, allows one to make a profound connection through intimacy and mutuality.

Schnarch discusses what he refers to as first and second generation approaches to desire problems. Different from previously proposed models, his second generation approach focuses on: (1) desire during sex, rather than just initiatory problems, (2) desire for one's partner rather than for sexual behavior, and (3) consciously chosen, freely undertaken desire rather than biological drive or natural function. Sexual desire, he suggests, is the most complex manifestation of sexual motivation among all living things. Also different from other systemic approaches, Schnarch notes that sexual desire is not simply a symptom of problems elsewhere in the relationship but is the process of the relationship itself (Schnarch, 2000). Although Schnarch's novel approach to HSDD has received a lot of media attention in recent years and his ideas are thoughtfully articulated, his concepts, not unlike those in the psychodynamic model, are vague. There is also no empirical data to suggest that they capture the nature of HSDD any better than preceding models.

The clinical experiences of Lobitz and Lobitz (1996) also lead them to believe that separateness and togetherness play a central role in the development of sexual intimacy. Unlike Schnarch, however, they argue that the two are not necessarily dichotomous states nor is one preferable to the other. Rather, they suggest that couples go through an ongoing process that is never fully accomplished. Sexual desire problems can occur at any stage of the process and therapy is successful only when the therapist understands the stage and can facilitate their moving out of that stage and into another.

In conclusion, many experienced clinicians agree that it is important to consider HSDD within the context of the marital dyad. Certainly, this is a step in the right direction and makes good intuitive sense. It is not much of a stretch to imagine that if

there are uncomfortable dynamics in a relationship or unresolved conflicts, one may not feel like having sex. However, some of the concepts presented within the systemic models are confusing (i.e. symbolic interactions, emotional fusion) and the whole idea of relational problems is wide open and could mean just about anything. Working from the assumption that all couples have relationship conflict of some kind, we still don't know what differentiates women who remain desirous from women who do not. Are there certain areas of conflict that are more related to HSDD than others, or are there other mediating variables (i.e., personality, coping style) that affect outcome? Most importantly, perhaps, it remains to be seen whether the empirical data will offer objective support for the systemic approach. At this point, only one controlled treatment study is available and it suggests only modest change when HSDD is treated as a systems problem.

Cognitive Behavioral Theories

Learning theorists have long argued strongly for the importance of external determinants of sexual behavior, emphasizing the role of individual experiences in shaping sexual desire (Beach, 1956). However, it was not until the late 1970's that behavioral and cognitive/behavioral approaches to HSDD became predominant in the field of psychology (Friedman & Hogan, 1988). Though perhaps the most wisely used approach, only 17 articles related either to cognitive behavioral etiology or treatment of HSDD were found in this review. Of these articles, seven were empirical studies, three controlled and four uncontrolled. The other 10 articles were theoretical in nature and aimed primarily at proposing treatment approaches for desire problems. Early on, Beach

(1956) proposed strict behavioral phenomena that he perceived as causing HSDD while Rook and Hammen (1977) argued that cognitive processes are implicated in problems of desire. However, subsequent authors have settled on the hypothesis that it is a *combination* of cognitive and behavioral factors that contribute to HSDD.

From a strictly behavioral point of view, Beach (1956) theorized that unlike other “appetites” (e.g., hunger, thirst), sexual desire is principally dependent upon external stimuli. Therefore, low sexual desire may result from earlier negative experiences, such as an unskilled lover, dissatisfaction, sexual dysfunction or painful intercourse.

Extinction of desire may occur if a spouse becomes less attractive over time or gains a lot of weight (Letourneau & O’Donohue, 1993). Others have suggested that individuals with low sexual desire have learned to associate too few activities or cues with sensuality and/or sexuality (McCarthy, 1984; Rosen & Leiblum, 1988). Rosen and Leiblum (1988) present a script theory account of sexual desire based on their clinical experiences. A script, in general, is a cognitive framework that organizes and directs behavior. Thus, a *sexual* script directs the dimensions of sexual functioning, including what sexual behaviors are acceptable, with whom, under what circumstances, how often, and for what reasons. Applied to desire problems, one of the partners’ sexual scripts is either under or over-inclusive. In other words, he/she is attending to too many or too few cues for sexual activity in comparison to their partner, resulting in a discrepancy between partners (Rosen & Leiblum, 1988).

Based on their understanding of nonsexual areas of human functioning, Rook and Hammen (1977) offer a list of cognitive processes that they believe affect arousal and desire levels. These processes include perception and misperception of internal and

external cues associated with arousal, labeling sensations and stimuli as arousing or erotic, and the effect of expectations on arousal. Applied to low desire, they assert that these individuals: (1) have not learned to accurately perceive their own levels of arousal, (2) have not learned how to facilitate arousal in themselves, (3) use a limited set of cues to define a situation as sexual, (4) use a limited set of cues to define their own sexual arousal, (5) have limited expectations for their own ability to be aroused, and (6) overall, tend not to perceive themselves as very sexual. Some of these processes, they suggest, are conscious and some are not.

More recent discussions within the cognitive framework have focused attention on the interaction between cognitions and behavior as it relates to HSDD. Although these cognitive-behavioral theories are broad-based, perceived etiologies for HSDD can be broken down into intrapersonal and interpersonal influences. Intrapersonal causes of HSDD may include: negative cognitions and anti-sexual attitudes, psychological states (i.e. anxiety, anger), sexual trauma, lack of pleasure or even pain, physiological/hormonal influences, infrequent use of fantasy, fatigue, or stress (e.g. work, financial).

Interpersonal factors may be: sexual skills or performance deficits, restricted sexual repertoire, lack of attraction for one's partner, lack of communication, lack of intimacy, power or control issues, inconsistent or conflicting sexual rhythms between partners, or marital conflict, in general. It is easy to imagine each of these individual factors affecting desire, yet it is the tremendous overlap and interplay between the variables that make adequate understanding and treatment of HSDD so complex. One also gets the impression that self-labeled cognitive-behavioral theories include just about every possible influencing factor conceivable, including ones related to systems theory.

Lazarus (1988) was one of the first to comment on the interactional nature of HSDD. Like Rosen & Leiblum, he views desire disorders as involving a discrepancy between partners. Based on his clinical work, he advocates assessing deficits and strengths by creating a profile of *Behavior, Affect, Sensation, Imagery, Cognition, Interpersonal Relationships*, and *Drugs* (biological variables), or “BASIC I.D.” Within the realm of *Behavior*, skills or performance deficits may be contributing to the desire problem. *Affect* includes feelings of anxiety, depression, guilt, anger, and fears of intimacy. Within *Sensation* there may be pain or absence of pleasure during sexual activity. *Imagery* includes negative or intrusive images and the presence or absence of fantasy. An individual’s ethics, morals, religious beliefs, and sexual attitudes may affect his/her *Cognitions*. Additionally, problems may exist within the *Interpersonal Relationship* such as poor communication, lack of attraction, and power issues, as well as sexual trauma. Finally, *Drugs* represents medication and physiological dysfunction. Each of these factors, Lazarus hypothesized, can affect desire and should be considered (Lazarus, 1988).

Another proponent of the cognitive-behavioral model of HSDD, Leslie LoPiccolo (1980) concludes that a whole host of psychological, physiological, sociological, learning/conditioning, and cognitive factors are implicated in cases of low sexual desire. The complexity of these influences, along with inadequate assessment, contributes to treatment failures. She emphasizes that the etiology of desire problems is broad and each case of low sexual desire unique, requiring a tailored treatment approach (LoPiccolo, 1980).

In an uncontrolled experimental study, Joseph LoPiccolo and Jerry Friedman (1988) studied *desired* frequency versus *actual* frequency of sexual activity among 93 couples. Interestingly, both men and women in the couples (married for an average of 9 years with an average of 2 children) reported desire for engaging in *more* sexual activity than they currently were engaging in. The authors concluded from this that factors other than desire alone play a role in the frequency of sexual behavior. Their multimodal treatment approach infers that a lack of sensuality/intimacy, inadequate intrapersonal insight, negative thought processes, and poor sexual skills are implicated in HSDD (LoPiccolo & Friedman, 1988). This represents an expanded theory regarding the etiology of HSDD that was developed after an earlier uncontrolled behavioral treatment study yielded unimpressive results (Schover & LoPiccolo, 1982). In this earlier study, archival data from a sex therapy center were analyzed to determine the effectiveness of treating desire problems with behavioral sex therapy only. While positive changes were seen post-treatment, they reflected only adequate sexual relationships and less than optimal intimacy and pleasure.

Barry McCarthy shares the philosophy that HSDD is multicausal, multidimensional and, therefore, without easy explanation. His understanding of HSDD includes five stages: anticipation, owning one's sexuality, deserving sexual pleasure, arousal and orgasm dysfunction, and valuing intimate sexuality (McCarthy 1995, 1999b; McCarthy & McCarthy, 2003). Regarding *anticipation*, he claims that desire cannot be willed or forced and is inhibited by routine, lack of communication, and taking for granted that all touching must lead to intercourse. Anticipation is facilitated, however, by making couple time, scheduling sexual dates, making sexual requests of your partner, utilizing turn-ons,

and increasing spontaneity. Individuals must own their own sexuality, including negative experiences in their past, and then choose to facilitate their own sexuality. *Deserving sexual pleasure* refers to feeling good about one's body and is particularly relevant for women. Increasing the *ability for arousal and orgasm* (in those experiencing difficulties) can promote increased desire. In fact, in a study comparing standard cognitive-behavioral techniques for HSDD to cognitive-behavioral techniques plus orgasm consistency training, the latter group reported greater sexual arousal and sexual assertiveness post treatment and at follow up (Hurlbert, 1993). However, McCarthy also recognizes that there are women who are regularly orgasmic when they have sex but still have little desire. Finally, it is important that both partners in a couple *value intimacy*, as McCarthy believes the most rewarding sex integrates both emotional and sexual intimacy.

Traditionally, men have valued sexual intimacy over emotional intimacy whereas women have focused on emotional intimacy. The emotional intimacy component of desire grows in importance for men as they age and their desire becomes less automatic and requires more interactive sex. That means that men become more dependent upon a woman's desire and arousal to elicit their own desire. The best aphrodisiac, after all, is an involved, aroused partner (McCarthy, 1995; McCarthy & McCarthy, 2003). Women, on the other hand, do not as often experience automatic desire; rather, their levels of desire are largely dependent upon emotional and relationship factors. Therefore, anger and disappointment may be major influences in female HSDD. McCarthy also recognizes the importance of maintaining a regular rhythm of sexual activity (McCarthy, 1995; McCarthy & McCarthy, 2003). Contrary to myth, refraining from sexual activity does not make one

“horny;” instead, not maintaining a regular sexual rhythm promotes problems of desire (McCarthy, 1999b).

Additionally, McCarthy proposes that marital styles play a role in sexual functioning. He postulates that, when sex is good in a marriage, it is an integral but not dominant factor (15-20 per cent) in the relationship. When the sexual relationship is not good, however, it becomes a very powerful negative force in the marriage, 50-75 per cent, and drains the relationship of its assets. He describes four major marital styles, each with sexual strengths and vulnerabilities. They are, in order of frequency: (1) complementary, (2) conflict-minimizing, (3) best friend, and (4) emotionally expressive. A couple’s task during the beginning of their relationship is to find a functional style of relating with mutually comfortable levels of intimacy (McCarthy, 1999a; McCarthy & McCarthy, 2003). *Complementary couples* have moderate levels of intimacy and maintain a balance between autonomy and “coupleness,” which promotes sexual desire. However, these couples can fall into routine, mechanical sex that is not given priority. Therefore, quality of sex and passion may be low. *Conflict minimizing couples* are traditional and emphasize stability, family, and religion. Emotional expression, including sexual expression, is minimized and avoided. Sexuality is undervalued and often marginal and mechanical. The couples that most value intimacy are the *best friend couples*, whose relationships are characterized by high acceptance, satisfaction, and security. Sex is a positive, integral, and vital aspect of the relationship and energizes the marital bond. Despite this, these relationships tend not to work well and frequently end in divorce due to unmet expectations, disappointment, anger, and alienation. A frequent trap for best friend couples is to sacrifice autonomy for “coupleness.” Finally, *emotionally expressive*

couples have the highest intensity of feelings, both good and bad. When these marriages are good, they are vibrant, passionate, and fun. Sex is spontaneous, playful, and satisfying. But when these relationships are bad, they are volatile, with risk of physical abuse and high rates of divorce. Sex may be used as a way to “make up” after a fight or abusive incident. Overall, McCarthy believes that it is important to consider a couple’s marital style because each has important implications for sexuality and levels of desire (McCarthy, 1999a; McCarthy & McCarthy, 2003).

McCarthy’s treatment approach for HSDD stems from the idea that it is a multifaceted problem with no standard set of techniques/exercises for all couples. In one experimental study without a control group, he applied four separate cognitive behaviorally oriented exercises (designed to restructure cognitions and increase the range of activities perceived as sexual) as well as bibliotherapy to 20 couples (McCarthy, 1984). One year post-treatment, couples rated change on a scale from 1-10. In 11 of the couples, both partners rated change a 6 or 7; in four additional couples, one of the partners rated change a 6 or 7, two of the partners rated 5, one 4, and one 2. The other couples were either unavailable or rated change as minimal. McCarthy suggests, based on these results, that cognitive-behavioral treatment of desire problems is promising. Later, he commented on the importance of relapse prevention with HSDD couples, warning that couples must not “rest on their laurels” after treatment but take active steps to maintain desire including: contracting about sexual initiation, broadening their sexual repertoire, dealing with nonsexual conflicts outside of the bedroom, arranging “sex dates,” and using creativity and eroticism (McCarthy, 1999b; McCarthy, Ginsburg & Fucito, 2006;).

Gilles Trudel also believes that interplay between interpersonal and intrapersonal factors affects levels of sexual desire (Trudel, 1991; Trudel, Aubin & Matte, 1995; Trudel, Ravart & Aubin, 1996; Trudel, Fortin & Matte, 1997). He and his colleagues considered the sexual repertoire of couples experiencing HSDD, hypothesizing that their sexual behavior would be more limited with a lower degree of pleasure than in couples without HSDD. This hypothesis seems rather obvious and it is no great surprise that a controlled experimental study confirmed their hypotheses. The question remains, as the authors acknowledge, whether couples experience HSDD because they engage in fewer activities and derive less pleasure from them *or* whether they experience HSDD and, therefore, engage in fewer activities and derive less pleasure from them (Trudel, Aubin & Matte, 1996). In another controlled experimental study, women with low desire reported being less satisfied with their partners' communication style than women without HSDD, suggesting that perhaps couples who have difficulty communicating their feelings outside the bedroom have similar trouble communicating their needs, wants, and feelings in the bedroom (Trudel, Fortin & Matte, 1997).

Trudel, Ravart and Aubin (1996) propose that the quality of a couple's relationship is one of the most important causal factors of HSDD and, in fact, a number of studies have pointed to marital dissatisfaction as being correlated with low sexual desire (e.g., Stuart, Hammond & Pett, 1987; Trudel, Boulos & Matte, 1993). They present a cognitive behavioral treatment approach for HSDD which focuses on improving intimacy and enhancing the quality of the marital relationship. In addition to marital dissatisfaction, they believe that absence of sexual fantasy plays a role in HSDD. Rosen and Leiblum (1987) have described fantasy as the "fuel" that drives sexual desire and Nutter and

Condron (1983) found, in one experimental study, that women with desire problems rarely fantasized compared to the other women. Trudel, Ravart and Aubin (1996) also theorize that cognitive distortions (negative self talk, faulty beliefs that reinforce antisexual attitudes), environmental and interpersonal factors (sexual trauma, fatigue, marital conflict work, financial stress), and psychological states (anxiety, depression, anger) all have the potential to interfere with sexual desire.

Based on their understanding of HSDD, Trudel et al., (2001) conducted the first extensive, controlled treatment study of HSDD, wherein treatment was comprised of cognitive, behavioral, marital, and sexual intervention techniques. This study represents one of the rare studies of HSDD utilizing a standardized treatment program, control group, and scientific methodology (Trudel et al., 2001). Participants consisted of 74 couples wherein the woman was experiencing HSDD, diagnosed via the Sexual Health Inventory (SHI; Schover, Friedman, Weiler, Heiman, & Lopiccolo, 1982). Treatment was short-term (12 weekly, two hour sessions) and offered in a group format (four to six couples). A variety of measures were completed before and after treatment and at follow up. Treatment consisted of nine therapeutic techniques: (1) analysis of short and long term causal factors, (2) sexual information, (3) couple sexual intimacy exercises, (4) sensate focus, (5) communication skills training, (6) emotional communication skills training, (7) mutual reinforcement training, (8) cognitive restructuring, and (9) sexual fantasy training.

Findings of this study support the theory that women with HSDD evidence dysfunctional cognitive processes, including automatic negative thoughts, antisexual attitudes, and unrealistic expectations about themselves, their partners, and their

relationship. Self-doubts and cognitive distortions about physical appearance, attractiveness, and self-image were also common. Women, in this study, suffered anticipatory anxiety about sex and reported feelings of shame and guilt. They presented with symptoms of anxiety and depression and tended not to perceive themselves as sexual. Furthermore, they reported a lack of emotional communication and commitment in the relationship as being a major source of their decreased desire. These findings are significant in that they point to both individual problems (cognitive distortions) and relational problems (lack of intimacy and communication) as centrally involved in causing HSDD.

Results from this study are quite promising. At the end of treatment, 74% of women were considered cured or improved, a number which decreased to 64% at three month follow up but remained stable at one year. Although only 38% of women described themselves as symptom free at one year follow up, these results are still quite good and participants reported being satisfied. Improvements were seen across individual variables, such as cognitive processes, and couple and sexual variables, with no such improvements in the control group. Of note, sensate focus exercises and communication skills training were judged by participants as most helpful, which would suggest that poor sexual skills, decreased intimacy, and ineffective communication styles are at the root of HSDD for many couples (Trudel et al., 2001).

In summary, then, there is exciting evidence to suggest that when HSDD is viewed from a cognitive behavioral perspective, treatment is at least moderately effective. However, additional studies like that of Trudel et al., (2001) are desperately needed to replicate the results and verify or disconfirm the effectiveness of these models. A major

limitation, even if additional objective support is documented for these models, is that we have no way of knowing what the effective treatment components are. It is easy to find significant results of some kind when treatment targets such a large number of possible sources for the problem. We are still quite in the dark about etiology of HSDD and need sound, experimental research in the area. Another concern is that despite wide-spread application of cognitive behavioral techniques to the problem of HSDD in recent years, there is no indication that treatment effectiveness is improving. Certainly, the possibility exists that techniques have not been consistently applied or that clinicians are seeing improvements not yet documented, but it remains to be seen whether the research being generated will have practical implications. If not, one is still left wondering if a lack of clear understanding of the etiology of HSDD is not the actual problem.

Interactional/ Integrative Theories

Much like the advocates of the cognitive-behavioral model of HSDD, Levine (1984), focuses on the interface between psychological and cognitive influences; however, he places added emphasis on biological factors. According to his interactional theory, sexual desire consists of three core components: biological drive, psychological motivation, and cognitive aspiration. *Biological drive* is the neuroendocrine process within the brain that seeks out sexual stimulation and serves to perpetuate the species. *Motivation*, or willingness, he believes is the most vital of the three elements and is induced by five types of stimuli: biological drive, the decision to excite oneself, interpersonal behavior (verbal and nonverbal interactions), voyeuristic experience (hearing of or reading about excitement in others), and attraction (perception that another meets a need in the

observer). The first two types are intrapsychic processes and the remaining three types are external influences. Motivation is embedded in four larger contexts: sexual identity (one's sense of masculinity or femininity), quality of the nonsexual relationship, reasons for sexual behavior (distraction from feelings, inducing sleep, relieving tension), and transference from past attachments. The third component of sexual desire, *cognitive aspiration*, is simply the wish for sex and may also be thought of as the acceptance or rejection of the experience (Levine, 1984). People make the decision to accept sex for a lot of different reasons, such as to feel good physically, to feel loved and/or connected to their partner, and to feel masculine/feminine and/or vital. Similarly, they choose to reject sex for reasons including feeling emotionally unready, fearing pregnancy or sexually transmitted disease, or believing it is morally wrong.

Within this model, fantasy is also thought to play a role in sexual desire and to be part of an intrapsychic mechanism that generates the earliest manifestations of arousal (Levine, 1988). Overall, the essence of sexual desire is the "ability of the brain and the mind to coordinate a behavioral sequence with the environment..." (Levine, 1984). More recently, sexual desire has been defined as the "sum of the forces that incline us towards and away from sexual behavior" (Levine, 2002; 2003; Rauch, Shin & Dougherty, 1999). This definition is appealing because it recognizes the complex nature of sexual desire and yet avoids all of the inherent jargon. In a recent commentary, Levine (2002) offered other considerations, some of which are highlighted here. First, sexual desire fluctuates even in the best of relationships. He argues the ordinary spectrum of desire looks like this:

Aversion ----Indifference----Interest----Need----Passion

In the positive range, people feel desire in their bodies. In the neutral range, one may consent to sexual behavior to make their partner happy (receptivity). In the negative range, the thought of sex may be unappealing or even revolting.

Not surprisingly, sexual desire fluctuates not only within a relationship but throughout the life cycle (Levine, 2002; 2003). Levine suggests the trend toward decreased sexual desire with age is biological in origin, an idea with which few would disagree. He also comments upon male-female differences, noting that males tend to experience greater desire than women from puberty onward. Female desire is weaker, less predictable, and less biologically supported. It is also highly sensitive to interpersonal influences. Intimacy is more central to a woman's level of desire than a man's. In fact, Levine stated "Women aspire to psychological intimacy as a gateway to sex. Men aspire to sex as a gateway to the sense of closeness." Within the interactional model, this phenomenon is also thought to be biologically based (Levine, 2003). Although Levine's model is relatively comprehensive and addresses some of the more subtle processes of desire, the major components are not well explained and even somewhat arbitrary (Rosen & Leiblum, 1987). It is also difficult to subject to empirical inquiry and this model is not currently empirically supported.

An integrative treatment approach reflecting some of Levine's ideas, proposed by Pridal and LoPiccolo (2000), addresses cognitive, behavioral, and systemic elements. The program consists of four stages which are affectual awareness, insight and understanding, cognitive and systemic therapy, and behavioral interventions. It targets multiple etiologies for HSDD: negative emotions (e.g. anger, anxiety, disgust, resentment), individual factors (depression, stress, history of sexual abuse, fear of closeness), and

relational factors (marital conflict, lack of attraction to one's partner, poor sexual skills in one's partner) (Pridal & LoPiccolo, 2000). The authors offer a single case example in which this integrative treatment model was successful but without a more systematic approach little can be said about its effectiveness.

Gerald Weeks and Nancy Gambescia (2002) offer another integrative treatment approach for HSDD which they refer to as an intersystems model. The foundation on which the intersystems model operates is to view every problem in terms of its individual, interactional, and intergenerational components. Within this model, physiological and psychological factors that may be contributing to loss of desire are included under the individual component. The couple's relationship is also seen as central, causing and maintaining loss of desire. Intergenerational factors may include negative messages about sex from families of origin, trauma, and family secrets about sex. These authors utilize a combination of psychoeducation, cognitive behavioral strategies, and traditional sex therapy techniques to treat HSDD in their clinical practices and subjectively report good success with this model (Weeks & Gambescia, 2002).

In general, the concept of sexual desire problems stemming from the interaction of biological, psychological, and cognitive forces is both comprehensive and practical. There is undoubtedly some validity to the model. Yet, just as has been the case with each of the proposed models of HSDD, one is left feeling frustrated by the lack of empirical research in this area while also acknowledging the myriad methodological and theoretical issues that, to some extent, justify the paucity of empirical support for any one etiologic factor or model (O'Carroll, 1991). Most of the individuals publishing articles on HSDD

are experienced clinicians with thoughtful ideas about the origin of low desire that have simply not been empirically investigated.

New Approaches to HSDD

Following years of relatively fruitless research and much untested theorizing, a handful of researchers have departed from mainstream theories, arguing that our approach to female sexuality is flawed in its reliance on male models. Leonore Tiefer was one of the first to insist that a new approach to women's sexual problems is necessary. Rosemary Basson, also an advocate for a new model of female sexuality, addresses HSDD specifically, proposing that the concept of female sexual desire is misunderstood. The research of Pamela Regan and Ellen Berscheid indicates there are important gender differences with respect to desire. As a result, the aim of their work has been to understand what desire means to women (and men). Finally, Roy Baumeister suggests that the female sex drive is more responsive than that of males to sociocultural and situational factors. Each of these ideas has emerged recently and are especially important to consider given the widespread realization that theories we have relied upon until now have not proven especially useful.

In the late 1990s, Leonore Tiefer began a campaign that would result in "A New View of Women's Sexual Problems." She and eleven social scientists and clinicians specializing in women's issues convened in the summer of 2000 to develop an alternate conceptualization of female sexual dysfunction free from what they perceived to be the escalating medicalization of female sexual problems. Tiefer (2001b) argues that publicity about new treatments for male erectile problems has provoked a hunt for "the female

Viagra,” an idea embraced by an uneducated, embarrassed public with a bias toward a biological approach. However, women’s sexual difficulties exist within human relationships and in social contexts, with a large number of factors influencing these problems. Therefore, Tiefer suggests that female sexual development and experiences cannot and should not be reduced to biological function.

The “New View” criticizes the nomenclature utilized in the Diagnostic and Statistical Manual of Mental Disorders, claiming that the framework (1) provides a false notion of sexual equivalency between men and women, (2) ignores the relational context of sexual behavior (which often lies at the root of sexual problems), and (3) fails to acknowledge differences among women themselves. Factors that often play a role in women’s sexual problems, such as relationship or cultural factors are unstudied and unaddressed. Tiefer and her colleagues offer a more “women-centered” definition of female sexual problems: “discontent or dissatisfaction with any emotional, physical, or relational aspect of sexual experience” (Tiefer, 2001a; Tiefer, Hall & Tavris, 2002). Female sexual problems may be the result of: (1) socio-cultural, political, or economic factors (e.g. inadequate sex education, inadequate access to information about and services for birth control and STDs, cultural inhibitions), (2) partner and relationship influences (e.g. lack of trust, abuse, desire discrepancies, lack of communication), (3) psychological factors (e.g. past trauma, personality disorders, depression/anxiety, pain), and/or (4) medical factors. Tiefer (2002) alleges that the partnership between academia and pharmaceutical companies threatens to bias clinical research in favor of medicalization and against these social, political, and relational factors.

Basson (2001b) also argues against a dualistic approach to sexual problems as being either physical or psychological and proposes that the human sex-response cycle consists of various cycles within the mind and body that mediate sexual experiences. She suggests that because of a wish to increase emotional intimacy, a woman is receptive to sexual stimuli (psychological and/or biological) and, therefore, proceeds from a state of sexual neutrality to a state of sexual arousal and desire. A variety of factors influence this sexual response cycle, however, and determine whether desire will increase and whether emotional and physical satisfaction will result. In addition to psychological and biological factors, cognition and affect also mold the sexual experience. Basson (2001b) notes that the sexual response cycle is quite vulnerable and subject to disruption at a number of levels, which accounts for the high prevalence of HSDD.

Length of a relationship may also play a significant role in HSDD, according to Basson (2001c). She insists that the very definition of HSDD is flawed in that it doesn't consider normal reductions in desire levels relative to relationship length. She offers an expanded definition of HSDD: "the persistent or recurrent deficiency (or absence) of sexual fantasies, thoughts, desire for sexual activity (alone or with the partner) *and* inability to respond to sexual cues that would be expected to trigger responsive sexual desire. These symptoms need to be causing personal distress" (Basson, 2001c). This definition is more appropriate, she believes, because it recognizes that women in long-term, monogamous relationships may not experience *spontaneous* desire but do remain receptive to sexual advances to be intimate with their partner. They may subsequently become desirous of sexual behavior for the pleasure it offers, but only after the behavior has begun. It is *receptive* sexual desire that Basson proposes is actually *normal* for

women in long-term relationships. The failure of clinicians to recognize responsive desire, as opposed to spontaneous desire, as the mainstay in long-term relationships, she argues, has resulted in over-diagnosis of up to 50% of women. Between 46-75% of women *without* sexual complaints report feeling spontaneous sexual desire less than once a month (Basson, 2002). If this is the case, low or absent spontaneous sexual desire in women may not be a disorder at all.

Attempting to address the question “what is normal desire for women (and men)?” Pamela Regan and Ellen Berscheid conducted a series of studies with undergraduate students. In one of these studies, participants were provided a definition of sexual desire and asked about causal antecedents of male and female desire (Regan & Berscheid, 1995). Results indicate that both men and women believe that male and female desire have different causes: intraindividual and erotic environmental factors influence male desire whereas interpersonal and romantic environmental factors are thought to stimulate female desire. Sexual desire is thought to be a thermometer for the quality of a relationship because, based on their research, the presence of desire is closely associated with romantic love and distinguishes romantic love from other types of love. In another experimental study, undergraduate men and women were presented scenarios of couples (Regan, 1998). Participants viewed couples who were sexually desirous of one another as having good, strong relationships whereas couples without desire were thought to be less happy together and more likely to be unfaithful.

In a third study, Regan and Berscheid (1996) explored men’s and women’s beliefs about sexual desire. Although both men and women in this study described sexual desire as being a motivational, cognitive, emotional, and psychological experience, they differed

in their goals for sexual desire. Women tended to report the goal of desire as love or intimacy and men defined the goal as sexual activity. Overall, women adopted a relational approach to sexuality and men took a body-centered, recreational approach. This study supports fundamental differences in the way that men and women view sexuality. Certainly, it is important that empirical evidence support such a contention, however, it comes as no great surprise as this supposed difference is central in popular culture about gender differences (e.g., *Men are from Mars Women are from Venus*).

Baumeister (1999) would agree and argues, with support of an exhaustive literature review, that female sexual desire is more subject to social and cultural influences than that of men. While male sexual desire tends to be relatively stable and unchanging, female desire is malleable and responsive to external circumstances. Implications of female erotic plasticity, as Baumeister refers to his theory, are: (1) that a woman's level of desire will vary more than a man's from situation to situation and time to time relative to any number of external influences, such as illness, fatigue, mood, and life circumstances, (2) that socialization, to include educational, religious, moral and cultural messages, will have a greater impact on women than on men, and (3) that women's behavior and attitude may not be as consistent as that of men because the decision to engage in sexual behavior or not is affected by situational variables and not just her internal disposition. The literature review provides strong support for each of these three theoretical predictions. Baumeister thoughtfully articulates that, at least in terms of sexuality, women tend to be "creatures of meaning" whereas "men are creatures of nature." In other words, for women the *meaning* of a sex act is central whereas men may experience and desire a sexual act primarily for its own physical gratification and value.

This recent questioning of traditional models of sexual desire, with an emphasis on gender differences, and renewed interest in relational and sociocultural factors as determinants of female sexual desire is, in a sense, an appeal to erase the slate of research on female sexual desire and start anew. These theories would also explain our historic difficulties understanding (let alone treating) HSDD. The news could be good in that, theoretically, if women's desire is flexible then it should have the potential to reappear when, relational and other influences are addressed. On the other hand, "relational and sociocultural influences" remains a vague and all-inclusive category that is likely to challenge attempts at condensation. So it seems that even with the introduction of fresh ideas regarding the nature and etiology of HSDD, we are left with exactly the same task of trying to tease out relevant influences in the absence of empirical support.

Summary of Proposed Etiologies of HSDD

The task of organizing and presenting the literature regarding HSDD in women presents a number of challenges. First, there is a striking paucity of empirical studies directly investigating the etiology of HSDD. In light of this empirical void and the urgency to treat this very common complaint, researchers have, by and large, favored treatment studies over etiologic ones. Treatments are necessarily based on implicit theories about causation so we are left to infer hypothesized etiologic theories for HSDD from these treatments. We are also left to assess their validity by the outcome of these studies. This is a daunting venture as the treatment studies have tended toward the "kitchen sink" approach without any attempt to isolate any one treatment's active ingredient(s) and the etiologic mechanism(s) implied. A second difficulty relates to the

abundance of theorizing about the etiology of desire and its loss. Much of what has been written about HSDD consists of the musings of frustrated clinicians. Although most literature reviews skip clinical impressions and privilege empirical research, this review includes unsubstantiated theories based on the assumption that, when so little is known about a topic, everything is worth considering. A third and final difficulty in reviewing the literature was posed by the tremendous overlap among supposed theories of HSDD. Many of the theories that self-label as different from others in fact share many of the same potential influences. For example, systems, cognitive-behavioral, and integrative theorists all point to poor communication as a factor in HSDD. Despite these overlaps, there seemed no clearer way to organize the literature than by these self-labeled theories. The alternative would have resulted in a laundry list of single factors, none of which have been individually tested.

The unfortunate reality is that, despite the seriousness of HSDD and years of seeking answers, at least from a scientific point of view, we are just getting started. In part, this is because what little empirical research does exist suggests that just about anything and everything has the potential to cause low sexual desire in women. In fact, each of the following psychosocial factors has been proposed to play a role in the development and/or maintenance of HSDD: unhealthy early attachments and consequent personality disorders, internalized rejection, penis envy, an inability to master stages of sexual development; psychological factors such as anxiety, depression, anger, disappointment, work related or financial stress, guilt, fears of intimacy or commitment; directly sexual factors including lack of fantasy, lack of pleasure or even pain during sexual activity, past negative experiences (sexual trauma), lack of attraction to one's partner, inability to

detect sexual cues in the environment, negative sexual self-talk, antisexual cultural, religious, or moral beliefs, and body image disturbances; and finally relational influences such as marital conflict, issues of power and control, lack of intimacy, overdependency on one's partner, ineffective communication styles, incompatible sexual rhythms, a limited sexual repertoire or poor sexual skills, failure to maintain a regular sexual rhythm, and time constrictions. Intuitively, it is difficult to argue with any one of these factors, with the exception of some of the more arcane psychoanalytic influences; however, it is the interplay and overlap among the factors that makes the conceptualization of HSDD fraught with difficulty. Even so, there must be a more parsimonious and, therefore, more useful way of explaining loss of female desire. Surely, other constructs, such as personality, are equally expansive and resistant to simple conceptualization. Yet, there have been empirically validated condensations such as the Big 5 Factor Theory of Personality. Similarly, it seems likely that several influences are most salient and relevant for the majority of women experiencing HSDD and might be predictive of a handful of different types of HSDD etiologies.

Curiously, it is only recently that researchers, clinicians, or theorists have examined differences between male and female desire. Although new approaches to female sexual dysfunction and HSDD have also yet to be empirically validated, they do offer fresh ideas regarding the way we conceptualize loss of desire, even questioning whether HSDD is, in fact, a disorder in women. Rather than simply add to the laundry list of potential factors, these new ideas seek to redefine and reconstruct the issue. This seems a step in the right direction, given our lack of knowledge about the etiology of HSDD and the failure of existing theories to differentiate among any of the reasonable influences

implicated in HSDD. Perhaps the time has come to shift focus and to generate a theory from the ground up by asking women about their own causal attributions for their loss of desire. If each of the potential factors the current literature points to is, in fact, contributing equally to HSDD, then interviews with women should reflect that idea. Additionally, if that is the case, a large number of women will need to be interviewed before a point of saturation is reached, before no new interviewees offer a reason not already mentioned by a previous interviewee. On the other hand, if women attribute similar reasons for their loss of desire and a point of saturation is reached early in the interview process, the problem may be more straight-forward than the literature has previously suggested. Unarguably, each woman is unique and the reasons she experiences HSDD varied. However, the science of other equally complex phenomena has managed to successfully condense ideas to a few, more manageable and useful dimensions.

Purpose of the Present Study

The present study was intended to serve as a means of cleaning the slate and constructing a psychosocial theory of HSDD in married women from the ground up, from the actual lived experience of women who once had desire and lost it. Through the use of qualitative methods, this study sought to investigate the causal attributions made by married women with acquired HSDD. It was believed that utilization of qualitative methodology would allow us to gain new insight from women experiencing the disorder. Combined with previous research this insight might facilitate the formulation of a theory that more accurately explains and condenses the causes of HSDD. By facilitating a more

accurate conceptualization of HSDD, this method of theory development might also support the design of more finely-tuned treatment approaches.

The question remains whether women can accurately assess the causation of their lack of desire. A large body of literature casts serious doubt on our ability to make accurate causal attributions about much. This study was not designed to test that question. However, the hypotheses and theory generated by our sample's causal attributions for HSDD will, of course, be amenable to further quantitative investigations which may be able to tease apart actual from perceived etiology. The fact is that, to date, perceptions of etiology are all we have. This study sought to shift our focus from the perceptions of researchers to those of the women who actually live with this problem.

CHAPTER 3

METHODOLOGY

Participants

Interviews were conducted with 22 participants, although data is reported on only 19 of these participants. One of the interviews was unknowingly not transcribed due to technical difficulties. Two of the women were judged not to meet study criteria based upon medical conditions: One had recently been diagnosed with an autoimmune condition, known as aplastic anemia, while another was judged by researchers to have dyspareunia, a sexual pain disorder. Therefore, these aforementioned interviews were eliminated from data analysis. Although it was judged that saturation had been reached by the 16th interview, the decision was made to continue interviewing in order to ensure that no new themes emerged. The average age of participants was 31.5 ($SD = 4.21$). The age range was from 26 to 40 years of age. Fifteen were European American, two were Hispanic, one was Asian American, and one identified as Native American. The average length that participants had been married was 6.52 years ($SD = 3.85$). For 16 of the women, this was their first marriage. Two of them had been married one other time and for one participant this was her third marriage. Six of the women had no children. Three women had one child and 10 had two or three children. Participants tended to be highly educated, with 18 of them reporting some college or more. Fifteen of them also worked

outside of the home, with seven of those working participants working a traditional 40-hour work week. All 19 participants reported having little to no sexual desire of at least six months duration but did report having experienced desire for their current spouse in the past. Seventeen participants reported currently engaging in sexual activity without desire to do so. Frequency of sexual intercourse among participants ranged from none at all during the past year (two participants) to three times per week (one participant). The most often cited frequency of sexual intercourse by participants was once or twice per month (seven participants). They had not undergone a hysterectomy and were premenopausal, free from chronic illness, and had not had a baby within the past twelve months.

Procedure

Participants were recruited through a variety of methods. Women were recruited from two obstetrics and gynecology clinics in the Las Vegas community: Drs. Warren Volker and Tammy Kelly-Layton and Drs. Joseph and Kirstin Rojas. Flyers outlining participant requirements and a contact telephone number were distributed by the physicians and also placed in the clinic waiting rooms (SEE APPENDIX I). Additionally, flyers were distributed at other OB/GYN and mental health clinics in the community. Furthermore, recruitment was expanded to include radio public service announcements, posting flyers in the community (e.g. libraries, gyms, yoga studios), and announcements in certain classrooms on the campus of the University of Nevada, Las Vegas after gaining instructor permission.

Women interested in participating in the study contacted the researcher by calling the telephone number provided. If a caller was determined eligible for participation through a series of questions covering inclusion and exclusion criteria and they agreed to participate after a brief description of the study, arrangements were made for the interview meeting. Inclusion criteria were self-identification as having a low level of desire for sexual activity of at least 6-months duration, being married, having had desire for their current spouse in the past, and pre-menopausal status. Exclusion criteria were self-identified physical or mental illness, pregnancy, or having had a child in the past 12 months. Assessment of HSDD criteria were further confirmed via a semi-structured interview about attributions for loss of desire (SEE APPENDIX III). Women were interviewed at an agreed upon, appropriate location that was both convenient for them and free from distractions and interruptions. The majority of women were interviewed at a professional office available to the researcher. Others preferred to be interviewed at their homes and were asked by the researcher to make arrangements for the interview to take place free from external distractions. Prior to beginning the interview, women were offered a brief description of the study, informed of their confidentiality, and reassured of their right to withdraw from the study at any time (SEE APPENDIX II). They were informed that the open-ended interviews would be audio-taped and were provided with the relevant contact information in the event they had questions or concerns. Only after the informed consent process was complete did the interviews take place. Each participant was assured that she did not have to speak about any topic that she was not comfortable discussing. In general, careful attention was paid to ensure the comfort of all participants, especially given the personal subject nature. Women were also asked to complete a brief demographic

questionnaire (SEE APPENDIX IV). Although it was estimated that 75 minutes would be required to complete the interview and questionnaire, the interviews tended to be lengthier than originally anticipated. The process averaged 2 hrs. 30 min. Women were advised of this before they committed to participate. Following each interview, the interviews were transcribed by a research assistant committed to maintaining confidentiality. Consistent with the grounded theory approach of this study, each interview was examined and coded for themes before the next interview took place. Emerging themes were incorporated into subsequent interviews in the form of additional questions.

Research Approach

Since the early 20th century, psychology has relied upon quantitative research methods based on the theory of Positivism which argues that all knowledge must be based on direct observation and sensory data (Krahn & Eisert, 2000). The current study, however, utilized qualitative methods in an attempt to gain meaning from data that is not easily quantified and, therefore, has not been amenable to more traditional methodology. Although historically there has been some reluctance in the field of clinical psychology to embrace the use of qualitative methods, their use is growing in popularity due to the richness and meaning they offer in describing human experience (Krahn & Eisert, 2000). Although diverse, all qualitative approaches are concerned with understanding the lived experience of a group of individuals, seeking to discover the meaning of events and the way that individuals make sense of their world free from the researcher's frame of reference. (Charmaz, 1995; Glaser & Strauss, 1967; Krahn & Eisert, 2000; Rubin &

Rubin, 1995; Strauss & Corbin, 1990). According to Maxwell (1996), qualitative methods are well-suited for studies that attempt to achieve the following purposes: (1) understanding what meaning individuals give to their subjective experiences; (2) understanding a particular context in which participants act and its influence on their actions; (3) identifying unanticipated phenomena and influences and generating new grounded theories about these phenomena; (4) understanding the process through which events and actions take place; and (5) developing causal explanations. Consistent with these research goals, the current study sought: (1) to understand the subjective experiences of women who once had but have lost sexual desire for their spouses; (2) to understand when and in what context desire was lost; (3) to examine potential reasons for loss of desire among women; and (4) to generate a theory for HSDD and/or female sexual desire based on elaborations offered by women.

Data Collection and Analysis

Data in this study was analyzed using grounded theory methodology, a set of systematic procedures for making sense of qualitative information and studying human experience (Charmaz, 1995). Several authors have commented on the benefits of applying qualitative methods and specifically grounded theory methodology to the study of women's health issues (Crooks, 2000; McBride, 1993; Stern, 1980). Grounded theory emerged during the 1960's out of a collaboration between sociologists Glaser and Strauss as a way to bridge the gap between quantitative and qualitative methods. Glaser's background was rooted in Positivism while Strauss was linked to symbolic interaction, a philosophy that humans are endowed with a capacity for thought that is shaped by social

interactions, which affect the way that we understand and make sense of our world.

Together, they challenged the idea that qualitative methods are inferior to quantitative methods and articulated a thoughtful set of analytic procedures for shaping and handling qualitative data that allows researchers to study human experience in a rich and meaningful way, using specific and systematic procedures (Charmaz, 1995).

Methods for collecting data in qualitative analysis include: (1) in-depth interviews using open-ended questions, (2) open-ended focus group discussions, (3) examination of documents, and (4) direct observation (Krahn & Eisert, 2000). The current study gathered data from in-depth individual interviews because of the sensitive nature of the topic and because it is believed this format allowed the researcher to learn the most about the reasons for loss of desire.

Despite some debate regarding the procedures befitting grounded theory methodology, theorists generally agree on several fundamental principles (Krahn & Eisert, 2000). An essential premise and one of the hallmarks of the grounded theory methodology is that the theory emerges not from preconceived ideas or hypotheses but from the data itself. Therefore, the theory is *grounded* in the data. Questions and not hypotheses serve as the beginning point for data collection because traditional hypotheses could introduce bias into the study and contaminate the researcher's openness to hearing what the participants are saying. A researcher may, for example, seek specific answers to prove or dis-prove a hypothesis rather than being sensitive to all the information provided by the participants.

An essential methodological strategy of grounded theory involves *simultaneous data collection and analysis* which allows the emerging theory to be continuously shaped

(Krahn & Eisert, 2000). This requires that the researcher expand each interview conducted based upon new information learned from each previous participant. That is, the researcher must carefully examine each interview before additional interviews take place in order to elicit different information from future interviewees based upon what previous ones disclosed.

Following grounded theory methodology, after each taped interview was transcribed, the data was broken down line-by-line, examined for themes, and labeled during a process called *open-coding*. Coding is seen as the pivotal link between data collection and the emerging theory. Line-by-line coding ensures that the researcher does not impose his/her own feelings or ideas onto the data. Basic questions that the researcher asks of him/herself during the coding process include: What is going on here? What is this person saying here? What are people doing? What do these actions assume? And how does the context support, maintain, or change these actions/statements? The coding process continued with themes being compared, conceptualized, and categorized. The resulting theoretical categories were examined for their various dimensions, properties, and relationships to other categories. This process was ongoing and is another hallmark of grounded theory, known as the *constant comparative method*. It involves checking and comparing each new category with those identified before and after allowing for constant refinement of the emerging theory (Charmaz, 1995; Glaser & Strauss, 1967; Strauss & Corbin, 1990). Questions that a researcher may ask him/herself when examining the data include: What process is at issue here? Under what conditions did this process develop? How does the interviewee feel, think and act while involved in this process? When, why, and how does this process change? What are the consequences? (Charmaz, 1995).

As categories and intercorrelations between them were discovered, theoretical sampling was utilized to support or disconfirm the findings. *Theoretical sampling*, another characteristic of grounded theory, refers to the process through which one seeks to construct a “trustworthy” theory and requires the researcher to actively look for exceptions to the rule. Data collection continued until the point at which no new information, or themes, were emerging from the data (interviews), a process called *saturation* in grounded theory (Chamberlain, 1999; Krahm & Eisert, 2000). In other words, interviews were conducted until a point at which interviewees were not offering new reasons and explanations for their loss of sexual desire.

Analysis of qualitative data is time-intensive and interactive because the researcher must sort through the data and search for meaning and discrepancies in order to weave together the emerging theory about the phenomena that is then confirmed or disconfirmed through further data collection. Strauss and Corbin (1990) offer a three-tiered approach to coding that illustrates its complexity. They refer to open coding as breaking the data down into discrete parts which are more manageable and can be examined more closely for differences and similarities. The second part of the coding process is axial coding, in which “data are put back together in new ways after open coding, by making connections between categories.” The third and final stage of coding is selective coding, during which ideas are integrated together at a higher level of abstraction. One seeks, at this level, to uncover a core category that encompasses the whole story. Because researchers may use terms interchangeably in qualitative research, some clarification is helpful. For purposes of this study, the researcher identified a code during the open coding process which was then translated into themes during axial coding when connections between codes were

identified. From themes emerged categories until one core category, or theory, about loss of desire emerged.

Using the procedures described, the goal of the current study was to identify an underlying theme, or core category, that unified all other sub-themes identified during data coding and analyses (Chamberlain, 1999). A second researcher was consulted throughout the entire data analysis process to assist in identifying emerging themes and, ultimately, a central theory that “fit” well with the data and provided an understanding of loss of sexual desire (Strauss & Corbin, 1990).

Reliability and Validity

Much of the debate surrounding qualitative studies focuses on their assumed lack of rigor. However, qualitative studies can be held to standards “of good science” in a modified version to fit the “realities of qualitative research and the complexities of social phenomena” (Strauss & Corbin, 1990). In fact, a number of criteria have been proposed to evaluate the rigor of these methods. Two such methods, offered by Lincoln and Gruba (1985) and Henwood and Pidgeon (1992), are outlined here because of their representativeness. Lincoln and Gruba developed a set of criteria that translate readily from quantitative approaches and provide transition into qualitative methods for positivistic-trained researchers, such as most psychologists. They propose the concept of *trustworthiness*, that is broadly analogous to reliability and validity in quantitative studies. Trustworthiness is determined by four criteria: credibility, transferability, dependability, and confirmability. *Credibility* is concerned with confidence in the findings and is accomplished by gathering evidence from different points of view or from

several different people or by asking participants whether the information gathered is consistent with their experiences. *Transferability* is the extent to which the findings are transferable to other groups or contexts. *Dependability* is determined by the extent of agreement in categorizing or coding the data and is similar to reliability of the study's conclusions. Finally, *confirmability* is the ability of the procedures to be formally audited and replicated by an independent researcher. In other words, another researcher should be able to follow the logic and arrive at similar conclusions.

Henwood and Pidgeon (1992) suggest an alternate set of criteria for evaluating the rigor of qualitative studies that reflect the uniqueness of qualitative methods rather than focusing on translation from quantitative criteria. Specifically, they propose seven criteria to assess the merit of qualitative data: (1) keeping close to the data, (2) integrating theory at diverse levels of abstraction, (3) reflexivity, (4) documentation, (5) theoretical sampling and negative case analysis, (6) sensitivity to negotiated realities, and (7) transferability of findings. *Keeping close to the data* means that categories and all information that emerges must be grounded in the data. *Integrating theory at diverse levels of abstraction* is the idea that at all levels of abstraction, data should be synthesized in ways that make sense according to the data. *Reflexivity* relates to an awareness of how the research procedures used and the researcher's own biases influence the subject of study. This awareness is often accomplished by the researcher documenting his/her personal hypotheses, intuitions, values and attitudes so that they can be constantly checked and confirmed against the data to avoid bias. *Documentation of the research process* means generating records of thoughts, decisions, and observations as one goes. *Theoretical sampling and negative case analysis* refers to sampling that seeks to find

exceptions to the rule to aid in the development of a comprehensive theory. The more alternatives that can be eliminated as implausible, the stronger the inference of validity. *Sensitivity to negotiated realities* means developing a shared interpretation of the findings through dialogue with the research participants. The resulting interpretation should be a negotiated reality between the perceptions of the participants and the observations and interpretations of the researcher. Finally, *transferability of findings* relates to how well the results of the study extend to other contexts.

Although there is some overlap between the two sets of criteria, the former is certainly more sensitive to the transferability of quantitative research criteria to qualitative methods. As researchers in psychology become increasingly accustomed to qualitative approaches, it is likely that more specific standards, such as those set forth by Henwood and Pidgeon, will be more frequently applied (Krahn & Eisert, 2000).

The current study adhered to the standards of rigor outlined by Henwood and Pidgeon. For example, the researcher utilized a research partner to play “devil’s advocate,” critically questioning the researcher’s analyses to avoid bias. Along these same lines, the researcher documented her own pre-existing values and attitudes in an effort to minimize their effects. Efforts were made to seek out alternative explanations and exceptions to the rule, in order to facilitate the emergence of a comprehensive and reliable theory about HSDD in married women or about female sexual desire within the context of long-term relationships.

Semi-Structured Interview

Data collection was accomplished using a semi-structured interview, conducted by the primary researcher, and consisting of open-ended questions regarding participants' attributions for the loss of sexual desire in their relationship (SEE APPENDIX III). The semi-structured interview format allowed participants to guide the discussion in the direction of topics *they* perceived to be related to their loss of desire. In order to build rapport and facilitate detailed responses to open-ended questions, the researcher also utilized non-directive prompts without imposing ideas on the participant. These included nonverbal gestures or brief comments, such as: Tell me more about that; What do you make of that? and Have you given any thought to why that is? Once each woman was unable to further elaborate open-endedly about her perceptions of why she had lost sexual desire, the author utilized semi-structured prompts based on possible reasons not yet discussed. These reasons included: family responsibilities, work obligations, household chores, fatigue, emotional difficulties, marital discord, diminished intimacy, and feelings about her own sexual desirability. Admittedly, these prompts were influenced by the literature regarding the etiology of HSDD. No research is bias free and this is especially true in qualitative research in which the researcher is the "instrument" of the research. Although some may perceive this closeness between the researcher and his/her research a weakness, Maxwell (1996) suggests it can be a source of strength when the researcher's personal experiences in the process offer a major source of insight. In the current study, threats to validity were minimized by posing all questions in as generic a manner as possible in order to elicit responses that accurately capture each woman's reality.

CHAPTER 4

RESULTS

Reliability Analysis

Each transcribed interview was coded by two independent raters. The percent agreement between raters on themes present in the interviews at the axial coding stage was .96, indicating very good interrater reliability. When differences arose or when only one researcher noted a theme, the discrepant theme was discussed. Each researcher presented her data-based reasons for including or not including the theme, and ultimately a joint decision was reached about whether or not the theme was adequately supported by the data. Themes were only included in the final analysis when both researchers agreed that they were supported by the data. Therefore, all themes considered and discussed had unanimous agreement by both researchers, either by way of initial coding agreement or after thoughtful discussion and reference to the data.

Emergent Themes/Model/Theory

In the process of interviewing participants, it became clear that women generally found it difficult to temporally distinguish between perceived causes for their initial loss of desire and current barriers to their sexual desire. In other words, they were not always sure what factors precipitated their declines in desire, but they were very clear about what

factors they believed continued to interfere with their sexual desire for their husbands. What emerged was a model of forces pulling down on sexual desire to the point of incapacitation. Three core themes emerged from the data which appeared to represent these dragging forces on sexual desire. They were the *institutionalization* of relationships, *over-familiarity* with one's partner, and the *de-sexualization of roles* within these relationships. The *institutionalization* of relationships theme was characterized by a set of sub-themes that primarily consisted of 1) a de-eroticized conceptualization of marriage, 2) the over-availability and over-accessibility of sex, 3) the dampening effect of marital responsibility on sex, and 4) the lack of transgression associated with marital sex. The *over-familiarity* theme was characterized by a set of sub-themes consisting of 1) a decline in perception of physical attractiveness, 2) the dissipation of romance and mystery, 3) overly familiar sexual advances, 4) mechanical sex, and 5) lack of individuality. Sub-themes subsumed under the *de-sexualization of roles* theme were 1) the "to do list" phenomenon, 2) multiple role incompatibilities, and 3) lack of perceived desirability. For a schematic representation of the model of forces pulling down on sexual desire within marriage and incorporating the aforementioned three emergent themes and related sub-themes, see Figure 1 below.

Forces Pulling on Sexual Desire: Emergent Themes in Current Study

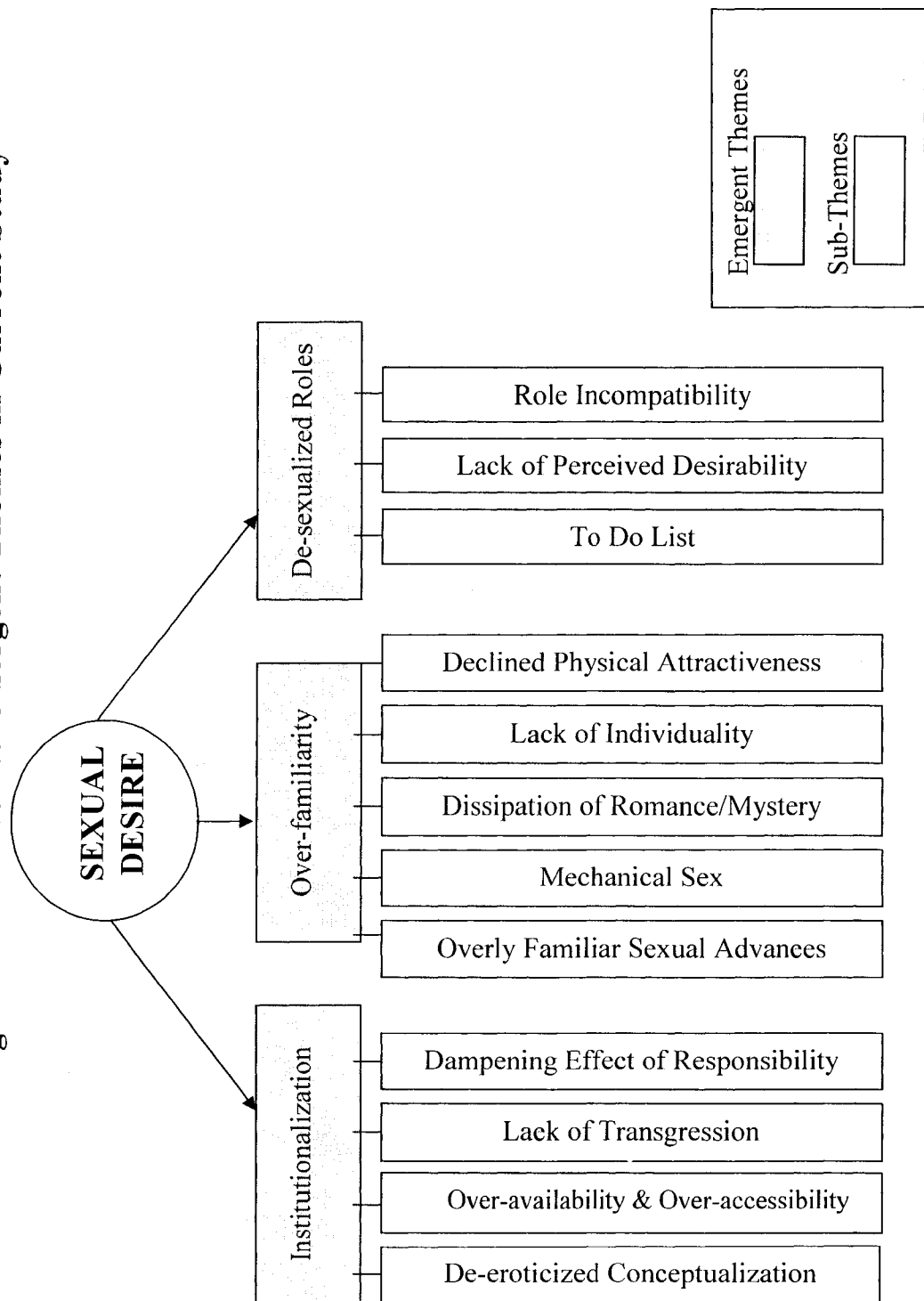


Figure 1

The construction of this model and the discovery of emergent themes involved collapsing first-order themes (or codes) originated from line-by-line analysis of the transcripts, into broader second-order themes. These second-order themes were then further collapsed into core categories, also referred to as emergent themes. Table 1 outlines the process of theory building from right to left, starting with first-order codes, which were collapsed into second-order themes and further collapsed into core categories, or emergent themes. The last row in Table 1 does not constitute an emergent theme but details the impact of the lack of desire on the sexual lives of our participants.

In the section following the table, we will provide a detailed elaboration of each of these core themes and sub-themes as described by participants. Readers should note that although the three core themes were present in all of the interviews with participants, there was variation from woman to woman in terms of the presence of subthemes. In other words, not every participant directly addressed every subtheme presented in her loss of desire. However, each subtheme that is presented was expressed by many women. Similarly, a few idiosyncratic themes that were specific to only one woman were not included in the development of a theory. Additionally, we will also provide a description of the perceived impact of HSDD as described by participants. Selected participant quotes will be offered to demonstrate the direct connection of emergent themes to the data.

Table 1 Documentation of discovery of emergent themes

Core Categories	Second Order Themes	First Order Codes
Institutionalizaon	De-eroticized conceptualization of marriage	<ul style="list-style-type: none"> • Passage into a non-sexual realm • Comfortable but not sexy or exciting • Incompatible with sexual desire and excitement
	Over-availability and over-accessibility of sex	<ul style="list-style-type: none"> • Makes it less appealing/de-eroticizes • Predictability of access makes it less exciting
	Dampening effect of responsibility	<ul style="list-style-type: none"> • Takes the fun out of sex • Choosing the good provider and parent was not a sexual choice
	Lack of transgression in marital sex	<ul style="list-style-type: none"> • Sex with husband is comfortable rather than exciting, illicit, adventurous • Sex within marriage not spontaneous • No risk involved • Stuck with one partner, no options • Sex as an obligation
Over-familiarity	Decline in perceptions of physical attractiveness	<ul style="list-style-type: none"> • Of self <ul style="list-style-type: none"> ○ Weight gain ○ Pregnancy related changes in body • Of husband <ul style="list-style-type: none"> ○ Weight gain ○ Inattention to grooming
	Dissipation of romance and mystery	<ul style="list-style-type: none"> • Efforts at romance cease • Making love vs. sex • Exposure to bad habits
	Overly familiar sexual advances	<ul style="list-style-type: none"> • Sexual initiations lack effort • Crude demonstrations of affection <ul style="list-style-type: none"> ○ Groping, grabbing • Offensive language to request sex
	Mechanical sex	<ul style="list-style-type: none"> • Sex is predictable • Sex is boring • Technique and foreplay de-emphasized • Sex literally a routine

	Lack of individuality	<ul style="list-style-type: none"> • Social isolation • Family became the priority • Lack of outside interests
De-Sexualization of Roles	To do list	<ul style="list-style-type: none"> • Cognitive distraction during sex • Sex not a priority • Sex as a chore • Work/financial stress • Incompatible schedules • Fatigue • No time
	Multiple Role Incompatibilities	<ul style="list-style-type: none"> • Role as mom not compatible with being sexual • Difficulty transitioning between roles of mom and lover • Focus on children, not each other • Worry that kids may hear/intrude during sex • Physical attention from children decreases desire for additional touch • Lack of quality time spent together • Discomfort with sexual attention
	Lack of perceived desirability	<ul style="list-style-type: none"> • Don't feel sexy/desirable • Shift to less sexy clothes • No reason to get ready • Lack of external validation about desirability • Inability to suspend disbelief for sex play or fantasy
<i>Impact of HSDD</i>		<ul style="list-style-type: none"> • Discomfort with experimentation • Squeamishness about sex • Decreased overall affection • Fears of infidelity • Guilt • Feeling abnormal and misunderstood

Institutionalization

Women in this study viewed their married life as a time during which the nature of their romantic relationship with their husband changed and they attributed this change directly to the impact of the institution of marriage. It was seen as a passage from a time

of independence, freedom, and excitement to one of commitment, responsibility, and routine. They reported that the meaning of sex also changed during this time from one of physical pleasure, fun, and excitement to an expression of love and, more negatively, to an expectation/obligation within marriage. Marriage had institutionalized their relationship and they perceived this institutionalization to have deleteriously impacted desire in the following ways:

De-eroticized conceptualization of marriage

Participants indicated that the very same reasons that motivated them to get married had also had the impact of dampening their sexual desire. They reported being cognizant that marriage symbolizes a couple's commitment to one another and, generally speaking, their intent to be monogamous. It represents comfort, stability and security. When two people get married, they often consider themselves a family. For many, marriage is associated with, if not followed by, having children. Our participants expressed having wanted all of these things when they entered into their unions but they seemed surprised to find that these properties of marriage were not experienced as particularly sexy.

...with my husband it [sex] is good and comfortable and happy...it is like our relationship...the sex is comfortable, it is not, like, crazy...

The words "comfortable" and "nice" were used often to describe sex within marriage.

Another woman explained:

There was a lot of desire when I was dating, excitement. On the flip side, when you're married, I know how much he loves me and I'm not embarrassed to take my clothes off. There's a comfort there that is important to me. It's just not as exciting...the desire is lost.

Finally, one woman said of her sexual desire, “*it seemed that after we got married it almost immediately just spiked down.*” Overall, participants indicated that they valued the traditional aspects of marriage but simply did not find them conducive to sexual desire.

Over-availability and over-accessibility

Participants reported that following marriage sex became too readily available and this had a de-eroticizing effect. Knowing that sex was available anytime hijacked its allure. One woman said simply, “*It was then that I had desire, when it wasn’t available...*” Another explained, “*we were having it so much...it wasn’t interesting anymore.*” Women recalled the days of having to arrange schedules and other responsibilities to steal time to see their lovers. They missed the “butterflies” and anticipation of these hastily planned encounters. Although it seemed an inconvenience at the time, they reported that the easy accessibility to one another following marriage made love-making less exciting.

When we were dating...there was very limited time when we were able to be intimate so we were more excited. And then after we got married we were with each other all the time...so there was no focus on being with him intimately...

Dampening effect of responsibility

Another way in which the institutionalization of the romantic relationship blocked desire was by creating a sense of responsibility. Participants shared that they felt weighed down by the obligations inherent to marriage. One woman said:

...now it’s kind of like being an adult and having the responsibilities and paying the mortgage and car payments and making sure there’s enough for leftovers...it takes the fun out of it

Interestingly, some women shared that they had married specifically for responsibility rather than because of sexual appeal. In other words, they chose their spouses because

they were men who would make good husbands and fathers, despite having felt stronger desire for other men in their past.

He's such a good guy, like kind of wholesome...sometimes I wish he had a little more bad boy in him. Like those are the types of guys I really liked, but I knew it wouldn't be the type of guy I should marry.

This finding supports the cultural stereotype that women are sexually attracted to “bad boys” yet choose to settle down with more stable and traditional men. It is important to note, however, that all the women who shared this sentiment expressed that they had experienced some sexual desire for their husbands in the past. So, even if these were not the guys they had most lusted after, they had certainly felt much more sexual desire for them at some point than they did now.

Lack of transgression in married sex

Consistently, participants talked about marriage having robbed sex of its excitement by making it sanctioned. They recalled feeling tremendous desire when sex was more forbidden and illicit. Sexual rendezvous were more spontaneous and frequently involved some risk of getting caught. For many women, sex under these conditions felt naughty, dangerous and sparked significant desire.

We weren't supposed to be having sex...we were not married and it was kind of a thrill...so that made it more exciting, more interesting and I was just more excited about it.

...it was really exciting before when we were sneaking...it was against the rules... I can see why people have affairs...it's the thrill of it...the excitement of the forbidden.

It is interesting to note the pattern in women's accounts of being sexually drawn to both men who violate rules *and* sexual activity that is considered taboo. Some participants went as far as to lament that they would never again have another sexual partner.

...once you're in a relationship, that's no longer an option. There is no longer that first kiss or that first touch. I think that's why a lot of people cheat...

Despite their current low level of desire in their marriage, some speculated that they would not have any trouble experiencing desire for a new man.

if it was some other guy, it [desire] would be higher, if I were to get a divorce and be single for awhile...it would all be exciting and new.

Not only did participants report feeling that sex was a sanctioned and unexciting act once they were married, but many felt that it became an obligation, whether they experienced desire or not. Consequently, most women reported engaging in sexual activity despite having absolutely no desire to do so. The following quotes echo the sentiments of many participants:

I don't feel like I'm giving him what he needs...I just feel like I have to keep doing it, it's like an obligation to me right now. Like, okay it's been a week. I need to give him sex or he's going to be upset...

...even if it's not something I'm really into at the moment, I'll approach him and initiate intimacy...maybe I should...it would be good for him...it is just me trying to do it for him...

Over-familiarity

Another core theme that emerged from the data was that the emphasis on closeness and intimacy within marriage, although particularly valued by women, tended to come at a sexual cost. Marriage, by nature, promotes familiarity and connectedness but, for these women, sexual desire thrived on mystery and otherness. This over-connected pattern of relating to one another affected sexual desire in several ways:

Declines in perception of physical attractiveness

Traditionally, we think of women as being less focused on physical appearance than men. However, participants reported that the focus on closeness and intimacy in their

marriages had de-emphasized the importance of more superficial but important matters such as physical attractiveness. A common reported result was that both our participants and their spouses neglected their physical appearances and this neglect appeared to impact their level of desire. Not surprisingly, women spoke about their *own* lack of perceived sexual desirability as a barrier to sexual desire. They shared that they had gained weight after marriage and felt “*fat*” and “*not sexy*.”

I've definitely put on weight. So that definitely plays a role in my sexual desire...I don't feel attractive so I don't want to be naked in front of him either.

I'm thinking like, is he looking at my boobs right now? Is he thinking how they would look if they were bigger? Is he touching me around the waist wanting my waist to be smaller? Is he seeing the cellulite on my thighs thinking 'my gosh she needs to go to the gym'?...So I'm on guard when we're having sex.

The following is a quote from a woman who wears a shirt during love making:

I am just feeling really fat and not desirable and don't want all my fat jiggling around.

Other women reported that their bodies had changed after child birth, leaving them feeling self-conscious, inadequate, and unattractive. Many women talked about their “*pooches*” and one woman was brought to tears speaking about how one of her breasts had shrunk after pregnancy and nursing:

I'm very insecure about it...it's something wrong with me...I just don't like it to be seen. It makes me feel kind of deformed... You see everybody with these perfect breasts.

Still others said that the lights had to be off or that they insisted upon certain positions to minimize their discomfort with their bodies. A number of women said they preferred to be “*on top*” because “*if I am closer to him then he can't see it,*” referring to her “*rolls*.”

Although it is not surprising that women's negative body image would be a barrier to sexual desire, what is somewhat surprising is the number of women who repeatedly

recounted the extent to which their *husband's* physical appearance impeded their desire. Participants openly acknowledged having lost physical attraction for their spouses. One woman admitted “...*I'm not necessarily attracted that much to my husband anymore.*” Like some of the women, many men had stopped attending to their physical appearance after marriage. A number of women commented that their husbands' weight gain was a sexual deterrent.

...he's put on a ton of weight and it doesn't help my sexual desire...he doesn't look like he used to...it's much lower as far as looking at him attraction-wise...I just like people who take care of themselves that way.

The following woman explains how her husband's lack of attention to grooming and, even his fatigue, make him sexually unappealing.

With his career, he has really let himself go...I still love him, but I am not as attracted to him because of it...he doesn't cut his hair as often, he doesn't work out like he used to...He doesn't try to make himself look presentable when we go out. I get sick of looking at scrubs [protective garments worn by doctors]. They're ugly and he's just always tired and his eyes are bloodshot, his hair is really long and he's really pale because he doesn't get into the sun very much...but I am not finding him sexually desirable because of it.

Overall, the way participants experienced their husbands' level of attractiveness played a much greater role in sexual desire than one might have imagined.

Dissipation of romance and mystery

It is not unusual for the passage of time and the development of intimacy to result in a decrease in efforts at romancing. Almost unanimously, participants longed for romance in their relationships and viewed its loss as central to their loss of desire. They reported that once they married, their husbands' stimulating courtship behaviors ceased. Most participants felt that a return of that earlier romancing alone would make them feel sexual desire.

I swear if there was more effort in our relationship, more romance. Make me feel special. Make me feel loved and I'll give you all the sex in the world because I would feel it.

..like playing with my hair, kissing me on the forehead, hugging me when he comes home from work. Things like that would make me...want to have sex with him...none of those things happen anymore.

Many women spoke about a desire to be *made love to* by their husbands and being disappointed by sexual encounters in this respect.

Come up to me and grab me by the small of my back and look me in the eye so that I could see that love that I know and kiss me, then it would be all over with. That would be perfect...not just the act and it's done. I know we're animals but hell, we do have opposable thumbs.

Some women added that their husbands continued to buy flowers on the appropriate occasions, such as anniversaries and Valentine's Day, but for some this felt "forced" and obligatory. Some women recalled lavish romantic productions in the past.

We went to the Bahamas...he had a sailboat chartered with its own private chef...we had music playing, we were sailing into the sunset and we had a bottle of champagne between us...he was trying to make a romantic evening out of our trip...then we got back to the room and there were like 100 candles lit and lingerie lying on the bed...

Other memories of when they felt romanced consisted of very simple gestures, as the following quote illustrates:

Like on Halloween he bought me a little scarecrow to put in my window. I thought that was the most romantic thing ever. It was probably \$2.99...

With the disappearance of romance, participants reported, so did the mystery of their partners. The familiarity of marriage appeared to force our participants to see their partners in a new and, not always flattering, light. They noted that exposure to their husbands' bad habits made it more difficult to see them in a sexual manner.

When you are first married you are real careful around each other and you are on your best behavior...when you start to get comfortable with one another, then

that changes, your bad habits come out, and your bad moods come out...that takes some of the desire away...I know that he farts all the time...It's just not as blissful of a picture. It's not as romantic.

Overall, participants indicated that the dissipation of romance and mystery in their marital relationships contributed to their lack of sexual desire.

Overly familiar sexual advances

Repeatedly, participants disclosed that their husbands' sexual initiations lacked effort and tenderness and had become a turn-off. This is another way in which the closeness created by marriage took a toll on sexual desire for participants. With the familiarity of marriage and passage of time, sweet words and subtle suggestions of love-making had been at times replaced with crude words and overt suggestions of sex, accompanied by not so welcome "groping," "pinching," "grabbing," and "smacking." One woman said, "He's always grabby, touchy on my boobs...like he's a perv...it's an ick!" Another shared, "...the groping...started to make me feel like a sexual toy." A number of women acknowledged that the very same behaviors had been, at one time, a turn-on. Therefore, some believed their husbands may have thought these gestures constituted compliments and acceptable demonstrations of how attractive they found their wives. A number of our participants had openly complained about these behavior and asked their husband to stop.

He'll just grab me...he is very rough. 'You grab me or you pinch me all the time, you grope me...and I can't stand it!'

Some women said they experienced the language their husbands' used in regard to sex to be an even bigger turn-off. One woman said that on more than one occasion her husband initiated sex by saying, "Can I poke you tonight?"

Mechanical sex

Another unfortunate effect of the familiarity of marriage was that it made sex routine and mechanical. Women said that they initially welcomed the idea that their partners knew their bodies well. After all, it is comforting to be with a partner who knows how your body responds and can please you. Over time, however, this comfort was replaced with boredom and predictability for a good number of our participants.

Sex is boring...so fucking boring

We just kind of did the same thing over and over...there was nothing different...the same thing every time.

Sex was enjoyable but so was eating chocolate cake...there's not that passion anymore...because we don't do anything new.

Repeatedly, women reported that both they and their husbands de-emphasized technique during their sexual encounters. They spoke about a lack of attention to foreplay, including hugging, stroking, kissing, manual and oral stimulation. Participants also suggested that sex had become overly orgasm-focused. One woman commented:

He knows what it takes for me to orgasm and he's going straight for that...there's no caressing...kissing or foreplay...he's going straight for the dirty...let's get it over with so I can orgasm.

Not unsurprisingly, when foreplay was ignored and women felt pressure to orgasm in the context of their already low desire, participants reported experiencing little pleasure and orgasmic difficulties.

When we have sex it lasts fifteen to twenty minutes...And all I can think is 'hurry up and cum so that we can get on with the day, hurry up!'...I can't even orgasm...I say I'm just stressed or I make something up.

One woman reported that she and her husband had fallen into a scripted sexual routine that never, ever, varied.

Like a routine way of going about having intercourse and foreplay...I can really just be there with him and tell you the moves he's going to make step-by-step...it's just one through four every time, that's what you get.

Lack of individuality

A final way that the familiarity of marriage dampened desire for participants was by creating a sense of social isolation. Participants made it clear that their husbands and families had become their priority. As a result, they had stopped nurturing outside friendships and interests. These women craved social interaction and a purpose outside of their roles as mother and wife. One woman actually agreed to do some of her husband's chores in order for him to "baby-sit" their children so that she could try out a home business. She spoke of their arrangement:

I need something else. I need adult interaction that doesn't revolve around talking about disciplining or somehow raising our children...a couple of hours a day I just put my mommy hat on the table and walk away...

Another participant echoed:

I go through my day being mom and cleaning, doing stuff...for everybody. I don't really do...things for myself. I don't really have any hobbies. I don't sit and read a book...If I could have some more time to myself then maybe I would want more time with him.

De-Sexualized Roles

The third and final core theme that emerged from the data is that the various de-sexualized roles that the women held were overwhelming and preoccupying. Participants found it very difficult to see themselves in a sexy and romantic light outside the shadows of their roles and independent of their responsibilities as wives, mothers, and professionals. It became a challenge for them to maintain sexual personae, to lose themselves in a sexual moment and consider themselves someone outside of their daily roles and responsibilities.

The “to do” list

A common expression heard throughout the interviews was “my ‘to do’ list.” Women felt bogged down by the burdens of everyday life and the obligations that accompanied their numerous non-sexual roles. For a number of women, the things on their “to do” lists preoccupied their thoughts and served as a cognitive distraction from sexual concerns.

I just feel there are certain things in a day that I want to do and if I haven't done all that I can't focus on him...I know I need to make him one of those things on my list...I would have to be without outside factors like those things I need to get done

Overwhelmingly, participants reported that sex was not a priority for them. One woman said, “I’m a wife last...” Another stated unapologetically:

Sex is just... not the priority right now. I would rather make sure the bills are paid, clean the house, I'd rather do things that need to get done.

In fact, a number of women said that sex was just too much work.

I have so much else to do...it's like another chore added to my list...something I have to do to make my husband happy

If we have sex there's more to clean up - I have to wash the sheets. If I go down on him I have to brush my teeth and use mouthwash after.

When we have sex it's like it's time to clean the pipes. He has to release. Today's the day, let's get it done, move on...

Amazingly, one woman likened sex to cleaning toilets!

Now it feels like sex is something that has to be done, like cleaning toilets or things like that.

Because sex was viewed as work, on the occasions that participants needed a sexual outlet, a significant number of them felt it was easier to masturbate than engage in sex with their husbands.

It's better to masturbate because it's fast and with my husband it goes on and on and it's like, are we done yet? It takes too much time that we don't have and I'm tired or want to go to sleep and there are other things that we should be doing or the house needs to be cleaned.

Women had specific concerns other than chores and their “to do” list, also. Specifically, work stress and financial worries served as barriers to sexual desire.

...we can never get our heads above water enough...the stress, the fighting, the worrying about money...then you hold grudges and you lose all desire.

An obvious consequence of the multiple roles that individuals are juggling is the lack of quality time couples have to spend together. Several participants reported that they were going to bed at different times and at least three of the couples regularly slept in separate beds, reportedly because of questions of physical comfort and snoring issues. It is also equally plausible that the participants' lack of desire had triggered marital discord which couples found easier to avoid by sleeping separately. Indeed, one woman relayed a nightly struggle with herself.

...I have a hard time sleeping. I get teary and I think to myself if I would just roll over and love on him, I wouldn't feel this way...why is it so hard?

A stock initial theory that participants offered for not wanting sex was that they were too tired. They described full lives that could certainly interfere with the timing of sex. However, in all cases, as participants continued to discuss with us the reasons for their lack of desire, they acknowledged that they had always found time before. More often than not, they discounted their own theory that fatigue was a causal factor. Fatigue, however, did not help. One mother said:

I work full time..I get home and we're doing homework and cooking dinner. And then at night when the kids are in bed, I'm just too tired to do anything...

Another woman made no apologies for her priorities, *“It’s more important for me to get sleep than to satisfy him.”*

Similarly, when desire is absent, sex becomes something for which there is little motivation to make time. It is not hard to understand that, for women who lack desire to engage in sex, the motivation to make time is low when time is already stretched so thin. One participant who worked full-time and attended school noted, *“There wasn’t a lot of time where it was appropriate...it just seems like we’re pressed for time.”*

Multiple Role Incompatibilities

Women have a number of different roles and wear several different hats on any given day. They are wives and mothers and professionals and lovers. Participants reported that their de-sexualized roles competed with their role as lover and blocked sexual desire.

It crosses my mind when I’m having sex.. I’m a mom, I’m not supposed to be sexy. And I can’t go from mom to sexy horny vixen – you know that’s a long distance.

Participants also reported having difficulty transitioning from one role to another. This was most salient for the transition from mom to lover and vice-versa. The following woman expressed feeling an incompatibility in her roles as wife and mother and a struggle to transition from these roles to that of lover. Interestingly, she also noted often feeling more like a mother to her husband than a wife. Not unsurprisingly, this did not leave her feeling “in the mood”.

I feel like I’m 90% mom and 10% wife. Half the time I feel I am my husband’s mom too. It’s hard to go from ‘mom, I need this’ and making dinner and cleaning up and doing laundry and changing diapers and then all of a sudden he’s in bed and I’m supposed to rip my clothes off and just feel like a sex-pot. I just can’t transition like that.

Women suggested that having children affected their sexual desire in many ways. Many stated that their focus had become on their children rather than on their relationship. One

woman felt that her obligation as a mother came first and that there would be time later to focus on her husband.

My mentality is that when you have kids...your whole life is the kids and then once you get the kids off, then you focus on hubby.

Others worried about their children intruding or otherwise learning about them having sex.

I am worrying if my kids are gonna wake up and walk in...my brain is constantly going.

If I go down on him and he cums in my mouth, then I'm going to have that smell and I worry about the kids waking up...in the middle of the night and smell this weird smell on my breath.

Although there is a stereotype that women want their husbands to be affectionate and cuddly, a good number of participants raising small children felt over-touched. At the end of a long day, they yearned for “space” and “alone time” rather than affection or sexual touching.

I have three young kids tugging on me, hugging on me and when they go to sleep I just don't want anybody touching me – even when I agree to do it, I don't even want cuddling.

Almost all of the participant mothers commented that having children made it difficult to spend quality time alone together.

Date night...we haven't done it in two months because we don't have a sitter. It gets to us...we both get frustrated.

I won't even have a couple of drinks with my husband. I'm always afraid something is going to happen with my son.

Another way that the role of mother affected participants was that they reported a new sense of discomfort with sexual attention. Dressing for and attracting sexual attention suddenly felt “dirty” and “inappropriate.”

I used to go out and dress up and think I'm some hot little number walking down the street and I just don't feel that way anymore. I'm a mom and I shouldn't be dressing like that.

Overall, the various roles held by women distracted them from their sexual selves and created a significant barrier to sexual desire.

Lack of desirability

A common theme throughout the interviews with participants, with and without children alike, was the experience that their non-sexual roles left them feeling a lack of perceived sexual desirability. That is, women stated they no longer felt sexy and desirable.

I don't want to take my clothes off and strut around. I don't feel like my body is desirable.

Several participants talked about a change in their manner of dress after they got married and/or had children. One stay-at-home mom explained:

I have no reason to get dressed up...When you get dressed up and you have fluffed your hair you feel more attractive...I wear jeans. I wear sweats...I only get dressed up if we are going out somewhere.

Others started dressing in a less provocative manner. For some women this change was self-imposed because dressing provocatively didn't seem appropriate for a wife or mother. For others, their husbands requested that they dress more conservatively. All of the women who raised this issue noted that they felt less sexual desire following this seemingly cosmetic change.

I used to not wear bras all the time and wore tank tops...I had a lot of half tops...now those wouldn't be okay...when I wear some of the things that are closer to that now I feel more sexy.

Surprisingly, women were not at all comforted by their husbands' reassurances about their sexual desirability. A large number of participants reported that their husbands told

them regularly that they were attractive and sexy. However, women perceived these compliments as disingenuous because, after all, their husbands wanted to have sex. What they missed, and found to be a more credible measure of their desirability, was external validation from other men, in the form of a positive glance, smile, or nod of the head.

Being at home all the time, I don't get feedback from other guys looking at me and stuff. And that's important.

Consistent with the DSM-IV definition of HSDD, none of the participants actively fantasized about sex. Because they were unable to see themselves as sexual and feel sexy, they were unable to suspend reality or create an illusion long enough to engage in fantasy or sex play. Only a few of them had ever tried. One woman recalled a failed attempt:

... 'hey why don't you be a strip dancer' ...all of a sudden I'd start laughing and he'd start laughing and we couldn't finish...this is freakin hilarious.

Impact of HSDD

Although the purpose of this research was to generate women's own attributions about loss of sexual desire within marriage, the importance of the impact of HSDD cannot be overlooked. The data suggest that with the loss of desire, participants developed very negative emotions surrounding sex and viewed it in a very aversive way. A pattern developed whereby participants dreaded having sex and tried to avoid situations that could conceivably lead to sex. However, they also felt guilty for not having sex. When they occasionally gave in, some of them experienced a wide array of negative emotions after sex, including confusion, frustration, disappointment, anger, and disgust. These negative emotions only served to reinforce the reasons they did not want to have sex in the first place. Others felt better following a sexual encounter. They were glad it was over and felt relieved to be "off the hook" and not expected to have sex again for

awhile. What can be inferred from the data quite intuitively is that when participants had sex without wanting to, it didn't feel good. What follows are some characteristics of sex, according to participants, when it was not desired:

Discomfort with Sexual Experimentation

Although participants reported that marital sex had become boring and routine, they also reported they had difficulty with sexual novelty and experimentation. Experimenting sexually with their husbands felt “dirty” and didn't fit with their married self images. One woman explained, “*I just don't see myself trying different things. I just don't see myself like that.*” Another woman described her husband's attempts to spice up their sexual relationship:

He really likes to be dare-devilish...I feel dirty and gross...I don't want to really use toys or porn...I feel so eww about it.

Others were afraid to suggest new ideas in the bedroom for fear of judgment from their husbands or what it might say about who they really are.

I've tried to be more adventurous but there's a part of me that feels I shouldn't be doing this. Being kind of nasty increases my desire but it makes me nervous because then I think 'how much nastier am I going to get?' And I worry my husband is going to think that what he's giving me is not good enough.

Essentially, participants said that “regular” sex was unappealing but that “kinky” sex was alienating.

Squeamishness

One very common and surprising finding was that of participants' squeamishness about sex. Women spoke repeatedly about developing a new sensitivity regarding hygiene in the context of sex. Most women *did* recognize and report that this was a new development, that they had not felt that way when they were in the heat of passion earlier

in their relationship when they had sexual desire. Of course, it is impossible with the current data to determine if, indeed, the decline in desire predated the squeamishness or vice versa; however, participants' stories certainly suggest the former. They appear to suggest that once sexual desire was gone, attention turned to mundane details and that aspects of sex that may even have once been turn-ons became turn-offs. For example, the thought of the "wet spot" on the sheets made a number of participants shudder. For these women, every episode of sex meant they had to wash the sheets. Participants' squeamishness was not only limited to the "wet spot," though. They were sensitive to their partners' breath, body odor, and other secretions. Essentially, the messiness, the smells, tastes, and sounds associated with sex had become aversive to them in a way that it had not been before.

It just has to be really sanitized...there is always a towel laid out so everything is collected and, afterwards, you know there is this whole ritual of keeping clean. And I prefer it after a shower. I don't like to do it before a shower. I like to be clean and I like him to be clean. I didn't have these preferences when I was young, though.

I particularly don't like to go down on him because I don't like the way it smells. I don't let him kiss me after he goes down on me. I particularly don't like that!

One woman, whose husband was in the military and often polished his boots was turned off by his finger nails. She said, "*He doesn't keep his nails very clean...it's just gross.*"

Most participants reported that they no longer engaged in deep kissing either. One woman who said that deep kissing would be worse than having sex, recalled:

As far as me coming home last night and seeing him asleep, like, with his mouth open, I'm right away thinking, 'oh, that wouldn't be something I would want to do' ...I'm very much like clean, clean, clean...it's like the breath thing.

Decreased overall affection

An unfortunate corollary of lack of desire was that participants engaged in less overall physical affection, such as hand holding, cuddling, hugging, nonsensual kissing, and even touching. They feared that any initiation of physical affection would be interpreted as a sexual overture.

I feel myself closing off from him...I don't run up and kiss him when he comes in the door...then he's going to get aroused and he's going to want sex.

Ironically, the non-sexual attention women were avoiding for fear that it might lead to sex was what many most yearned for. If the threat of sex could be removed they would have luxuriated in this affection, but affection had become threatening. It had become a marker or a gateway to the one activity they did not want – sex. Ironically, if the affection had been separated from the sex, it is possible, and even probable, that engaging freely in this affection might have resulted in an increase in sexual desire for these women.

Fears of infidelity

Participants expressed concern that their spouses would not remain faithful to them because their sexual needs were not being fulfilled. Interestingly, women seemed to have developed a sense of how long they could put off sexual relations before it was “too long” and their husbands became “frustrated,” “grumpy,” or “nasty.” Several women stated that they worried their husbands were vulnerable to having an affair because their sexual needs were not being met at home. The following woman shared her concern:

I worry that he's going to cheat on me...if a chance ever presented itself, if a girl ever came onto him and made him feel desirable...I would be afraid of the choice he would make.

In one sense, for these participants sex became necessary act to prevent their husbands from being unfaithful. It had become the cost of keeping their husbands.

Guilt

On a related note, for many participants sex was imbued with feelings of guilt and was often engaged in simply to relieve a guilty conscience. Participants stressed that they felt they were letting their husbands down by not wanting to have sex. For the most part, women described committed and loving relationships. Most volunteered that they valued their marriages tremendously and had no intentions of leaving their husbands. They expressed remorse for the way their lack of desire affected their husbands. Common sentiments included “*I don’t feel like a good wife,*” “*I should want to have sex with my husband,*” and “*I don’t want to keep rejecting him.*”

Feeling abnormal and misunderstood

Participants consistently reported that they felt something was wrong with them because they had no sexual desire. They had no idea about the high prevalence rate of HSDD in women. Some had even expected to become more sexual in their 30’s as they had heard that this was the age at which women peaked sexually. Several participants cited *Sex in the City* and other media references as standards of comparison. They wondered why they had no desire at all. They reported feeling alone, misunderstood, confused, and helpless. One woman described the various emotions she experienced after she ignored her husband’s sexual advances.

I imagine other people have this desire and I feel like I should have some...it brings like bad feelings from both sides...I want him to understand how I am doing, but I know that he’s feeling rejected or like something is wrong with him...then I’m sitting there frustrated like something is wrong with me too...But I need him to understand and I want him to sympathize...I want him to let me know it’s okay or we’ll figure something out...I don’t even understand myself. It’s just frustration and I’m crying. I’m just totally frustrated.

Many participants shared that they had difficulty communicating their feelings about their loss of desire with their husbands. Understandably, spouses of women with HSDD experienced their wives' loss of desire as a reflection on them.

I know that I make him feel unattractive...I hurt him. He says to me 'are you not attracted to me anymore?' He wants me to want him.

Most participants were also reluctant to talk to friends and, even doctors, about the problem because they were embarrassed. The result was that most women were left feeling abnormal and with little emotional support. These feelings only further added to their lack of desire.

Summary

The current data support three emergent core themes which act as barriers to and weights bearing down on the experience of sexual desire. They are the *institutionalization of relationships*, *over-familiarity* with one's spouse, and the *de-sexualization of roles*. The data also support the deleterious effects of low or no female sexual desire in the lives of married men and women who are confused and distressed about its impact on their self-perceptions and on their relationships. Working directly from this data and our thematic organization of it, we ventured to propose what conditions might be optimal for female sexual desire to thrive within the context of marriage and its attendant realities. This extension of our emergent themes represents a speculative extension from the data which would require further qualitative investigation to confirm. More specifically, it would require a sister study of women who have not lost sexual desire for their husbands in the context of marriage.

Toward the development of a psychosocial theory of female sexual desire

The data revealed a number of intriguing paradoxes that led us toward the speculative development of a model of female sexual desire. A number of our participants recounted enjoyable pre-marital sex lives that were very active, adventurous and quite experimental. Yet during those periods of experimentation, these women were hoping to meet their future husbands. They were searching for the very situation in which they found themselves when we interviewed them, married with children, committed, and secure. In addition, our participants often expressed that their sexual desire had been at its peak when sex felt forbidden and naughty. In contrast, marital sex felt mechanical and boring. Yet, engaging in activities to re-capture its illicitness left them feeling either silly or “dirty”. Additionally, participants craved closeness with their husbands, to be known intimately and feel understood, yet this intimacy took a sexual toll. They yearned for “alone time”, they missed the attentions of strangers and they deeply felt the loss of their individuality – the part of them that was nobody’s wife or mother. And yet being somebody’s wife and mother was so important to them and so valued that it overshadowed their development of sexual personae. None of them expressed a desire to live a life driven by lust and sexual abandon. This series of paradoxes led us to the consideration of an intriguing possibility - that perhaps female sexual desire could thrive somewhere between these polar opposites – that perhaps the nurturing of female sexual desire within a marriage required achieving a balance between opposing drives, the drive for security, connectedness and purpose and the drive for excitement, autonomy and recreation.

Based on the processing of the aforementioned paradoxes, we propose the following speculative model of the ideal conditions for the nurturance of female sexual desire in long-term relationships. We suggest that female sexual desire may exist on a continuum along three separate dimensions and that, for any one woman, sexual desire may optimally thrive somewhere between the two poles on each of the dimensions. The dimensions, which developed directly out of the current data, are *structural*, *role*, and *relational* (for a schematic representation of this proposed model, see Figure 2 below).

A Three Dimensional Psychosocial Theory of Female Sexual Desire

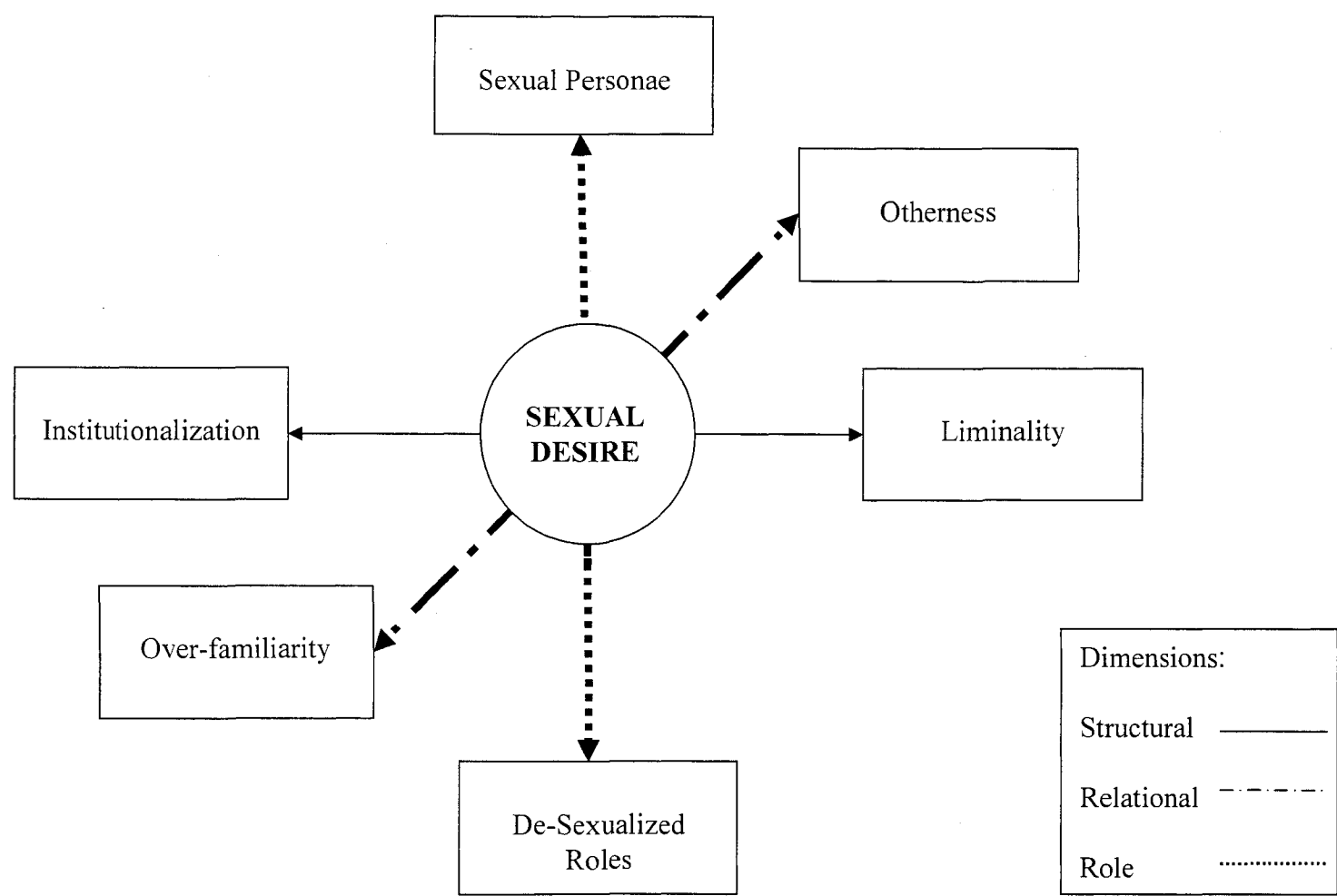


Figure 2

The *structural* dimension, which characterizes the structure of the relationship, is anchored on one end at institutionalization and on the other end at liminality. For the purposes of our model of female sexual desire, institutionalization refers to the highly organized, rule-governed, expectation-heavy conceptualization of what a long term romantic relationship develops into. Our participant narratives were rich in what that relationship looked like. Liminality (a word borrowed from anthropology referring to a stage in coming of age rituals characterized by ambiguity, openness and indeterminacy – a stage when it is permissible to temporarily break societal rules) is meant in this model to refer to a state that is characterized by a complete relaxation of rules and obligations, a state in which anything goes in the pursuit of pleasure. In regards to female sexual desire, the pole of liminality would represent behavioral openness, sexual freedom, and self-exploration, largely devoid of responsibility or long-term commitment.

The *relational* dimension, which describes the quality of the marital relationship, is anchored at one pole by extreme familiarity and on the other pole by a completely separate otherness. The familiarity pole in this model refers to that state in which the relationship between two people has become so enmeshed and intertwined that there is no longer a sense of each person having a life that is separate from the other. In this state of over-familiarity, there are no boundaries between one person and their partner. There is no longer any attempt at decorum or at protecting certain aspects of one's life from a full invasion by the other person. The emphasis is on love and intimacy and there is no significant appreciation or valuing of autonomy and separateness. To borrow a term from David Schnarch, the couple has become emotionally "*fused*." The otherness pole represents the opposite extreme in which there is a lack of connection and in which two

people come together solely to satisfy their own needs with little concern for or knowledge of their partner. This pole implies little intimacy and the interpersonal interactions that typify the proverbial “two ships that meet in the night.” It infers that individuals put their own interests and needs above all else and pay little attention to the well-being of the couple or family.

Finally, the *role* dimension is anchored at one end by desexualized roles and on the other by sexual personae. *De-sexualized roles* is a term used here to describe what occurs when women define themselves entirely by their non-sexual roles and lose touch with their sexual selves. As we witnessed in the data collected for this study, women see themselves as mothers or wives or housekeepers or household managers and have difficulty integrating sexuality into these roles. The polar opposite of de-desexualized roles would be a woman for whom her *sexual persona* is so central to her self-concept that that she is willing to neglect her non-sexual obligations in order to pursue the gratification she gets from sexual attention and the creation of desire in others and in herself.

The proposed model of female sexual desire suggests that sexual desire may best thrive somewhere on a continuum between the extremes described for each of the three dimensions of desire. Rather than being anchored in the “safe side” of the continuum, female sexual desire requires a balance between opposing impulses. That is, each woman requires a delicate balance of comfort and freedom, of security and risk, of intimacy and individuality. In other words, female sexual desire may live best in that space between “madonna” and “whore”. At the very least, our data suggest that the “madonna” pole is

not an erotic one for women. Our speculation is that neither is the “whore” pole, at least not for very long.

When the balance is disrupted or never achieved on any or all three of the dimensions, loss of desire may be the result. The exact nature of that balance is likely to be different for every couple and for every woman. That calibration would most likely be an individual calculation and it would be expected that over the course of a lifetime the balance would be upset by myriad factors and require frequent recalibration. What is clear is that all of the women in this study lacked that balance. Indeed, all of the participants in the current study functioned sexually at the far left end of the spectrum, where family, closeness, and non-sexual roles were central and sexual relating was infrequent or altogether absent (see Figure 3 below for a schematic delineation of the side of the spectrum on which the women in this study fell). Perhaps for women with HSDD, the pendulum has swung too far along all three of these dimensions, wrecking havoc on sexual desire.

A Three Dimensional Psychosocial Theory of Female Sexual Desire: Current Study

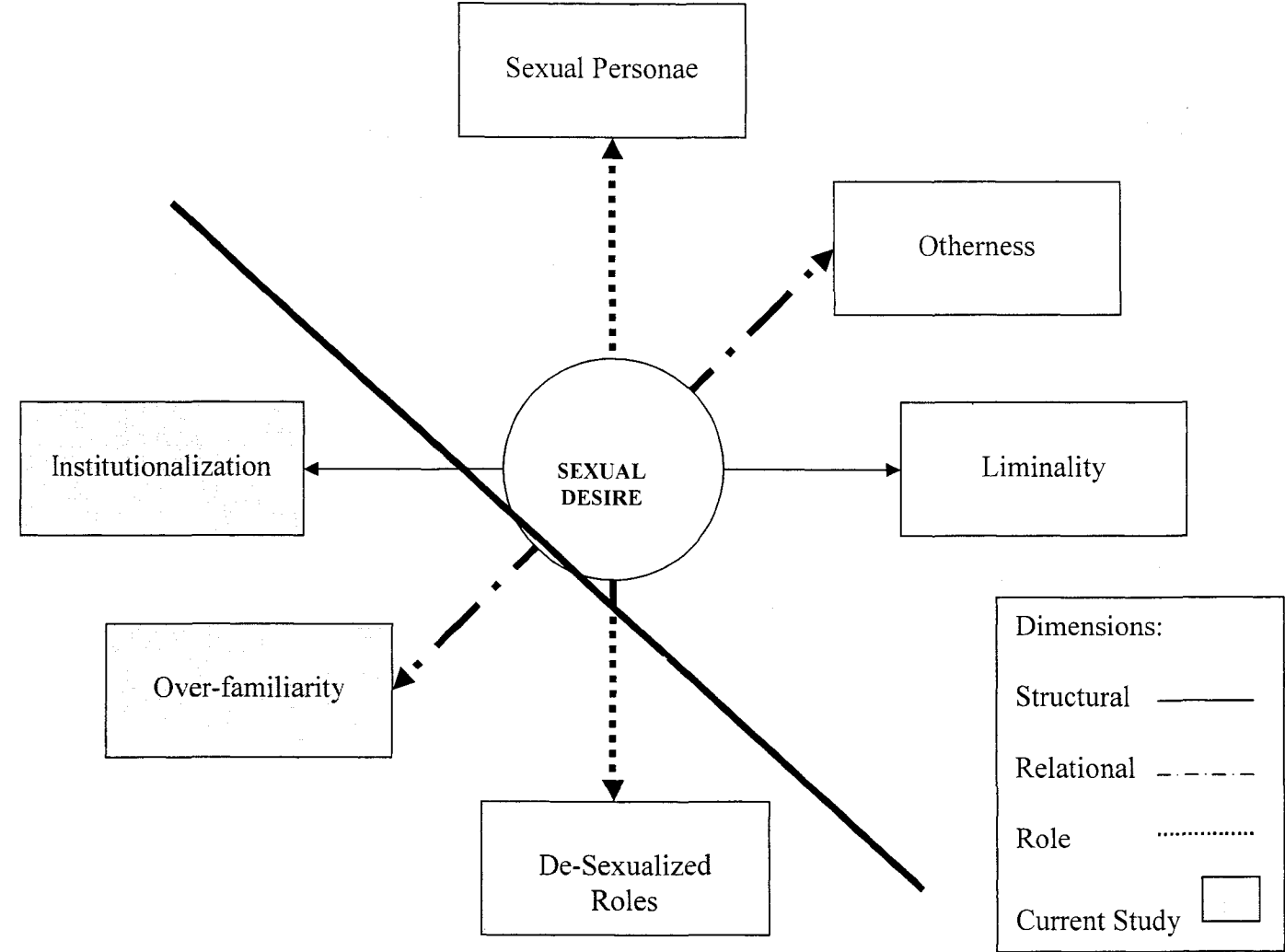


Figure 3

CHAPTER 5

DISCUSSION

For many years, theorists and clinicians embraced a motivational model of sexual desire wherein desire was considered an innate and primarily biological appetitive drive that individuals sought to meet. No gender differences were posited in the motivational nature of sexual desire other than perhaps one of magnitude. Like all other drives, sexual desire was governed by the avoidance of discomfort and the pursuit of pleasure. It was assumed that in the absence of some physiological condition or deep-rooted psychological conflict, women would seek out sex and entertain sexual fantasies to satisfy this hedonic impulse (e.g. Freud, 1938; Kaplan, 1977). More recently, high prevalence rates of HSDD and poor treatment outcomes have led some theorists to suggest that our very definition of female sexual desire may be flawed in its reliance on a male-centered, motivational conceptualization of desire (e.g. Basson, 2001a; Tiefer, 2002). They have proposed a relational framework to better account for female sexual desire which, rather than reduce desire to a biological function, emphasizes context and the interpersonal dynamic between two people. This shift in the field was long overdue and a welcome departure from the previous reductive, motivational conceptualization. However, our data suggest that the relational framework alone may not be any more successful than the motivational one in accounting for female sexual desire. We speculate

that perhaps female sexual desire exists at an intersection of hedonic and relationship factors.

Desire as Drive and the DSM-IV

In the 1930's, Havelock Ellis and Sigmund Freud were among the first to consider sexual desire as an innate, biological drive (Ellis, 1933; Freud, 1938). In fact, Freud suggested that sexual desire, or libido, was the motivating force behind all human behavior (Freud, 1938). Masters and Johnson also assumed desire to be a natural human drive which led to a predictable response pattern, in the absence of pathology. They so took for granted that sexual desire was a natural drive that they did not even attempt to account for it in their proposed sexual response cycle (excitement, plateau, orgasm, and resolution). Women who did not experience spontaneous desire were thought to have brought it on themselves. Because of emotional conflict, they were not allowing themselves to function sexually (Master's & Johnson, 1970). In the 1970's, Helen Kaplan formally introduced desire as a stage in the sexual response cycle but she also subscribed to the belief that it was an appetite. She suggested that it sought to be expressed in order to restore emotional equilibrium and was of the opinion that desire problems were deeply rooted in anxiety. She later made the observation that inhibited desire was at the center of many sex therapy treatment failures but this did not lead her to revisit her motivational conceptualization of sexual desire (Kaplan, 1977, 1979).

More than 20 years later diagnostic criteria in the DSM-IV for HSDD were still deeply entrenched in biological origins. Sexual fantasies and spontaneous desire for sexual activity were assumed to be the norm in the absence of a physiological abnormalities or medical conditions (APA, 2000). Frustration among couples and those

whose help they sought escalated. Understandably, even though evidence suggests that most women with HSDD have nothing physically wrong with them, physicians and women themselves began looking for the female counterpart to Viagra (Heiman, 2002). Herbal products that promise to “kickstart libido” and “restore female sexual desire” started to fly off the shelves.

The Relational Revolution

The suspiciously high prevalence of HSDD in women, the growing medicalization of female sexuality, and the recognition that we were not successfully treating couples with low sexual desire prompted a number of theorists to question our very definition of female sexual desire (Tiefer, 2001b). With HSDD affecting as many as one in three women, it seemed quite likely that the motivational framework, in which female sexual desire is considered an innate drive, was not accurately reflecting its true nature (e.g., Basson, 2001a, Tiefer, 2002). Perhaps the difficulties lay in the generalization of a male model of sexual desire that was not appropriate for women *because* of its decontextualizing emphasis on desire as a biological drive. After all, sex takes place within human relationships and in a social context. Why then, should it be reduced to a biological function (Tiefer, 2001a; 2001b)?

Over the past ten years, these concerns have created a momentum away from conceptualizations of female sexual desire as a biological need to a relational framework wherein female sexual desire is governed by the relationship and interpersonal dynamic between two people. In particular, Rosemary Basson has advocated a model based on receptivity, emotional health, and intimacy. She has suggested that although women in long-term relationships may not often experience sexual desire spontaneously, most

experience receptive sexual desire – that is, they feel desire in response to their partners' sexual advances. In other words, feeling desire in response to the other's initiation rather than initiating because of a spontaneous drive for sexual activity is probably a more realistic measure of normative desire in women, especially those in long-term relationships. Basson does not believe that women whose desire is characterized primarily by receptivity have HSDD at all. In fact, she has argued that not recognizing this important sexual dynamic in long-term relationships has resulted in the field pathologizing what may actually be normal for women (Basson, 2001a, 2002b). Basson further argues that women require appropriate sexual stimuli and emotional connectedness to be either spontaneously or receptively desirous (Basson, 2007).

Other sex therapy theorists and clinicians have also acknowledged the possibility of these hypothesized gender differences and stress the importance of emotional intimacy for female sexual desire. In his work with couples, Stephen Levine found that women's desire was highly vulnerable to interpersonal influences within the couple. He wrote eloquently about the different reasons that men and women seek sex. "*Women aspire to psychological intimacy as a gateway to sex. Men aspire to sex as a gateway to intimacy*" (Levine, 2002). Barry McCarthy also found that his female clients' sexual desire was dependent upon them feeling good about their spouse and their life. He noted that, although women value emotional intimacy over sexual intimacy, men tend to value sexual intimacy over emotional intimacy (McCarthy, 2003). In other words, it may be more important for women to be getting along well and feel connected with their husbands, whereas it may be more important for their husbands to feel satisfied sexually. Studies in which men and women were asked what they think generally turn men and

women on have evidenced results consistent with these theorized differences. Both men and women perceived that women are turned on by quality couple time and by romance while men are turned on by sexual fantasies and visual sexual stimuli (Regan & Berscheid, 1995).

The movement toward stressing the importance of relationship factors in female sexual desire was a positive one and long overdue considering the lack of fit between the strictly motivational model and most women's experiences. Consideration of context and connectedness was a welcome departure from the previously more male "male-centered" definition of desire. Our data suggests, however, that the pendulum may be swinging too far. A model of female sexual desire that lies strictly in the relational realm may also be missing the mark.

The Motivational/Relational Dilemma

We interviewed married women who had little or no sexual desire within the context of self-defined close, committed, and intimate relationships. All of the women in our sample stated that they loved their husbands and valued their marriages greatly. None of the women in our sample had either spontaneous nor receptive desire. Their narratives did not bemoan their lack of spontaneous desire but rather their lack of receptive desire. They had ample opportunity to exhibit receptive desire as their husbands continued to make sexual advances. The majority of the time, though, they shrugged off their husbands' attempts. This was not simply a matter of not feeling a sudden urge to have an afternoon roll around in the sheets while the kids napped. It was a dread of the sexual advances and, in many cases, active avoidance of any activity that might lead their husbands in that direction. Some did complain of the appropriateness of the sexual

advances and maybe we could speculate that if their husbands came on to them in just the right way and offered to help fold the laundry first, they may have warmed up to the idea. But our data suggests not. Many of these women said they would rather fold the laundry than have sex. Often times when they did acquiesce it was done out of a sense of obligation. Said bluntly, it was “pity sex.”

Our data suggest that most of the sexual desire barriers relatively happily married women identify may be strongly related to commitment, intimacy, security and love. Our data suggest that relational factors may be important but in a very different way than suggested by the new relational approaches to understanding female sexual desire. In short, some of the consequences of close and committed relationships acted as forces pulling down on female sexual desire. The institution of marriage with its emphasis on responsibility and commitment, the non- or even anti-erotic nature of many of the important roles in these relationships, and the familiarity that is often endemic to intimacy were seen by our women as interfering with their sexual desire. From this data, we speculated that perhaps a conceptualization of sexual desire that combines elements of both the motivational and relational perspectives may be more fitting.

Women find themselves in an interesting predicament. As our data shows, they have competing needs that present them with a number of dilemmas that, if not well negotiated, can lead to desire problems. In her book *Mating In Captivity: Reconciling the Erotic and the Domestic*, Ester Perel (2006) comments from a clinical perspective, about some of these dilemmas. On one hand, marriage is a serious business. In many homes, it is a well-oiled machine that operates efficiently in order to accommodate two careers, getting the children to school on time and homework accomplished. There are healthy

dinners to be made, a home to clean, doctor's appointments to attend to, Little League practices, retirement to plan, and college tuition to worry about. Sex, on the other hand, is frivolous and playful. Questions such as "*Can you take the dog to the vet today?*" and "*Do we have enough life insurance?*" don't exactly lend themselves to fun and frivolity.

Of course, marriage is an equal opportunity employer and the responsibilities associated with it could just as easily take a toll on men. Although men do not suffer as much from HSDD as do women, there is no reason to believe that that these desire-dampening forces in married life do not have a similar effect on them. The reason it does not as often result in a loss of desire may have more to do with gender differences in the magnitude of sex drive (Baumeister, Catanese & Vohs, 2001). Furthermore, according to Baumeister's theory of female sexual desire as more socially and contextually dependent than male sexual desire would predict that the new roles and responsibilities associated with marriage might take a greater toll on women's desire. In fact, he suggests that women are "*creatures of meaning*" and, if that is the case, it appears from our study that for women with HSDD, the meaning of marriage has become more about responsibility and taking care of business than about romance (Baumeister, 1999).

Intimacy may also pose as many barriers as incentives to desire. Though love thrives on closeness and familiarity, sexual desire may require a certain degree of distance and mystery. Intimacy can result in emotional fusion. The concept of fusion is at the very center of David Schnarch's (2000) theory of sexual desire. From his perspective, couples become emotionally fused when they do not maintain enough separateness, or differentiation. It is this emotional fusion that Schnarch theorizes to result in low desire. Only through differentiation, he maintains, can couples experience true desire for one

another (Schnarch, 2000). Unfortunately marriage, especially when children are involved, is a breeding ground for emotional fusion.

Another paradox that may impact women's sexual desire lies in our culture's mixed messages regarding women's sexuality. On one hand, sex is everywhere in the media. The message seems to be that "*everyone is having it*" and if you are not, then you ought to be. Plastic surgery to make oneself more sexually appealing has soared in popularity. Programs such as "Sex in the City" and "Desperate Housewives" tout a very active and licentious female sexual drive. Yet, this very same culture is grounded in sexual conservatism in which Puritan values endure. We are moralistic, judgmental, and quick to point the finger at those who stray from traditional "family values." According to Perel (2006) this results in a profound disconnect between what is promoted and what is allowed. Women are left with the daunting task of trying to reconcile these competing values about sexuality. Is it any wonder so many women are not able to do so successfully? What woman has not heard men complain that women send them mixed messages about sex? One reason may be that women give their partners mixed messages because they themselves are trying to navigate amid two competing messages about sex.

A more essentialist potential explanation for the motivational/relational dilemma may be that it is socio-evolutionarily adaptive. Not easy, but adaptive. It could be that women require these competing drives to maximize their reproductive capacity. The motivational, hedonistic end of the spectrum may serve as the engine to procreate while the relational, security-based end of the spectrum may serve as the engine to ensure the viability of offspring. While it may be adaptive for men to seek sexual activity with a spontaneous vigor we do not typically see in women, this short-term strategy would not

be as adaptive for women in the long-run (Buss, 1998). So, perhaps married women who are distressed by their waning passion are in some sense pining for the sexual strategies that secured them their spouses but which seem to have abated, if not altogether disappeared, with time and, more importantly, security.

Clinical Implications

As theorists have begun re-visiting conceptualizations of female sexual desire, treatment approaches have also changed. The resistance of HSDD to therapeutic interventions may be due, in part, to the fact that sex therapists have been working under the premise that low female sexual desire is a function of relationship factors such as a breakdown in communication, anger, built up hostility, and unresolved marital conflict. Although a handful of our participants reported these problems, they were rarely the major reasons offered for lack of desire. Obviously, when marital conflict is significant, it makes intuitive sense that a woman would not want to have sex. It also stands to reason that these conflicts would take a greater toll on a woman's sexual functioning in light of what we know about the importance of interpersonal factors for women, relative to men. However, there may be a much larger group of women with HSDD for whom marital conflict does not appear to be a significant contributing factor. Most of the women in our study would fit this profile.

Of course, all married couples have conflict and it is difficult to tease apart what types of arguments separate women with HSDD from those without. We are proposing that clinicians who find themselves treating a couple in which the woman has HSDD may be wise to consider a relational-motivational approach to treating HSDD and seriously consider that lack of emotional connectedness may actually not be playing a role at all.

Clinicians should not abandon drive theory but rather combine elements of both approaches to tailor strategies and treatment techniques to suit each couple profile on the motivational-relational spectrum. It would appear that women are just as turned on as men are by physical attractiveness, anonymity, illicitness, and excitement. Not only should these drive-based elements be given equal weight for women, they may be even *more* important for women. There is an extensive literature to suggest that female sexual desire is inherently weaker than male sexual desire (e.g. Baumeister et al, 2001; Beck, Bozman & Qualtrough, 1991; Laumann et al, 1994). That drive magnitude discrepancy may paradoxically predict that female sexual desire requires *more* stimulation than male sexual desire to be maintained, especially throughout the challenges of long-term relationships (Meana, 2007).

Treatments to help women tap into these drive-based elements and assist couples re-kindle desire will require creativity on the part of clinicians. Ultimately, any new treatments based on the model of desire we are here proposing will have to be empirically validated to see if there is any measurable impact on sexual desire. However, it seems that a good starting point may have more to do with acceptance than with change. Couples have to acknowledge and accept that marriage and familiarity can be tough on sex and passion. Taking responsibility for their part and choosing to take action will necessarily have to follow. Clinicians could conceivably help this process with cognitive reframing and behavioral activation related to the lack of calibration between hedonistic and relational impulses in any one couple. The women in our study had schemas for marriage, wifehood, and motherhood that stood in contrast to eroticism. This polarization may be amenable to cognitive re-structuring. Behavioral activation that urges couples to take

risks in their sexual relating may also be useful. Finally, more psychodynamically oriented treatment components targeting attachment styles and differentiation may also yield positive outcomes for the couple's sexual life.

Limitations

The current study is not without limitations. The most serious one is that women's reports of the causes of and barriers to low sexual desire are nothing more than their perceptions. It is impossible for us to know how accurate these perceptions are in terms of revealing true relationships between marital conditions and sexual desire. Perceptions of etiology are all we could access with this methodology. Only a very complex longitudinal study that staked its hypotheses on a number of theorized mediators would have any chance of identifying any true cause and effect relationships. However, perceptions do have causal force and remain important as long as we remain vigilant of their limitations. Furthermore, a shift from the perceptions of researchers to those of the women who actually live with HSDD seemed a step in the right direction.

A second limitation that is important to note is that, although the first model we presented (The Forces Pulling Down on Desire) was firmly and closely grounded in our data, the second model we presented (A Psychosocial Model of Female Sexual Desire) was more speculative in nature. This latter model was proposed in the spirit of exploration and would require further testing. In any case theory building is, by nature, a subjective exercise even when closely guided by the data. It is possible that two other researchers, having gathered the same data, would have developed a different theory about HSDD. Our adherence to the data, however, make us feel confident that our model was, at worst, a reasonable and fitting interpretation of the data.

Third, participants were self-selected. It is unclear what type of bias this presented but there are at least couple of possibilities. Women who volunteered to participate were obviously willing to disclose information of a very personal nature to a stranger. It is likely that they were experiencing significant distress surrounding HSDD, motivating them to seek assistance. Our recruitment strategy also sampled from educated women who understood what research was and who volunteered for it. Further research would be necessary to investigate whether similar themes would emerge in a more socio-economically disadvantaged sample.

Our sample size and methodology made it unlikely that we would obtain an ethnically representative sample. Minorities were significantly underrepresented. It is worth noting, though, that the stories of the ethnic minority women who participated were not unlike those of non-minority participants. Furthermore, all participants were self-identified primarily as heterosexual since we expressly recruited married women. Findings may not be generalizable to sexual minority women in long-term relationships.

Future Research

Women are not alone in the experience of loss of desire, with as many as 15% of men complaining of low libido (Laumann et al, 1994). Growing demands placed on families have changed the way that “traditional” families function. With two career families, many parents (mothers and fathers) are working a “second shift.” It would be important to investigate how men are coping with their responsibilities. Do they feel bogged down by work, helping with homework, coaching the soccer team, and mowing the grass? Do they yearn for time away from the family? Has it become difficult to see themselves, or their wives, as sexy? We suspect the situation is not that different for men. Perhaps the

calibration on the motivational-relational spectrum is different for men than for women but it is hard to conceive that our three-dimensional model of desire would not apply to them also. These seem to us important questions that promise to shed more light on the origins of HSDD for both men and women and on gender differences in sexual desire.

Another study that might enhance our understanding of sexual desire in women would be a sister study of married women who continue to have sexual desire. What is different about these relationships and marriages? How do they combat the dampening effect of familiarity on sexual desire?

Finally, the development of a treatment manual for female HSDD incorporating the finding of this study would be a valuable next step. Would the incorporation of correctives to recalibrate the sexual psyches and behavior of married couples have measurable effects on desire, sexual activity frequency, or satisfaction? If it did, this would be a significant contribution to a treatment effort that has historically shown little to no efficacy.

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APPENDIX I

RECRUITMENT FLYER

***Are you a woman who currently
experiences little to no sexual desire
but once did?***

If you are married & have experienced little to no desire for sex for at least 6 months, you might be interested in participating in a research study that could help you.

Your participation just requires one interview.

For more information call Karen Sims at:

283-4149

If you agree to be interviewed, you may be eligible to receive treatment for your low desire at no cost to you!!!

* This study is being conducted by Dr. Marta Meana, a licensed clinical psychologist & professor in the Department of Psychology at UNLV and Karen Sims, M.A. We are looking for women free from chronic illness who are between the ages of 30 and 40 & who have not had a baby in the past 12 months and have not had a hysterectomy.

APPENDIX II

INFORMED CONSENT

I am Karen Sims, a doctoral student at the University of Nevada, Las Vegas in the Department of Clinical Psychology working under the supervision of Dr. Marta Meana. I am requesting your participation in a research project on low sexual desire. The purpose of this research is to understand the reasons that many women experience decreased sexual desire in their relationships.

Your participation will involve completing a brief demographic questionnaire and then describing your perceptions of when and why you lost desire for sexual relations with your spouse. The interview will be conducted by myself, Karen Sims, and will be audiotaped. The audiotapes *will not* include your name or any identifying information. I will be respectful of your privacy and sensitive to the fact that I am asking you to discuss very intimate aspects of your life. The expected length of time of your participation is approximately 75 minutes. In exchange for your participation, you may request psychoeducational information about desire problems and treatment opportunities available, if you

so desire. Additionally, you will be offered brief psychotherapy specifically targeting your desire problems with either myself or another advanced graduate student in Clinical Psychology, under the supervision of Dr. Marta Meana, a licensed clinical psychologist, specializing in sexual difficulties. You are, of course, under no obligation to engage in this therapy if you do not wish to do so. Only the interview will be used for research purposes. The offer of therapy is intended only as a measure of our appreciation for your participation.

The only risk associated with your participation is the possibility of temporary discomfort that some people understandably feel when discussing very personal feelings and behaviors. Again, I will remain sensitive to this issue at all times. By agreeing to participate, you are not obligated to answer any question with which you are not comfortable. Keep in mind that my intentions are to understand the experience of low sexual desire from your unique point of view.

Your participation is completely voluntary and your anonymity will be protected at all times. Nothing you say will be associated with your name, only your participant number. The audiotaped interviews will be transcribed but will contain no identifying information, thereby protecting your confidentiality. All records will be maintained in a locked facility in the psychology department at UNLV. After three years the information will be shredded. You may withdraw from participation at any time.

For more information or questions/concerns, you may contact myself, Karen Sims, at (702) 283-4149. Information regarding university policy and procedures for research

participation can be obtained by contacting the Office for the Protection of Research Subjects at (702) 895-2794.

I will be happy to answer any questions you may have regarding the research.
By signing below, you are agreeing to participate in this research.

Signature of Participant

Date

Signature of Researcher

Date

APPENDIX III

INTERVIEW QUESTIONS

Participant Number _____

It is not unusual for couples to experience a high level for desire for each other when they meet and for this desire to go down somewhat over the first year. No one expects the excitement of the first few months to remain at that level forever. However, some couples settle into a level of desire they feel comfortable with, while in others, either the woman or the man experience a very dramatic decline or maybe no sexual desire at all. Since you have agreed to participate in this study, I am assuming that latter applies to you. Is that correct?

I am now going to ask you some questions about this issue that I'd like you to give some thought to. Take your time. These are not yes or no answers. They are intended to get you thinking. There are also no right or wrong answers. Everyone's experience is different and I'd really like to understand your point of view. Don't be embarrassed to say something because you don't think it sounds right. Sometimes it's difficult to express in words what we are thinking or feeling. All responses are valid and legitimate and you can just think and wonder aloud.

Do you have any questions?

OK. I will turn the tape on now.

1. Why or how do you think you lost your sexual desire? Do you have any personal theories about how this came about?
2. When did you start getting concerned about your low level of desire?
3. Do you remember what was going on in your life at that time?

4. Do you think any of these things that were going on at the time were related to your losing desire? How?
5. Have you had different theories over time about why you lost desire? For example, did you first think it was related to one thing and then changed your mind and thought it was related to something else? What are some of these theories you had?
6. Was there any incident or incidents in particular that made you realize your desire was going down? Can you tell me about these? Was it abrupt or gradual?
7. How did you feel when you realized that your desire was going down? Were you worried? What were you thinking? Are you still worried?
8. In what ways do you think that having little desire has affected your life?
9. What do you think you have lost, if anything, in losing your lack of desire?
10. To what extent is your lack of desire a problem in your relationship? How does the distress over this problem manifest itself? How does it show?
11. Are there ways in which you try to compensate for your lack of desire in your relationship? What I mean is do you try to excel in other areas in order to make up for your lack of desire?
12. What have you done to re-spark your desire? Why do you think it has not worked?
13. What do you think would have to happen to you or your life for you to feel sexual desire again? Feel free to say things that are possible and those things that are not (ideal).
14. Would you like to increase your level of sexual desire? Why?
15. How do you know when you are feeling sexual desire? What kinds of things do you think about? Are there any specific bodily sensations? How do you know when you are "in the mood"? How can you tell?

16. Do you currently engage in sex without wanting to? If yes, tell me what that feels like.
17. What kinds of physical affection do you enjoy other than sex?
18. Do you feel a sense of intimacy/closeness with your husband and in what situations?
19. Do you feel that you are sexually desirable? Do you feel sexy?

APPENDIX IV

DEMOGRAPHIC QUESTIONNAIRE

Participant Number _____

- 1) What is your age? _____
- 2) What is your nationality? (optional) (Please circle)
 - a) Caucasian
 - b) African-American
 - c) Hispanic
 - d) American Indian
 - e) Asian American
 - f) Other _____
- 3) How long have you been married? (Please circle)
 - a) a year or less
 - b) 2-4 years
 - c) 5-7 years
 - d) 8-10 years
 - e) 11-15 years
 - f) 15 or more years
- 4) This marriage is your: (Please circle)
 - a) 1st
 - b) 2nd
 - c) 3rd
 - d) 4th or more
- 5) Do you have any children? Yes No
If yes, how many?
 - a) 1
 - b) 2 or 3
 - c) 4 or more
- 6) How old are your children? _____
- 7) Highest level of education completed?
 - a) High School
 - b) Trade/Vocational School
 - c) Some college
 - d) Associates Degree
 - e) Bachelor's Degree
 - f) Advanced Degree (Master's, Doctorate, Medical, Law)
- 8) Are you currently working outside the home? Yes No

If yes, how many hours on average?

- | | |
|-----------------|-----------------|
| a) Less than 10 | d) 26-35 |
| b) 11-20 | e) 36-40 |
| c) 21-25 | f) more than 40 |

VITA

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Dissertation Title: Why Does it Wane? A Qualitative Study of Hypoactive Sexual Desire Disorder in Married Women

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