

**A PHENOMENOLOGICAL INQUIRY INTO THE LIVED  
EXPERIENCE OF LOW SEXUAL DESIRE IN WOMEN:  
IMPLICATIONS FOR CLINICAL PRACTICE**

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## **DECLARATION**

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## SUMMARY

It is a common phenomenon that women's sexual desire diminishes in relationships, yet, to date, limited research has been done locally on this topic. International studies indicate that low sexual desire affects more than half of women, and that an even greater proportion of women indicate that they have sexual intercourse with their husbands without they themselves having a desire to do so. In spite of this, there is an expectation in society that couples should continue to have an active sex life. Low sexual desire may lead to distress in the individual or discord in the couple, and in this aspect the practitioner can render a service.

The aim of this study was to gain a better understanding of the life-world of women with low sexual desire towards their life-partners, and the extent to which this causes her distress or impedes on her relationship. The objectives of the study thus included providing an overview of models of sexual response, an evaluation of the diagnostic criteria for sexual dysfunctions, and an exploration of factors affecting the experience of sexual desire, including the role of social scripts on sexual behaviour.

The context for the study is provided by a review of relevant literature, and a qualitative study with a phenomenological interpretative approach was executed. Data gathering focused on a non-probable purposive sample of ten participants, and used an interview schedule with open-ended questions.

Seven themes emerged from the analysis of the data, namely

(1) perceptions of sexual desire, (2) experience of sexual desire, (3) experience of sex life without desire, (4) the perceived impact of low desire on the individual or the relationship, (5) personal reasons for decline in desire, (6) relationship factors affecting sexual desire, and (7) the experience of low desire in the socio-cultural context.

It was found that 'desire' is difficult to conceptualise, that women put a higher premises on the emotional component of desire, and that there is a difference between innate sexual desires and desire that is evoked by stimuli. Reasons for low sexual desire include an array of personal medial, psychological, and life context factors, and in many cases the lack of desire is specific to the present life-partner. Women are especially sensitive to a wide variety of aspects in the relationship and with regards to their partners, and it emerged that even in happy and intimate relationships low sexual desire is experienced.

Women experience a loss of emotional intimacy as a result of low sexual desire but do not necessarily feel that their low desire is abnormal. The impact on the relationship is limited mostly because women concede to sex for many reasons, including a need for emotional intimacy. Many strategies, including faking orgasms, are implemented to cope with sexual relationships in the absence of desire. It also appears that social scripts have a big influence on the inception of negative perceptions on sexuality, and generate unreasonable and idealistic expectations of sexual experiences in long-term relationships.

Several recommendations flowed from the findings and conclusions. The most important recommendation is that professional people should gain a deeper understanding of the complexity of the phenomenon of low desire in women, in order to render a more effective therapeutic intervention.

## OPSOMMING

Dit 'n baie algemene verskynsel dat vrouens se behoefte aan seks afneem in verhoudings, maar tot dusver is weinig navorsing plaaslik hieroor gedoen. Internasionale studies toon aan dat lae seksuele begeerte meer as die helfde van vrouens affekteer, en dat selfs 'n groter aantal vrouens aantoon dat hulle met hulle eggenote seksueel verkeer sonder dat hulleself 'n begeerte daartoe het. Tog is daar 'n verwagting in die samelewing dat egpare se aktiewe sekslewe voortduur. Lae seksuele begeerte mag lei tot kommer in die individu of onmin in die egpaar, en in hierdie opsig kan die praktisyn 'n diens lewer.

Die doel van hierdie studie was om 'n beter begrip te verkry van die lewenswêreld van vrouens met lae seksuele begeerte aan hulle lewensmaats, en tot watter mate dit haar kommer verskaf of die verhouding belemmer. Die doelwitte van die studie het dus 'n oorsig van modelle van seksuele response ingesluit, sowel as 'n evaluasie van diagnostiese riglyne vir seksuele disfunksies, en 'n eksplorاسie van faktore wat die belewenis van begeerte affekteer, ingeslote die rol van sosiale voorskrifte vir seksuele gedrag.

'n Oorsig van relevante literatuur het die konteks van die studie voorsien, en 'n kwalitatiewe studie met 'n interpretatiewe fenomenologiese benadering is benut. Data-insameling het gefokus op 'n nie-waarskynlike doelbewuste steekproef van tien deelnemers deur die gebruik van 'n onderhoudskedule met oop vrae.

Sewe temas het uit die data ontwikkel, naamlik:

(1) persepsies van seksuele begeerte, (2) ervaring van seksuele begeerte, (3) ervaring van sekslewe sonder begeerte, (4) effek van lae begeerte op die individu en verhouding, (5) persoonlike redes vir afname van begeerte, (6) verhoudingsfaktore wat bydra tot afname van begeerte, en (7) ervaring van lae begeerte in sosio-kulturele verband.

Daar is bevind dat 'begeerte' moeilik is om te konseptualiseer, dat vrouens die emosionele komponent van begeerte meer belangrik ag, en dat daar 'n verskil is tussen spontane begeerte en dié wat 'n reaksie is op stimuli. Redes vir lae begeerte sluit in 'n verskeidenheid van persoonlike mediese, sielkundige, en lewenskonteks faktore, en in baie gevalle is die gebrek aan begeerte spesifiek gerig op die huidige lewensmaat. Vrouens is egter verál besonder sensitief vir 'n groot verskeidenheid aspekte in die verhouding, en met betrekking tot die lewensmaat, en dit blyk dat selfs in gelukkige en intieme verhoudings lae seksuele begeerte ervaar word.

Vrouens ervaar 'n verlies aan emosionele intimiteit wat ontbeer word as gevolg van lae seksuele begeerte maar voel nie noodwendig dat hulle lae begeerte abnormaal is nie. Die effek op die verhouding is beperk merendeels aangesien vrouens vir 'n verskeidenheid van redes toegee tot seks, veral weens die behoefte aan emosionele intimiteit. By die gebrek aan begeerte word allerlei strategieë, soos fop-orgasmes, gebruik om die ervaring te verduur. Dit blyk ook dat sosiale voorskrifte 'n groot invloed het in die ontstaan van negatiewe persepsies oor seksualiteit, sowel as onrealistiese en idealistiese verwagtinge van seksuele ervarings in langtermyn-verhoudings.

Verskeie aanbevelings is gemaak na aanleiding van die bevindinge en gevolgtrekkings. Die belangrikste aanbeveling is dat professionele persone 'n dieper begrip moet verkry oor die kompleksiteit van die verskynsel van lae begeerte by vrouens, ten einde 'n meer effektiewe terapeutiese intervensie te kan lewer.

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## **DEDICATION**

To Cate, Ernst and Jürgen for enriching my life.

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ADDENDUM E: Transcript conventions

ADDENDUM F: “Feedback from Gwen”

# CHAPTER 1

## INTRODUCTION

### 1.1 RATIONALE FOR STUDY

“... not tonight dear... I have a headache ...”

McIntosh (2005:30), a sex therapist practising in Johannesburg, reported: “*In my practice 60% of women tell me that they love their husbands but they don’t want sex*”. When women choose not to engage in sexual activities, clinicians ascribe the diagnosis of “Sexual Desire Disorder” (APA, 2000). Sexual desire disorders are both the most common and the most challenging of all the sexual problems confronting clinicians, with international statistics suggesting that between 33% and 67% of women indicate low sexual interest (Hawton, 1985; Davies, Katz & Jackson, 1999; Pridal & LoPicollo as cited in Leiblum & Rosen, 2000; Basson, 2002b; Lauman, Gagnon, Michael & Michaelso, cited in Hicks, 2006). Dysfunctions of sexual desire are also now the most common presenting problem at sex therapy clinics (Beck in Brezsnayak & Whisman, 2004). In South Africa, for instance, Craig (2002:242) found that lack of desire was the most frequent sexual problem (51%) encountered by social work practitioners.

Clinical attention to problems of sexual desire is a relatively recent development in the history of modern sex therapy. Low sexual desire was not mentioned in the initial publications of Masters and Johnson (1966) or Kaplan (1974), where the focus was exclusively on *physiological* response (Schnarch, 1991:15). In subsequent work, Kaplan (1979) addressed *subjective* experience and developed the term desire phase disorder, later replaced by the term sexual desire disorders (APA, 2000). In 2002, Basson (2002a:357) added *contextual* factors to the physiological (biological) and subjective (emotional) factors that contribute to female sexual functioning. She suggested that, in the context of demonstrations of emotional intimacy, a woman’s desire might develop after or during arousal, rather than precede it.

Sexual desire disorders are categorised as follows in the DSM-IV-TR (APA, 2000):

***Hypoactive Sexual Desire Disorder:*** the persistent or recurrent deficiency (or absence) of sexual fantasies and desire for sexual activity.

***Sexual Aversion Disorder:*** the persistent or recurrent extreme aversion to, and avoidance of, all (or almost all) sexual contact with a sexual partner.

Both Hypoactive Sexual Desire Disorder and Sexual Aversion Disorder cause marked distress and interpersonal difficulty for women that experience them.

Interpersonal difficulty stems from the problems that arise in marriages, or indeed any committed relationships, as a result of sexual problems between partners (Hawton, 1985:53; King, 1999:310). Craig (2002:133) points out that many couples with sexual problems choose to present for marriage/couple therapy with social workers, rather than at a sex therapy clinic because of the social stigma attached to the latter. The World Health Organisation (1975) stated that social workers in particular should be trained in the field of human sexuality because of the close contact these professionals have with a wide range of people, and the complex interplay of sexuality and relationship issues (Lister & Shore, 1984:15). A social work perspective on sexual health can be described as an enhancement or restoration of optimal sexual functioning within a relationship context (Craig, 2002). Within this perspective, couple therapy is an appropriate therapeutic context through which sexual difficulties can be explored and managed, and implies that psychological treatment is an appropriate response to sexual difficulties. In other words, the social work practitioner has an important role to play when the client presents for treatment with relationship problems with an underlying problem of low sexual desire.

The distinction between psychological treatment for managing sexual difficulties as opposed to medical treatment, and the interplay between the two, is important, particularly in the context of the recent emphasis of medical remedies. The discovery of sildenafil (Viagra) in 1998 marked the advent of a new era in sexual pharmacology, and its early successes led to a reverting back to an emphasis on physical causality and a renewed focus on medical, rather than psychological, treatment. Leiblum and Rosen (2000) cautioned that the field of sex therapy will become more “medicalised”, and that simple medical solutions will be sought for complex problems experienced by individual or couples. Indeed, Tiefer (2000) and Moynihan (2003) went as far as to question whether female sexual dysfunction was a “disorder” that had been identified deliberately to build the pharmaceutical markets for new medications. Lister and Shore (1984:18) pointed out that the pure medical model limited and distorted a comprehensive view of sexual functioning within a social context and a social work perspective. Basically, the concern is that drugs alone cannot address the complex phenomenon of women avoiding sex, and that effective multifaceted approaches should be developed to manage this common occurrence.

From a clinical perspective, women who present with low sexual desire symptomatically experience marked distress or interpersonal difficulty. Tiefer and others (Smith, 2003), however, point to a study where only 24% of women interviewed indicated that their sexual “problems” distressed them. Similarly, sexual problems have been cited as a prominent cause of marital problems (Hawton, 1985:53), but interpersonal difficulties may stem from any number of causes, such as a partner’s frustration with the low frequency of sexual activities, rather than from the woman’s experience of “sexual problems” *per se*. Thus, the question arises as to whether healthy women are simply being cast into a “sick role” by conventional medical, clinical and societal viewpoints.

To gain a better understanding of women’s sexual experiences from *their* point of view, Wood, Koch and Mansfield (2006:242) proposed that further research be done into the question “*What is sexual desire for women? How does it operate in women’s lives?*”

The paucity of local research in the field of sexual disorders (Robinson, 2005) means that there is a need also for local perspectives on the issue and for the development of local expertise in the realm of sexual health (Craig, 2002; Smit, 1997). My interest in sexual desire, specifically low sexual desire in women, arose from my focus, in my private practice, on the fields of sexuality and couple therapy. Since there was no formal training in sex therapy available to me locally, I joined the Southern Africa Sexual Health Association (SASHA) and have attended several case discussions and workshops within a multi-professional group to broaden my understanding of the field of sexuality. This study grew out of my interest and involvement in sexuality and couple therapy, and a growing realisation that little if any attention had been paid to the subject of low sexual desire in women in South Africa.

## **1.2 RESEARCH PROBLEM AND FOCUS**

The phenomenon of low sexual desire in women is purported to have a profound impact on the individual who presents with the problem, as well as on her intimate relationship (APA, 2000). Such women may present at clinical practices for “help”, with feelings of failure or abnormality, or may experience problems in their relationship brought on by the sexual frustration of their partner. The question arises as to whether such a woman *is* in fact distressed, or is she *made* to feel distressed and abnormal by her partner or society in general. The *real life experiences* of these women are the focus of the study.

### **1.3 THE RESEARCH QUESTION AND OBJECTIVES OF THE STUDY**

The research question in this study is:

#### **How do women themselves experience low sexual desire?**

The study aims to improve understanding of the subjective experience of women who present with low sexual desire, by exploring their experience of “marked distress” or “interpersonal difficulties” in the cultural and social context in which they live. Furthermore, in accordance with Shaw (2001), this study aims to examine the meaning of low sexual desire within contemporary culture by focusing on the significance of low sexual interest in women’s everyday lives.

The specific objectives of the study are:

- to provide a framework of sexual response models and an overview of sexual dysfunctions
- to explore factors affecting the experience of sexual desire
- to explore women’s experiences of sexual low desire in marriage or partnership;
- to establish whether women experience marked distress or interpersonal difficulties due to their experience of low desire
- to examine the meaning of low sexual desire within the social context and culture
- to place the implications of the findings in context for the practitioner.

### **1.4 THEORETICAL POINTS OF DEPARTURE**

Phenomenology is “*the study of personal experience and subjective perceptions of phenomena*”, rather than objective truths about those phenomena, and its application as a research method may be the oldest use of qualitative methods (Giles, 2002:208).

Phenomenology is interested in the world as it is experienced by human beings within particular contexts, and is concerned with the phenomena that appear in our consciousness as we interact with the world (Kvale, 1996; Willig, 2001; Giles, 2002). This philosophical framework provides guidance as to how such knowledge of phenomena may be achieved, and thereby inspired phenomenological research methods (Kvale, 1996; Lemon & Taylor, 1997; Willig, 2001).

Phenomenology has undergone change and development since the formulation of Transcendental Phenomenology by Husserl in the early twentieth century. Husserl (in Willig, 2001) proposed that it was possible to describe phenomena as they present themselves to us, and identified a series of steps to transcend presuppositions and arrive at a fresh perception for the extraction of essences that give the phenomena their unique character (Moustakes, 1994). So, even though transcendental phenomenology was conceived as a philosophy, its methodology gained popularity with researchers in the social sciences (Kvale, 1996; Giorgi & Giorgi, 2003). Van Kaam (1959, in Moustakes, 1994) was the first to operationalise empirical phenomenological research in psychology. This form of research appealed to psychological researchers as “*any human experience can be subjected to phenomenological analysis*” (Willig, 2001:52).

A contemporary variant of phenomenological research is Interpretative Phenomenological Analysis (IPA), as developed by Jonathan Smith (Smith, 1994, 1999; Willig, 2001; Giles, 2002). IPA aims to explore the participant’s *experience* from her perspective, but also recognises that such an exploration must necessarily involve the researcher’s own view of the world, and as a result the analysis is an *interpretation* of the participant’s experience (Willig, 2001).

Phenomenology forms the theoretical base of this study, with IPA the approach of choice. The methodology of IPA and its application to this study is described briefly in the next section, and in more detail in Chapter 4.

## **1.5 RESEARCH DESIGN AND METHODS**

This study is a *qualitative study with an interpretative phenomenological approach* (Shaw, 2001; Willig, 2001), using the framework offered by IPA.

A qualitative study is an in-depth inquiry aimed at achieving new insights into and comprehension of a phenomenon, here of low sexual desire in women, through an investigation of individuals’ experiences (Babbie & Mouton, 2001; Fouche, 2002:108).

IPA aims to explore in detail the participant’s view of the phenomenon under investigation (Smith, Jarman & Osborn, 1999) and to use insights gained from this to produce an

understanding of the essence of that phenomenon (Willig, 2001). It is an evolving approach that, as such, provides guidelines, but is not prescriptive with regards to methodology. The methodology is summarised here and discussed in more detail in Chapter 4.

IPA is characterised as “an attempt to explore the participant’s perspective” (Willig, 2001). It is so named because such an exploration implicates the researcher’s *own worldview* as well as *the interaction* between researcher and participant. Hence, the analysis produced by the researcher is thus an *interpretation* of the participant’s experience (Willig, 2001). The researcher should therefore bracket the phenomenon to set aside presuppositions, and engage in critical self-monitoring to prevent bias (by the process of reflexivity) to arrive at an understanding of the lived experience of the participant (Hayes, 1997; Shaw, 2001; Willig, 2001).

IPA shares many features with grounded theory (Shaw, 2001; Willig, 2001), such as aiming to produce a “cognitive map” that represents a person’s or group’s view of the world, and the systematic analysis of a pre-recorded text to identify themes that capture the essence of the phenomenon under investigation. The main difference between Grounded Theory and IPA is, however, that Grounded Theory aims to identify contextualised *social* processes that *account* for a phenomenon, whereas IPA is concerned with gaining a better understanding of the texture of *individual* experiences and the *nature or essence* of a phenomenon (Willig, 2001).

IPA reveals the idiosyncratic, subjective aspects of experience, i.e., those that are unshared and unique to an individual. It also reflects the shared aspects of experience, i.e., those that are constructed by external forces within a culture and a subculture (the environment) (Shaw, 2001).

Henning (2004:6) explains that qualitative research makes meaning from the research data by conveying the raw empirical information into a “thick description”, which is the rich, detailed description of a phenomenon that includes the researcher’s interpretation. In the context of this study, detailed descriptions of women’s subjective experiences of desire disorder, from the participant’s perspective, will be used to derive a more complete description of the general phenomenon.

In accordance with Creswell (1994), recent literature related to low sexual desire is referenced briefly in the introduction to provide a backdrop and frame the research problem. It is then considered in more detail, in Chapters 2 and 3, for the benefit of the practitioner. In Chapter 6, reference is again made to the literature, as appropriate, in order to provide a broad contextualisation of the results of this study.

### **1.5.1 Data collection**

IPA uses transcripts of semi-structured (open-ended and non-directive) interviews. Participants can also be asked to produce accounts of their experiences using other means, e.g. in written form such as diaries or letters (Shaw, 2001; Willig, 2001:54), but in this study only interviews were used, as it is the most commonly used tool and provided sufficient in-depth data to meet the objectives of the study.

Involvement of participants was voluntary and based on **informed consent** (Addendum A). Informed consent was obtained at the start of each face-to-face interview, where after a **semi-structured interview schedule** (Addendum B) was used, which was tape-recorded and later transcribed for analysis. The semi-structured interview allowed the introduction of unanticipated answers, which were then further probed using “funneling” techniques (Grinnell, 1998:276).

### **1.5.2 Sampling**

IPA proposes a small sample size of up to about ten participants (Smith *et al.*, 1999). Accordingly, the number of participants was limited to ten. I made use of “purposive sampling”, (Singleton *et al.*, 1988:153, as cited in Strydom & Venter, 2002), selecting “typical” persons (Grinnell, 1988:278) who met the criteria of the phenomenon being researched for inclusion in the study. The sample therefore reflected women who typically present with low desire at practitioners’ offices. The criteria for inclusion were:

- being a women
- having low or no desire to engage in sexual activity with their partner;
- being in a relationship for more than two years;
- intending to continue the relationship;
- between 35 and 55 in age.

### **1.5.3 Analysis of data**

The transcripts of the interviews were analysed according to the principles of IPA (Willig, 2001; Shaw, 2001; Smith, 2003). This involved three main phases, *viz.*:

- 1 Analysis of individual transcripts.
- 2 Integration of participants' transcripts.
- 3 Interpretation of participants' lived experiences.

#### **1.5.3.1 Analysis of individual transcripts**

I analysed the individual transcripts according to the four steps involved in individual transcript analysis (Willig, 2001), namely:

- 1 Familiarisation with the text through reading and re-reading the transcript, and the production of notes reflecting initial thoughts and observations.
- 2 Identification and classification of themes characterising each section of the text. These are usually recorded in the right margin and capture the essential quality represented by the text.
- 3 Introduction of structure by clustering of themes.
- 4 Production of a summary table of the structured themes, with quotations that illustrate each theme.

#### **1.5.3.2 Integration of participants' transcripts**

Once the individual transcript analysis was completed for all participants, the cases were integrated to arrive at an inclusive list of master themes that reflected the experiences of the group of participants as a whole. There after, the data were written up.

#### **1.5.3.3 Exploration of participants' lived experiences**

In moving beyond exploration and description, the final step is explanation of the participants' "lived experiences". Henning (2004) asserted that the understanding and explanation of the phenomenon is indicated by articulated *interpretation* of the data, and cautioned that the researcher should not simply present rearranged information.

## **1.6 ETHICAL CONSIDERATIONS**

The focus of research is an intensely private matter for individuals and their partners and I did my best to remain ethical and to ensure that the participants did not feel violated. My proposal for the research incorporated a list of ethical considerations, which were approved by the Ethics Committee of the University of Stellenbosch (Addendum C). These included: informed consent, guaranteed confidentiality, participants' debriefing, and adherence to the codes of conduct of the social work profession and social workers in private practice. As the topic of research is a sensitive one, I offered the participants free of charge debriefing sessions either with myself or with a colleague (Grinnell, 1988:255).

## **1.7 ANTICIPATED VALUE OF THE RESEARCH**

There is a dearth of local knowledge and studies in the field of sexology. Most of the local literature on sexuality is focused on AIDS, and even then not much on clinical practice. This study partially addresses this shortcoming in South African literature, as identified by Robinson (2005) and others. As such, the study should make a constructive contribution to research pertaining to clinical practice in sexology and marital therapy.

More generally, new knowledge and understanding of the underlying experiences of women presenting with low sexual desire is used to critique existing treatment models and make recommendations for interventions. As such, the study should therefore be useful for practitioners (Fouché, as cited in De Vos, Strydom, Fouché & Delport, 114:2002).

## **1.8 LIMITATIONS OF THE STUDY**

The low number of participants limits the extent to which the findings of this study can be generalised. This limitation applies to most qualitative studies. Indeed, the sensitive, and very personal, nature of the topic meant that there were some difficulties initially in finding research participants, but these were overcome. Additional discussions about the limitations of the study are provided in Chapter 4.

## **1.9 OUTLINE OF THE DISSERTATION**

- Chapter 1: Sets out the motivation for the study, the research problem, the objectives and theoretical points of departure and a summary of the research design and methods. Ethical considerations, analysis, the value of the research and the limitation of the study are also discussed.
- Chapter 2: Discusses the literature pertaining to models of normal human sexual response, the addition of the “desire” phase, and the contemporary cyclical model. It further outlines the literature pertaining sexual dysfunction, and in particular sexual desire disorders. The DSM classification system is described, and its shortcomings summarised. More recent classification systems that address the limitations of previous classifications, for women in particular, are introduced.
- Chapter 3: Explores perceptions and conceptualisations of sexual desire. The factors that impact on sexual desire, such as cultural influences, personal and relationship factors and life contexts are highlighted. The controversy of “normal” and “abnormal” sexual behaviour is also discussed.
- Chapter 4: Explains the research methodology, including the use and placement of literature, the choice between qualitative and quantitative designs and a broader explanation of IPA. The research question is described more completely, and the participants are introduced.
- Chapter 5: The empirical data and analysis of individual transcripts data are presented, with the analysis of, and integration of participants’ transcripts. Seven themes emerged from the empirical data and the findings are contextualised using the applicable literature.
- Chapter 6: Summary of the findings of the study, conclusions, and recommendations for practice and further research.

## CHAPTER 2

### SEXUAL RESPONSE AND DEFINITIONS

#### 2.1 INTRODUCTION

Slowinski (2001:217) remarked that there is “*still as much to learn about the range of ‘normal’ female function as there is to learn about its dysfunction*”.

A fundamental knowledge of human sexuality, and the role and place of desire, is central to understanding the subjective experiences of women who do not have a sexual desire towards their life partners (according to the recommendations of Creswell, 1994 and Fouche & Delport, 2002). Such understanding will enhance concepts such as “low” desire as opposed to “high” desire, and inform the debates around “healthy” sexuality.

This chapter provides an overview of the development of the Human Sexual Response Cycle (HSRC) (Masters & Johnson, 1966), which was incorporated in the manuals widely used in the clinical world (Kaplan & Sadock, 1998). The HSRC for many years formed the basis of the understanding of “normal” sexual functioning, and promoted further research. The development of alternative models to those based on the HSRC, which emphasise the psychological or phenomenological components of sexual experiences are also discussed in some detail. A detailed description of sexual anatomy falls outside the scope of this dissertation, but sexual physiology and sexual response are discussed.

The chapter also draws attention to the clinical definitions of lack of sexual desire and dysfunctions pertaining to sexual desire. It will emerge that this is a controversial arena with many contradicting viewpoints.

Despite decades of research, psychologists have yet to reach agreement on a definition of sexual dysfunction (Mansfield, 2006). The reason for this is partly attributable to the lack of consensus on what constitutes “normal” sexual response. Feminists, in particular, have rejected the sexual response model provided in the widely cited Diagnostic and Statistical Manual of Mental Disorders (DSM) on the grounds that leads to diagnoses of sexual

dysfunction when none exist (Tiefer, 2007). They have also put forward alternative models to remedy the perceived shortcomings of the models used in the DSM, in an effort to provide more realistic and fair definitions of sexual dysfunction (Basson, 2005).

Nonetheless, an understanding of the accepted definitions of sexual desire and the factors affecting this are essential for the clinical practitioner to be able to manage this problem if and when it arises in the therapy process.

## **2.2 “NORMAL” SEXUAL FUNCTIONING**

### **2.2.1 Pioneers in the field of sexology**

Reference to human sexual behaviour have long been available, as early as 4500 BC with illustrations of sexuality in Stone Age statues, for example, and ancient beliefs described in the Talmud, a Jewish holy book, noting sexual norms and values as long ago as 3000 BC (Westheimer & Lopater, 2005). It was only in the late 19<sup>th</sup> and early 20<sup>th</sup> century that the pioneers in the field of sexology, such as, Richard Krafft-Ebing, Havlock Ellis, Magnus Hirschfield and Sigmund Freud introduced objective, applied studies of human sexuality (in Westheimer & Lopater, 2005). Their findings and theories contributed to an understanding of the diverse and fascinating manifestations of human sexual motivation, the place of sex in a person’s life and its impact on quality of life (Westheimer & Lopater, 2005). Despite the serious psychological intent and scholarly quality of the works of Krafft-Ebing and Ellis (cited in Westheimer & Lopater, 2005), their work was banned because of the inclusion of (the first) clinical descriptions of sexual practices such as homosexuality, masochism, sadism and other fetishes. It was, however, the seminal works of Kinsey, Pomeroy & Martin (1948; 1953) and Masters and Johnson (1966) that provide much of our current understanding of human sexuality, although they too experienced resistance and criticism from some sectors of society. Nonetheless, Alfred Kinsey’s books became best sellers.

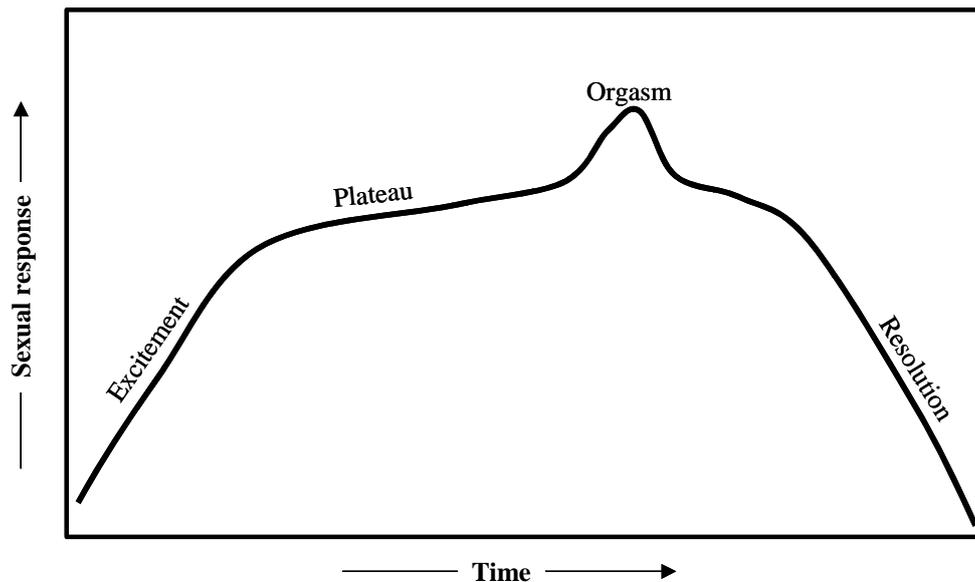
Kinsey and his colleagues undertook the first and most extensive general population surveys of human sexuality. Between 1938 and 1950, they conducted detailed interviews with more than 6000 men and nearly the same number of women (Hawton, 1985). These surveys, methodological flaws notwithstanding, provided a rich source of information on human sexuality and the sexual practices of men and women in the first half of the 20<sup>th</sup> century. Information on topics such as the average age of first sexual intercourse, masturbatory

practices, infidelity, frequency of orgasms and homosexual experiences was available for the first time, and an enormous range of sexual behaviours was documented. Although arduous, statistics could be drawn also on the prevalence of sexual dysfunction.

Desire or sexual interest was, however, not among the topics covered by these early surveys. Kinsey made passing reference to desire as “sexual capacity”, which he defined as the capacity to respond to stimulation with physical arousal (Kinsey *et al.*, 1953). In almost all instances, the early sexologists researched and compared participants by looking at frequency of behaviour. Beach (as cited in Tiefer, 1995) noted that Kinsey equated sexual drive with the frequency of orgasm. Thus, although human sexuality as a field of research gained popularity, none of the earlier researchers recognised the role of sexual desire as an element of sexuality. Indeed, even as recently as 1966, when Masters and Johnson (1966) conducted their studies into the nature of the physical responses during sexual activity, sexual desire did not feature. Even so, their Human Sex Response Cycle provided a framework on which future researchers could build.

### **2.2.2 The evolution of the Human Sex Response Cycle**

While Kinsey’s work (Kinsey *et al.*, 1948; 1953) was based on interviews and did not include direct observation of sexual behaviour, William Masters (1966) used modern instrumentation to explore the body response to erotic stimulation empirically. He and his colleague, Virginia Johnson, were the first to study sexual intercourse and masturbation in the laboratory. They did this with the aim of answering the question: “*What physical reactions develop as the human male and female respond to effective sexual stimulation?*” From their observations, they formulated their famous linear, sequenced *four-stage “phase” model of excitation, plateau, orgasm and resolution* known as the Human Sexual Response Cycle model (Masters & Johnson, 1966:4; Figure 2.1). In subsequent works (Masters & Johnson, 1970; 1979) they also wrote comprehensively about sexual dysfunctions and sex therapy, and provided numerous new insights into how men and women’s bodies respond to erotic stimulation and how sexual dysfunctions develop (Westheimer & Lopater, 2005).



**Figure 2.1 Human Sex Response Cycle** (Masters & Johnson, 1966)

The HSRC model remains extremely popular in the field of human sexuality research, and most writers still refer to it or use it as a basis for describing the various sexual response phases in more detail (e.g., Hawton, 1985, Kaplan & Sadock, 1994; Westheimer & Lopater, 2005). The accuracy and reproducibility of their data provided the foundation on which most subsequent research is built (Westheimer & Lopater, 2005).

Both men and women are purported to experience the four phases, excitement, plateau, orgasm and resolution, of the HSRC. The four phases, as they pertain to women, are described further in Section 2.2.2.1.

### **2.2.2.1 Sexual arousal and response**

#### *(a) The excitement phase*

Erotic feelings in response to sexual stimulation build more gradually in women than they do in men. Vasocongestion (the accumulation of blood in blood vessels) in the vagina and lower pelvis coincides with feelings of warmth and swelling, usually accompanied by vaginal secretion. The inner two-thirds of the vagina expands and lengthens. The labia minora and labia majora change colour, become larger, and the clitoris becomes wider and longer, making it more exposed and more sensitive to touch. The breasts become enlarged and the nipples erect. A “sex flush” may appear over the woman’s breasts, neck and upper abdomen and heart rate and breathing rate and blood pressure increase.

*(b) The plateau phase*

With continued erotic stimulation there is a slight retraction of the clitoral shaft and glans beneath its hood. There is a significant narrowing to the opening of the vagina resulting from localised vasocongestion. The uterus loses some of its elevation, and the inner two-thirds of the vagina becomes wider and deeper (the so-called “tenting effect”). The areola of the breasts swell and vasocongestion enlarges the breasts, while the sex flush may grow in intensity. Muscular tension throughout the body increases, heart rate and breathing rate, and blood pressure increase. This phase represents a heightened state of sexual arousal and desire.

*(c) The orgasm phase*

Orgasm is associated with pleasant sensations and a number of muscular contractions in the musculature surrounding the anus, the vagina and the uterus. There is no physiological difference between orgasm reached as result of direct and indirect clitoral stimulation. Some women are able to experience multiple orgasms, and there is no refractory period for women in the response cycle. Heart rate, breathing rate and blood pressure generally reach their peak during orgasm.

*(d) The resolution phase*

The physiological changes that occurred in the earlier phases are gradually reversed and the body returns to its pre-excitement state. This is usually accompanied by a sense of relaxation and well-being.

#### **2.2.2.2 Comments and critique of the HSRC**

Tiefer (1995) expressed concern that the HSRC claims to be a “*universal*” model, and objected to Masters and Johnson’s reference to it as “the” human sexual response cycle, as this suggests that there is only one set of human sexual responses. Tiefer also (1995) questioned the generalisation of Masters and Johnson’s results and the universal application of the HSRC because they used pre-selected subjects who did not represent a cross-section of socio-economic backgrounds, and who had undergone a period of training resulting in experimenter bias. She also asserted that Masters and Johnson’s focus on orgasm as the ultimate point in progression predetermined their results and “*facilitated a response that conformed to the HSRC*” (Tiefer, 1995:48).

The HSRC has also been criticised for its *linearity* (Tiefer, 1995; Wood *et al.*, 2006; Basson, 2004), and the notion that each phase is a necessary precursor to the next. According to the HSRC, a “normal sexual response” entails a linear passage through the four stages and “dysfunctions” are impairments in one or more of the phases. This creates the impression that there is only one correct way to have a sexual response. Recently, researchers such as Basson (2002), and Graham, Sanders, Milhausen and McBride (2004, in Wood *et al.*, 2006) have argued that the phases overlap, are not necessarily experienced in a progressive way, and that sexual desire is *not* necessarily a precursor to arousal in women. The HSRC is currently recognised as a limited and often inaccurate portrayal of women’s experiences (Hicks, 2005).

The underlying assumption of the HSRC that emphasised *male-female sexual similarities*, and posited the same phases apply for both men and women has also been challenged, and Bancroft (1989:2002 ), Bancroft, Loftus and Scott Long (2003) and Wood *et al.* (2006) have shown that women’s sexual responses and concerns are not always similar to those of men. Wood *et al.* (2006) point out that the field of human sexuality has traditionally focussed on men’s sexual response and behaviour, establishing men’s sexuality as the norm.

The *exclusive focus on physiological response* (changes in respiration, heart rate, muscle tension, and various sex organ changes) is also seen as a weakness of the HSRC, as it leaves no place for phenomenological experience. People’s feelings were addressed by Masters and Johnson in their treatment approach, but were never included in their model of function and dysfunction (Schnarch, 1991).

Masters and Johnson also *failed to give recognition to the existence of sexual desire*, or a phase wherein the need to initiate or partake in sexual arousal would occur (Masters & Johnson, 1966). As Levine (2002) pointed out, very few people move from a complete absence of sexual excitation to the excitation phase. Tiefer (1995) asserts that the HSRC lacked initiating components because the focus of their research was on the physical reactions in the response to sexual stimulation (Masters & Johnson, 1966:4). It is therefore understandable that they omitted sexual desire/passion/sexual drive or libido from their model. Their one reference to sexual drive indicated that they believed that the sexual response was an inborn drive to orgasm: “*The cycle of sexual response, with orgasm the ultimate point of progression, generally is believed to develop from a drive of biologic origin deeply integrated into the condition of human existence*” (Masters & Johnson, 1966:127).

Tiefer (1995) asserted that the HSRC model, and its application in clinical work, *favours men's sexual interests over those of women*. She argued that the model disguises and trivialises the social reality of gender inequality. In general, men and women are raised with different sets of values, with men leaning more towards varied experience and physical gratification, and women towards intimacy and emotional communion. The HSRC focuses on the physical aspects and ignores the emotional aspects. Also, men have greater experience with masturbation, which encourages them toward a genital focus in sexuality, whereas women learn to avoid acting on genital urges because there is a threat of loss of social respect as in some societies respectable women should not enjoy sex. For instance, in the Victorian era, women were in danger of being ostracised or even declared insane if they enjoyed sex (Bancroft, 2002). Thus, the genital focus of the HRSC marginalises women's experiences (Tiefer, 1995). In addition, gender inequality is widely acknowledged as diminishing women's sexual knowledge and assertiveness. The view of orgasm as the ultimate point of progression, has also been questioned as whether of relevance to women, as the majority of women indicated that they rate affection and emotional communication as more important than orgasm (Hite, 1979). Furthermore, most women do not get maximum physical stimulation or orgasm from vaginal intercourse (Bancroft, 2002; Bancroft, Loftus & Scott Long, 2003), which is men's preferred way of sexual expression. "*Effective sexual stimulation*" to reach orgasm in the HSRC thus serves men's needs above those of women. Lastly, Tiefer (1995) also questioned the biological reductionism of the HSRC as indicated by the use of terminology such as "*males*" and "*females*" rather than "*men*" and "*women*", and their frequent reference to the animal kingdom.

Thus, while there can be no doubt that the work of Masters and Johnson represented a significant advance in the study of human sexuality, their model, the HSRC, is seen by many researchers as limited as a description of human sexual response. These shortcomings are particularly relevant for the practitioner managing sexual problems as the HSRC forms the basis of definitions in the DSM system (see Sections 2.2.4 and 2.3).

Subsequent studies have tried to address some of the perceived deficiencies in the HSRC, especially the concept of "desire" and its place in the sexual response cycle, as is explained in the next section.

## 2.2.3 The incorporation of a “desire” phase in the sexual response cycle

### 2.2.3.1 Bi-phasic model

Kaplan (1974) disagreed that the sexual response is an orderly sequence of a unitary and inseparable event. She provided evidence to support a two-phase sexual response in both men and women. She proposed that these two phases were not only distinct, but were relatively independent of one another. She summarised her theories in the **Bi-phasic model**, which comprised an *excitement* and an *orgasm* phase (Kaplan, 1974). Like Masters and Johnson (1966), she discussed the role of human emotions in sexual dysfunction, but did not include these in her Bi-phasic model, which focused on physiological responses.

### 2.2.3.2 Tri-phasic model

The suggestion that there must be a phase *before* sexual excitement where people felt desire to experience sexual stimulation was first proposed by Dr Harold Lief (Lief, 1977). Kaplan too had noticed that some patients, especially women, had a complete lack of sexual desire, and had no wish to undertake sexual activity. As a result, she added a third and separate phase, desire, to the Bi-phasic model, which she called the **Tri-phasic model** (comprising of *desire, excitement and orgasm*), and which she claimed had greater conceptual completeness and clinical effectiveness than its predecessor (Kaplan, 1979; Figure 2.2).

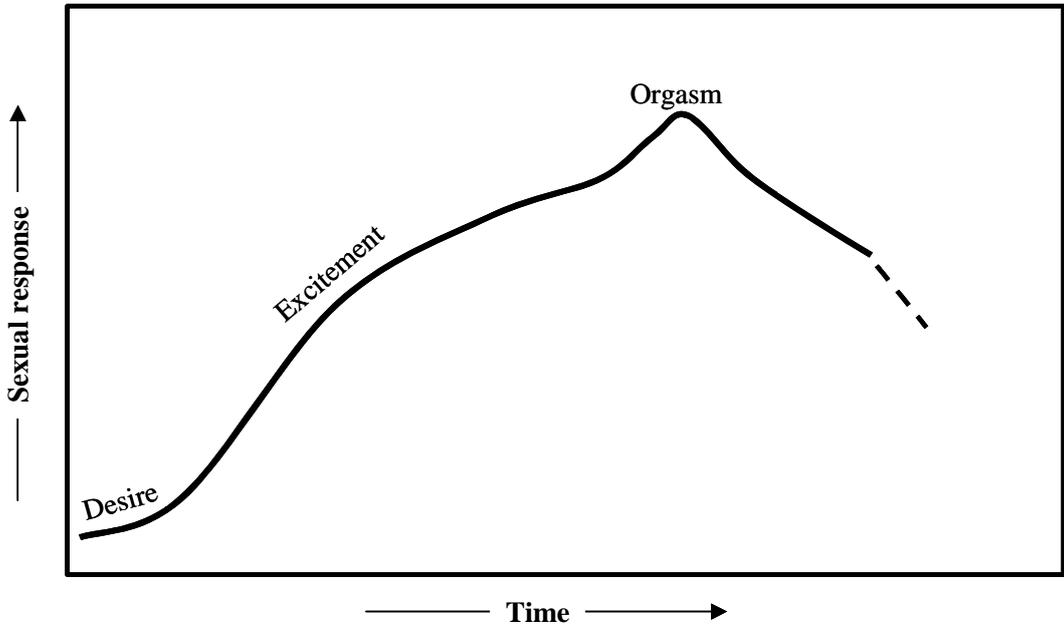


Figure 2.2 Phases of the Tri-phasic model (Kaplan, 1979)

With this model Kaplan (1979) reflected on the growing professional attention to the problems of inhibited sexual desire and attempted to address the psychological issues her predecessors had ignored (Schnarch, 1991:16) in that she clearly distinguished between desire as a psychological issue opposed to the exclusively physical first phase of response of the previous model, i.e. the “*excitement phase*”.

Essentially, Kaplan’s three stages mirrored those of Masters and Johnson’s HSRC, but with a different conceptualisation of the first stage – “desire”. Desire was conceived as an appetitive response preceding sexual arousal and leading to sexual arousal (Kaplan, 1979). The Tri-phasic model is consistent with notions of sexual drive (libido), which derive from the psychoanalytic framework (Freud, 1921, in Masters & Johnson, 1966; Freud, 1949).

Kaplan’s Tri-phasic model can be summarised as follows:

*(a) The desire phase*

Kaplan (1979:9) defined desire as an “*appetite or drive, which is produced by the activation of a specific neural system in the brain*” and inferred that the sex drive is similar to other drives, such as hunger, thirst or the need to sleep. Desire or libido is experienced as specific sensations, which prompt the individual to seek out, or become receptive to, sexual experiences. When this neural system in the brain is active, a person feels “*horny*”, may feel genital sensations, may feel vaguely sexy, interested in sex, open to sex or generally restless. These sensations cease after sexual gratification (orgasm). When this neural system is inhibited, the person has no interest in sex or erotic matters, loses his or her appetite for sex, and becomes asexual (Kaplan, 1979:10).

Kaplan (1979) conceded that it was a “*mystery*” how the neural activity of the sex circuits translates into the experience of sexual desire. In an attempt to explain sex drive, she alluded to the pleasure/pain principle, the studies on endorphins, and referred to the evolutionary perspective where individual survival comes before reproduction. She also considered the role of hormones, and of emotions in the inhibition or enhancement of sexual desire.

*(b) The excitement phase*

The excitement phase in the Tri-phasic model links Masters and Johnson’s excitement and plateau phases in a single closely-related but separable phase, with the accompanying physiological changes.

(c) *The orgasm phase*

The final stage of the tri-phasic model is orgasm, with the physical changes as described by Masters and Johnson (1966). A resolution phase is not included in Kaplan's Tri-phasic model.

### **2.2.3.3 Critique of the Tri-phasic model**

Like the HSRC, Kaplan's Tri-phasic model has been criticised. The basis of the critique is that she based her model on the HSRC (Masters & Johnson, 1966), which itself had evoked much criticism (see Section 2.2.2.2) particularly for its focus on biological factors as the primary source of desire. "Sexual desire" had traditionally been viewed and measured as *spontaneous* sexual thoughts and fantasies and biological urges creating a need to self-stimulate or initiate sexual activities with a partner (Masters & Johnson, 1966; Kaplan, 1974).

One of the main criticisms, however, was that by essentially pre-fixing a "desire" phase to the HSRC, the Tri-phasic model presupposed that desire was a necessary precursor of the sexual experience, despite evidence that a large majority of sexually experienced women *never* experience spontaneous sexual desire (Levin, 2002; Westheimer & Lopater, 2005). For instance, in the Beck, Bozman and Qualtrough (1991) study, 66% to 97% of women reported engaging in sexual behaviour *without desire*. The argument had already been made, however, that the HSRC was a male-orientated model and should not be used as the standard for human sexual desire.

Westheimer and Lopater (2005) also pointed out that while Kaplan (1979) emphasised the importance of cognitive and emotional factors *preceding* sexual excitement, a flaw in her model is that she did not give the same importance to similar psychological matters *after* the sharing of intimacy and sexual intercourse.

Like the HSRC, however, the Tri-phasic model had a large impact on the understanding of human sexuality, and as a result impacted on clinical practices with clients, as will be explored next.

### **2.2.4 "Human sexual response" in the DSM**

The first publications (pre-1980) of the Diagnostic and Statistical Manual of Mental Disorders (DSM) did not pay much attention to sexual response, but DSM-111 (1980) and subsequent DSM revisions largely incorporated Kaplan's views on normal human sexual response (Kaplan, 1979) (see Section 2.3). The DSM-111 and DSM-111-R (1987) versions

consolidated Masters and Johnson's "excitement" and "plateau" phases into a *single* excitement phase (the "*appetitive*" phase), in accordance with Kaplan (1979) (Schnarch, 1991:17). The DSM-1V (1994) replaced the term "appetitive" with "*desire*", as did DSM-1V-TR (2000) but both retained the HSRC as the criteria for a normal sexual response cycle. "Normal" sexual experience would entail progression through the following phases: *Desire, Excitement, Orgasm* and *Resolution*.

#### **2.2.4.1 Critique of the DSM-view of human sexual response**

Leiblum (in Wood *et al.*, 2006) and Basson (2002a) noted that the DSM is based on Kaplan's Tri-phasic model, which has received considerable criticism for having its foundation in the HSRC (Masters & Johnson, 1966) (see Sections 2.2.2.2 and 2.2.2.3). Slowinsky (2001) and Wood *et al.* (2006), amongst others, criticised the use of the male-oriented models of linear human sexual response that disregard the differences between the genders, and discount women's non-linear sexual progression.

Tiefer (1995) pointed out that the DSM focuses exclusively on genital performance, and that the sexual acts mentioned are mostly heterosexual coital acts, omitting other means of sexual expression and homosexual experiences.

Despite its shortcomings, the DSM lead to more research on women's experience of sexuality, chiefly the development of non-linear models of human sexual response, which are addressed in the next section.

#### **2.2.5 Development of non-linear models of human sexual response**

The aspects such as the linearity of the response "cycle", the equalising of male-female experience, the favouring of men's sexual interest and the omission of the psychological aspects were specifically targeted and models formulated to improve on these earlier conceptualisations (Palace, 1995, in Westheimer & Lopater, 2005; Basson, 2000).

##### **2.2.5.1 Focus on psychological processes**

Whereas earlier researchers focussed on *physical* responses in sexuality, in recent years there has been a greater focus on the *psychological* dimension, which emphasises the importance of perception and thought processes in people's cognisance of and response to erotic elements in their environment (e.g., Money, 1986; Morin, 1995). Other research include the work of Reed

(Westheimer & Lopater, 2005), who developed a model of *seduction, sensations, surrender* and *reflection*, Palace (1995, in Westheimer & Lopater, 2005) whose research emphasised that sexual arousal is not simply a reflex, but that affect and cognition play a major role. Whipple and Brash-McGreer (1997) in turn proposed a circular sexual response pattern for women, based on Reed's model. This circular model proposed that pleasure and satisfaction during one sexual experience may have a reinforcing effect on a women, leading to the seduction phase of the next sexual experience.

The work of Basson (2000, 2001, 2002a, 2002b, 2005) provided a generally accepted and comprehensive explanation of the sexual response of women as different from that of men. As such, it is discussed in more detail particularly as her emphasis on the role of desire in the sexual response is of specific relevance to this study. Basson's model is variously referred to as the "non-linear model", the "Basson model" or the Sex Response Cycle model, which is the term used here.

#### **2.2.5.2 Sex Response Cycle model**

In 2000, Rosemary Basson developed a circular model, which she initially called the "different model" or "an intimacy-based sex response cycle" (Basson, 2001, 2002b), with a "*blending of the traditional and alternative cycles*". In later works she incorporated a broader spectrum of motivations for sexual response than intimacy alone (2005) and called the model the Sex Response Cycle model.

As some women's sexual response follows the traditional cycle as described by her predecessors, Basson's model was partly in accordance with the HSRC and Tri-phasic models. She acknowledged that some women do "*experience innate spontaneous sexual hunger or need as in the traditional model*" (Basson, 2002a:359). This spontaneous desire may be related to cyclical hormonal levels, or may be stimulated by the "dating" atmosphere at the beginning of a relationship. However, the Sex Response Cycle model, which has been adjusted and expanded several times (Basson, 2000; 2001; 2002a; 2002b; 2004, 2005), departed from the HSRC and Ttri-phasic models based on her conclusion that, in long-term relationships, women lose the experience of innate spontaneous desire, at which point, women's responsive desire stems from intimacy (and other) needs rather than a need for physical sexual arousal (Basson, 2002a; 2002b). In Basson's view, "*women, compared with men, have a lower biological urge to be sexual for release of sexual tension*" (Basson, 2000:52). Indeed, prior to the formulation of the Sex Response Cycle model, Lief (1995)

found that women could experience desire *in* sex even with no desire *for* sex, meaning that once the barrier to having sex was overcome, these women were passionate and orgasmic, in accordance with the later developed Sex Response Cycle model (2000, 2005).

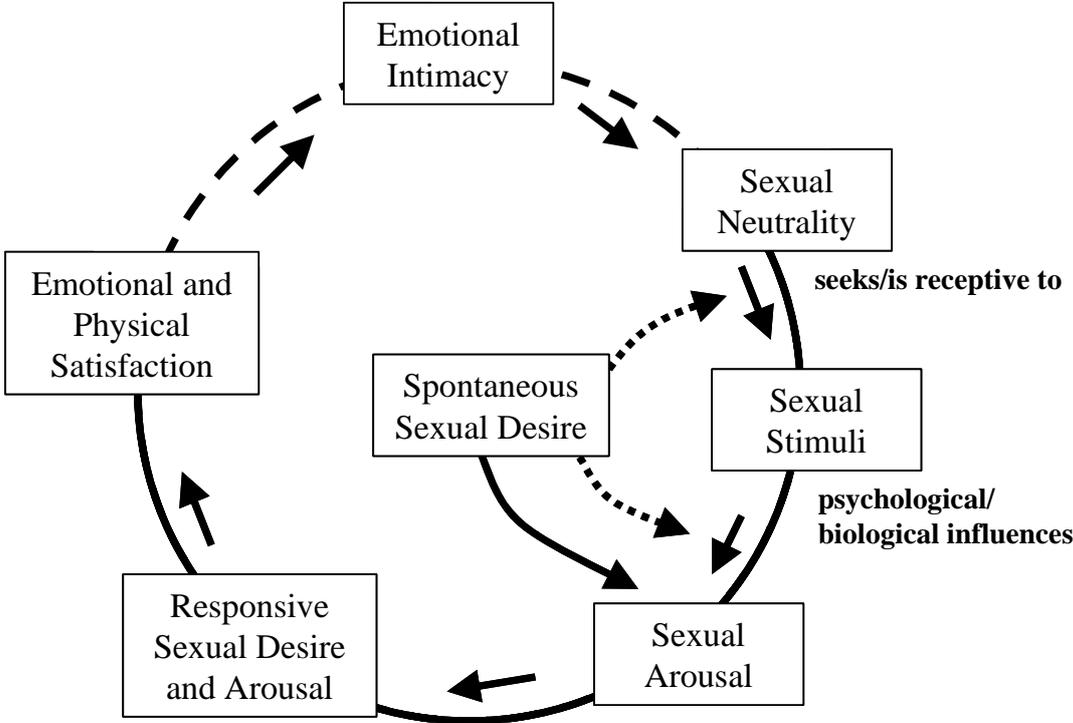
In her original intimacy-based model, Basson (2000) acknowledged that desire develops after or during arousal, rather than before arousal. Basson (2000, 2001, 2002a) pointed out that a woman frequently begins a sexual experience being sexually neutral, or having no sexual desire *per se*, for intimacy-based reasons. When a woman is willing to become aroused and enjoy a sexual experience, she finds or receives sexual stimuli that could potentially move her to a state of sexual arousal. She focuses on the sexual stimulation she and her partner can supply. If the stimulation is as she wishes, she can stay focussed, and her sexual excitement and pleasure intensify (Basson, 2000, 2002b). With further arousal, sexual desire is ignited, which enables her to go on with the experience for the sake of the sexual enjoyment and sexual tension. Basson makes a clear distinction between responsive and spontaneous desire: sexual desire in the context described above is responsive (Basson, 2000:53).

The rewards of intimacy and emotional closeness resulting from a sexual experience are motivational factors that may activate subsequent response cycles. This motivation may also be accompanied by a sense of physical sexual neediness. Evaraerd and Both (2000) supported Basson's contentions, arguing that, although desire can be ignited spontaneously, or through fantasy, desire can also be felt *because* a woman is having sex, and attending to the sexual stimuli whilst doing so. In such instances, desire follows sexual arousal.

The views on desire of Kaplan (1995) and Basson (2000) are acknowledged by Levin (2002), and incorporated in his proposal of two desire phases: the first phase being a spontaneous desire phase created endogenously which occurs before the excitation phase and in the second phase sexual desire is activated by sexual excitation.

Continued research and increasing data confirmed that women instigate or agree to sexual activity with their partners for a *variety* of reasons, of which only *one* is the need for intimacy. Basson (2001, 2004, 2005) acknowledged that these results indicated that women's motivations to be sexual are complex, and there may be many reasons why they may agree to have sex, ranging from wanting to experience sexual pleasure, to please a partner who wanted to have sex, to relieve tension, or increasing her own well-being and self-image/sense of

feeling attractive and feminine. Accordingly, Basson expanded her Sex Response Cycle model to incorporate these findings of multiple motivations, as will next be expanded upon, and illustrated by Figure 2.3.



**Figure 2.3 Sex Response Cycle model** (Basson, 2005)

The Sex Response Cycle model thus departed from the linearity of previous models, and adopted the notion of true cyclicity (Basson, 2005). In the cyclical model, *intimacy (and other) needs* lead to seeking out or being *receptive to sexual stimuli*, with biological and psychological factors affecting the processing of stimuli that lead to *sexual arousal*, creating the *sexual desire* to continue the activity, which leads to further arousal, pleasure and a positive outcome (emotionally and physically) resulting in *enhanced intimacy*. The emotionally and physically positive outcomes then increase subsequent motivation. Thus, Basson (2004, 2005) moved away from the notion that spontaneous desire initiates a sexual response cycle, to a need to focus instead on women’s arousability. Women therefore are also dependent of factors *external* to themselves, which may potentially arouse them and trigger sexual desire.

The Sex Response Cycle model considers not only *biological*, but also *subjective* and *contextual* factors that contribute to female sexual functioning. Basson and others (Basson,

2002a; 2002b; Wood *et al.*, 2006) contend that sexual intimacy is the primary contributor to sexual desire in women, but that it can be affected by level of tenderness, mutuality, respect, communication, or pleasure from physical touching. As will become clear in this study, it is an important finding that *women may have many other reasons, apart from intimacy based, to engage in sex.*

### **2.2.5.3 Critique of the Sex Response Cycle model**

The Sex Response Cycle did not escape critique. Both and Everaerd (2002) disagreed with Basson's notion of fundamental neurobiological differences in male and female sexuality, and criticised her use of terms such as "biological urge" and "physical neediness or hunger" (Basson, 2000, 2002a) as being based on outmoded drive models of sexual motivation. They argue that recent research had transformed the concept of sexual motivation from drive- to incentive-based motivation (Agmo, 1999, in Both & Everaerd, 2002). They also asserted that desire was always responsive, although it may be subjectively experienced as spontaneous. According to Both and Everaerd (2002), subjective experience of desire is a reflection of sexual motor effects, which make a person *aware* of sexual feelings, where after they to respond voluntarily. This they noted means that desire is never spontaneous and all sexual feelings are a response to stimuli.

### **2.2.6 Review**

Models of the human sexual response have greatly enhanced the understanding of sexuality. The earlier ones, such as HSRC (Masters & Johnson, 1966) provided a foundation and a context on which subsequent theories could be built and tested, leading to better models that more accurately depict the complexity and gender-specificity of human sexual responses. The early models, which focused strongly on biological/genital motivation for sex, were challenged and alternative models developed, which afforded greater importance to emotional motives.

The alternative models, which are arguably less biased towards women, have, however, not been incorporated into the DSM classification scheme (DSM-1V-TR, 2000), which still bases its definitions of "normal" sexual response primarily on the HSRC phases of sexual response (Masters & Johnson, 1966) with some modifications introduced by the Tri-phasic model (Kaplan, 1979; 1995). This is despite the fact that Kaplan, herself, made the point that our

interest in sex is greatly influenced by our emotional states and the quality of our relationships with our partners (Kaplan, 1995).

There are, however, a host of other factors that affect sexual functioning in humans, not the least of which is that human reproductive behaviours have evolved to the point where they are (relatively) free from the structures of mating seasons, and hormonal fluctuations that control many other species. One consequence of this is that human sexual functioning is predominantly shaped by learning, childhood experiences, and the social context in which they occur. These factors are given more attention in the Chapter 3.

## **2.3 CLASSIFICATION AND DEFINITIONS OF SEXUAL DYSFUNCTION AND DESIRE DISORDERS**

### **2.3.1 The DSM and sexual dysfunction**

The Diagnostic and Statistical Manual of Mental Disorders (DSM)-classification system is widely used and recognised in the western world as the basis for diagnostic criteria (Kaplan & Sadock, 1998), and is an important reference for clinicians.

The first DSM- manual (1952) did not address “sexual dysfunctions”, but DSM-11 (1968) listed sexual dysfunction as symptoms of psychosomatic disorders (Tiefer, 1995).

As noted in the previous section, DSM-111 (1980) and DSM-111-R (1987) based the diagnostic criteria for normal sexuality on the HSRC (Masters & Johnson, 1966), with some variations based on the Tri-phasic model (Kaplan, 1979).

Thus, the definitions of “normal” sexual response are still based primarily on the HSRC phases of sexual response (Masters & Johnson, 1966) and some of the subsequent modifications, e.g., primarily the inclusion of a “desire” phase (Kaplan, 1979; 1995). This fact means that the criticisms levelled against the HSRC and the Tri-phasic model (Sections 2.2.2.2 and 2.2.3.3) are particularly relevant for clinicians involved in the treatment of sexual problems. Indeed, Tiefer (1995:50-51) questioned whether, from a *clinical* point of view, if it is appropriate to use the HSRC to generalise a clinical standard of normality and “*enshrine the HSRC as the standard of human sexuality such that deviations from it become the essence of abnormality*”.

Tiefer (1995) pointed out that the DSM defines the boundary between normal and abnormal sexual function exclusively on genital performance, and that the sexual acts mentioned are mostly heterosexual coital acts. This genital and heterosexual focus excludes and demotes non-genital possibilities for sexual expression and pleasuring (which also have implications for therapy). Basson, *et al.* (2000, in Wood *et al.*, 2006) in turn criticised the DSM diagnostic system for being ambiguous, inconsistent and too limited, and clearly needing assistance to reflect the experiences of women.

### **2.3.2 The DSM and sexual desire disorder**

The controversy surrounding the definition of “*sexual dysfunction*” extends to the definition and diagnosis of “*sexual desire disorder*”.

Kaplan (1979:10) described sexual desire, or libido, as the experience of sensations that result in an individual seeking sexual experiences. In the absence of these sensations, the person loses interest in erotic matters, loses “appetite” for sex and becomes “asexual”. “*Inhibited Sexual Desire*” was therefore evidenced by low libido, where the person would neither pursue sexual gratification nor avail themselves of such should the opportunity arise (Kaplan, 1979). This term was included in the DSM-111 (1980) in accordance with Kaplan’s Tri-phasic model (Kaplan, 1979).

Critics of the term “inhibited” (e.g. Apfelbaum, 1988) contended that it had an accusatory tone and implied that the conditions for desire were present but that sex was purposefully withheld. In response to this criticism, the DSM-111-R (1987) changed the term to “*Hypoactive Sexual Desire Disorder*” because it reflected greater neutrality. This term was retained in DSM-1V and DSM- 1V-TR (2000), and underscores the possible biological causes of some cases of sexual apathy (Rosen & Leiblum, 1995).

Research into sexual desire has, however, shown that a wide variety of intra-psychic, interpersonal and biological factors contribute towards low desire. These essentially indicate that, as with other sexual problems, low desire may be a symptom of an underlying disorder, but is just as likely to be a normal response to any number of circumstances (Rosen & Leiblum, 1995; Tiefer, 2001; Basson, 2005; Hicks, 2005).

The shortcomings of these models notwithstanding, their inclusion in clinical definitions means that concept of “desire” was introduced over 30 years ago, and has increasingly become the focus of more contemporary research (e.g. Wood *et al.*, 2006). Fortunately, much of this more recent research has paid more attention to women’s experience of sexuality, chiefly the development of non-linear models of human sexual response, which are addressed in Section 2.2.5, but also the promulgation of alternative clinical definitions and diagnostic criteria that have greater relevance to women (see below).

### **2.3.3 The Consensus Report and DSM Term Revision**

#### **2.3.3.1 Sexual dysfunctions**

In an effort resolve the growing concerns about definitions of sexual dysfunctions as they pertain to women, an International Consensus Development Conference convened in 1998 (Basson *et al.*, 2000). The organisers, supported by funding from pharmaceutical companies, invited nineteen specialists in female sexuality to participate. The delegates initially agreed, *inter alia*, to develop a classification system for female dysfunction that would complement the existing ones that were more applicable to men. Ironically, however, although the panel noted that the DSM classifications were ambiguous and limited, they recommended their continued use (with some minor changes as will be pointed out in the next section), thereby reinforcing the *status quo* (Bancroft *et al.*, 2003; Wood *et al.*, 2006:240). Thus, in the so-called Consensus Report, the major diagnostic categories of the DSM were retained, and others were redefined and expanded (Bancroft, 2002) and incorporated in the DSM-1V-TR in 2000. These are given greater attention in Section 2.3.4.

Significantly, the conference recommended the inclusion of “personal distress” as a criterion for a definition for sexual dysfunction, acknowledging women’s sexual rights, choices and self-determination, i.e. “sexual agency” (Wood *et al.*, 2006). A woman hereby should not be diagnosed as having a disorder if she herself is not “distressed” by her situation (for example, out of choice is celibate). The addition of the “personal distress” criterion was seen as a significant step forward, as it recognises the unique circumstances of each women, avoiding the creation of an artificial norm by which a women’s response is measured as either appropriate, sufficient or normal (Slowinsky, 2001).

### 2.3.3.2 Desire disorders

The consensus conference redefined “*Hypoactive Sexual Desire Disorder*” as “the persistent or recurrent deficiency, (or absence) of sexual fantasies/thoughts, and/or desire for or receptivity to sexual activity, which causes personal distress” (Basson *et al.*, 2000).

The proposal for inclusion of the notion of “*receptivity*” in the definition of sexual desire disorder was seen as an improvement on the DSM-IV definition, but as “*receptivity*” was not clearly defined it also drew criticism (Wood *et al.*, 2006). Everaerd and Both (2001) highlighted several problems with the term. They asked whether a woman is considered dysfunctional if her partner is unable to arouse her desire, causing her to be “not receptive”. They also pointed out that sexual stimulation that results in arousal and desire can occur in the absence of a partner, thus “*receptivity*” should not be limited to sexual activity with a partner.

Similarly, as noted before, the addition of the “*personal distress*” criterion was added to avoid classifying women dysfunctional when they themselves were unconcerned with her level of sexual desire. In terms of the consensus definition, if the person feels no distress, there is no dysfunction. Everaerd and Both (2001) commented that it must be comforting for people to know that finding sex unimportant is not regarded as “unhealthy”.

The term “*personal distress*” also caused some disquiet as this may arise for reasons unrelated to a disorder. For instance, incompatibility of desires between partners can lead to distress without either partner being dysfunctional or needing treatment for such (Everaerd & Both, 2001). Tiefer (2001) observed that the consensus document omitted non-medical problems, complaints and difficulties women repeatedly report as being their primary areas of “*personal distress*”, including a wide range of socio-cultural, political, economic, relationship, and psychological factors, which contribute to sexual problems.

Several other prominent researchers questioned the Consensus Report, in particular its emphasis on quantifiable measures, which are often unreliable (Everaerd & Both, 2001); its omission of advances based on theoretical approaches (Everaerd & Both, 2001); its exclusion of non-medical origins for sexual dysfunction (Tiefer, 2002); and its continued use of the term “*dysfunction*” (Weerakoon, 2001). Weerakoon (2001) suggested that the term “*concern*” would be more appropriate and acceptable to women.

One of the most candid challenges came from Moynihan (2003) who opposed the report on the grounds that the researchers responsible for defining and classifying female sexual dysfunction as a “medical disorder” had close ties with pharmaceutical companies. He criticised what he termed “*sponsored definitions*” as misleading and potentially dangerous, and argued that it serves the pharmaceutical companies’ interests to create a need and demand for drug treatment. Similarly, Rosenthal (2001:204) questioned the focus on “*finding pills to cure just about any problem*”.

Following the conference, efforts to find drugs (mainly testosterone based) that could treat the perceived sexual problems in women increased significantly (Tiefer, 2001; Bancroft *et al.*, 2003; Hicks, 2005). The psychosocial factors that contribute to sexual problems did not, however, receive nearly as much attention (Rosenthal, 2001:204). Unsurprisingly, the general consensus was that the contributions of female biology, sexual scripts of what is “normal” and anxiety about sexual response towards low sexual desire require additional clinical exploration (Slowinsky, 2001).

### **2.3.4 DSM-1V-TR (2000)**

#### **2.3.4.1 Classification of sexual dysfunctions**

The DSM was updated in 2000, to include the recommendations in the Consensus Report, and the new reference became DSM-1V-TR (Term Revision). The DSM-1V-TR retained the view that “normal” sexual functioning requires the smooth progression through the four stages of the sexual response cycle: desire, excitement, orgasm and resolution, and that “failure” or disorders of sexual response, may occur at any one of these phases (Westheimer & Lopater, 2005). The DSM-IV-TR, however, included for the first time the criterion of “personal or relationship distress” before a diagnosis could be made of “dysfunction”, as per the recommendations of the Consensus Report (Bancroft, 2002).

Sexual dysfunctions in the DSM-IV-TR (Table 2.1) are therefore defined as “*disturbance in the processes that characterise the sexual response cycle or by pain associated with sexual intercourse*”, and that cause “*marked distress and interpersonal difficulty*” (APA, 2000:535).

**Table 2.1 The DSM 1V-TR (2000) classification of sexual dysfunctions<sup>1</sup>**

1	Sexual Desire Disorders <ul style="list-style-type: none"><li>• Hypoactive Sexual Desire Disorder</li><li>• Sexual Aversion Disorder</li></ul>
2	Sexual Arousal Disorders <ul style="list-style-type: none"><li>• Female Sexual Arousal Disorder</li><li>• Male Erectile Disorder</li></ul>
3	Orgasmic Disorders <ul style="list-style-type: none"><li>• Female Orgasmic Disorder</li><li>• Male Orgasmic Disorder (Premature Ejaculation)</li></ul>
4	Sexual Pain Disorders <ul style="list-style-type: none"><li>• Dyspareunia</li><li>• Vaginismus</li></ul>
5	Sexual Dysfunction Due to a General Medical Condition
6	Substance Induced Sexual dysfunction
7	Sexual Dysfunction Not Otherwise Specified

As with all other disorders defined by the DSM-1V-TR, sexual disorders can only be diagnosed after general medical conditions and substance use have been excluded as possible causes. Thereafter, clinical judgement is needed for diagnoses, as the DSM criteria do not specify the frequency or type of sexual encounters associated with any of the disorders. The clinician needs also to take into account factors such as age, experience, chronicity of the symptom, and subjective distress (DSM-1V-TR, 2000).

The DSM 1V-TR inclusion of a diagnostic criterion that the sexual complaint has caused difficulty in a relationship (“interpersonal difficulty”), recognises that sexual dysfunction often occurs within a personal relationship. Unfortunately, this criterion may result in a woman being diagnosed with a sexual dysfunction solely on the grounds that her partner has complaint with their sex lives. For instance, if a man requests frequent sex and the woman is unwilling (for whatever reason) to satisfy his request, it is she who is diagnosed with a desire dysfunction (Slowinsky, 2001; Basson, 2005). Furthermore, the wisdom of casting distress as a “dysfunction” as opposed to a normal and logical response to difficult circumstances, such as relationship conflict, has also been queried (Basson, 2005). In the words of Sugrue and Whipple (as cited in Wood *et al.*, 2006:40), the DSM “*inaccurately pathologises what seems normal and natural for many women*”.

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<sup>1</sup> This study focuses exclusively on the first category, i.e. that of “**sexual desire disorders**”. This will be expanded upon in the section on “desire” problems specifically.

The next section concentrates on desire disorders, which are the focus of the study.

#### 2.3.4.2 Classification of Sexual Desire Disorders

DSM-1V-TR (2000:541) defines Sexual Desire Disorders as:

**Hypoactive Sexual Desire Disorder:** persistent or recurrent deficient (or absent) sexual fantasies and desire for sexual activity. The judgement of deficiency or absence is made by the clinician, taking into account factors that affect sexual functioning, such as age and context of the person's life. This condition causes marked distress or interpersonal difficulty.

**Sexual aversion disorder:** the persistent or recurrent extreme aversion to, and avoidance of, all (or almost all) sexual contact with a sexual partner. This condition causes marked distress or interpersonal difficulty.

The following diagnostic criteria needs to be considered:

##### *(a) Diagnostic features of Hypoactive Sexual Desire Disorder*

The clinician, taking into account factors that affect sexual functioning, makes the judgement of the occurrence of persistent or recurrently deficient (or absent) sexual fantasies and desire for sexual activity. The disturbance causes marked distress or interpersonal difficulty.

##### *(b) Diagnostic features of Sexual Aversion Disorder*

The essential feature is the aversion to and active avoidance of genital contact with a sexual partner, causing marked distress or interpersonal difficulty. With Sexual Aversion Disorder some individuals report generalised revulsions to all sexual stimuli, while others focus on a particular aspect of sexual experience (e.g. genital secretion, vaginal penetration).

##### *(c) Subtypes*

There are several subtypes of these disorders depending on variations in:

- Onset: The sexual dysfunction may be “*lifelong*” or “*acquired*”, depending on whether the dysfunction has manifested since the onset of sexual functioning, or developed after a period of normal functioning.
- Context: The sexual dysfunction may be “*situational*” or “*generalised*” depending on whether the dysfunction is limited to certain types of stimulation, situations, or partners, or not.

Aetiological: “*Due to psychological factors*”, or “*due to combined factors*”, i.e., psychological plus a general medical condition or substance use.

There are four basic diagnoses of each category (DSM 1V-TR, 2000):

- Hypoactive Sexual Desire Disorder/Sexual Aversion Disorder due to psychological factors.
- Hypoactive Sexual Desire Disorder/Sexual Aversion Disorder due to a general medical condition.
- Hypoactive Sexual Desire Disorder/Sexual Aversion Disorder due to combined factors.
- Substance-induced sexual dysfunction.

The sexual dysfunction may be “*due to psychological factors*”, when psychological factors have the major role in the onset, severity, exacerbation or maintenance of the sexual dysfunction, and no medical condition or substance abuse is causative.

The sexual dysfunction may be “*due to a general medical condition*” if physiological effects of a specified general condition based on findings from physical examination, laboratory findings or on history of the patient have the major role in the onset. Certain general medical conditions such as neurological (e.g., multiple sclerosis, spinal cord lesions), hormonal (e.g., testosterone abnormalities), endocrine conditions (e.g., diabetes, hypothyroidism), genitourinary conditions (e.g., genital injury, urethral and vaginal infections, post surgical complications such as episiotomy scars, shortened vagina and cystitis), and metabolic abnormalities may impair the physiological substrates of sexual desire (DSM 1V-TR, 2000).

The sexual dysfunction may be “*due to combined factors*” if it is judged that the sexual dysfunction is not due exclusively to either psychological factors or the direct physiological effects of the medical condition.

“*Substance-induced sexual dysfunctions*” are judged to be exclusively a result of the direct physiological effects of a substance (e.g., anti-hypertensive medication or drug abuse).

Clinical judgements should take into consideration the individual’s ethnical, religious and social background, as these may influence sexual desire, expectations and attitudes about performance. Low sexual interest is also frequently associated with problems of sexual arousal or with orgasm difficulties.

The clinician may also need to assess both partners, to ascertain whether for example discrepancies in sexual desire are contributing to the desire disorder, as an apparent low desire may reflect an excessive need by the other partner.

*(d) Associated features and disorders*

Mood disorders and anxiety disorders can be associated with sexual desire disorders. When confronted with a sexual situation, individuals with Sexual Aversion Disorder may present with extreme anxiety, and symptoms of a panic attack. They may also use covert strategies to avoid sexual situations, such as going to bed early, or being over-involved in work.

Sexual Aversion Disorder may also occur in association with other dysfunctions, such as Dyspareunia (pain disorder), and if so both should be noted. The additional diagnosis is not given when the aversion is better accounted for by another disorder, such as a major depression (Axis 1 disorder), only if it predates this disorder or receives independent clinical attention. Although it may meet the criteria of Specific Phobia, the additional diagnosis is not given.

*(e) Course*

Sexual desire disorders usually develop in adulthood after a period of adequate sexual interest, although there are “lifelong” cases, which have their onset in puberty.

DSM 1V-TR (2000) states that onset may be accompanied by or caused by psychological distress, stressful life events, or interpersonal difficulties. Depending on relationship or psychological factors, the loss of desire might be continuous or episodic, with episodic loss of desire frequently being associated with problems around intimacy and commitment.

DSM 1V-TR (2000) does not provide any criteria related to minimum frequency, the range or settings of activities or the types of sexual encounters in which the dysfunction should occur. This is left to the judgement of the clinician.

#### **2.3.4.3 Critique of the DSM-IV-TR**

The DSM-1V-TR, even in its updated and expanded form, did not escape critique. Tiefer (2001:90) asserted that the DSM “*promotes a specific norm of sexuality – correct genital performance.... It’s overly genital, suspiciously phalocentric, and ignores subjectivity and meaning. If it’s wet and hard and works, it’s normal; if it’s not, it’s not*”.

Slowinsky (2001) emphasised the need to re-examine the common use of the male-oriented models of human sexual response to explain female functioning, as from clinical practice it is known that women's sexual response does *not* always follow the linear progression through the phases, as is the case for men. Leiblum (in Wood *et al.*, 2006) and Basson (2002a) also noted that even the latest version of the DSM is still based on Kaplan's 1979 Tri-phasic model, despite the considerable, supported criticism of its foundation in the HSRC of Masters and Johnson (1966).

The New View (Tiefer, 2001; Hicks, 2005) criticised DSM-1V-TR as still based on the false notion of sexual similarity between men and women, not considering the relational context of sexuality by assuming that treatment can occur without regard for the relationship in which sex occurs, and ignoring differences among women.

In turn, the American Foundation of Urological Disease criticised the DSM-1V-TR for its focus on the linear model of human sexual response, which portrays *discreet phases* of sexual response. The resulting diagnostic categories in DSM reflected this linear model, which is conflicting with recent research findings of women's sexual functioning, which indicates that the *phases of sexual response overlap* (Everaerd & Both, 2000; Basson, 2005).

The DSM-1V-TR term "Hypoactive Sexual Desire Disorder" is depicted by Basson (2005:1330) as an "*older term*" with a diagnostic criterion of an absence of *spontaneous or initial desire, which is based on the notion of men's spontaneous /innate desire*. Importantly, it is normal for most women to not retain this initial ability for spontaneous desire, and in longer-term relationships the women rather has a *preparedness/receptivity* to deliberately choose to experience sexual stimulation because of an awareness of the rewards that sexual intercourse will bring (Goldmeier, 2001; Basson, 2005). The lack of desire therefore does *not* constitute by itself female sexual dysfunction in the new definitions. Desire, in the circular model, may only be triggered *during* the sexual activity as response of sexual stimulation. Hence, the absence of *responsive* desire might indicate a disorder (Goldmeier, 2001).

Basson (2005) furthermore criticised the DSM-1V-TR definition for having focused on the absence of *sexual fantasies* and sexual desire *prior* to sexual activity and arousal, even though the incidence of this form of (spontaneous) desire was known to vary greatly among women without sexual complaints. Women report that sexual fantasies can be deliberate as a means to

stay focussed on the sexual stimulus *during* sexual activity, rather than an indication of sexual desire *prior* to sex (Basson, 2005).

Suggested alterations to the DSM-IV-TR, specifically those from the New View Working Group (2000) and from the American Foundation of Urological Disease (ICUFUD) (2003) are covered in more detail in Sections 2.3.5 and 2.3.6, respectively.

Now that the clinical view of desire disorders have been highlighted, the next section will examine the feminist approach to desire disorders from women's point of view.

### **2.3.5 A New View on women's sexual problems**

Following the Consensus Conference of 1998, and in response to both the ratification of the DSM diagnostic criteria and the upsurge in drug-focused research into sexual desire disorders with its attendant emphasis on medicalisation, a working group (referred to here as the New View Working Group) was formed under the leadership of Tiefer (2000). The group aims offer a "*multidimensional model of sexual function that will assess women's experience as accurately as possible and lead to more successful treatment outcomes*", whether in psychosexual therapy or a medical context (Hicks, 2005). Since its inception in 2000, the New View Working Group has produced a numerous research articles disputing the biomedical model used to construct the DSM classification scheme.

The group claims that the DSM-IV-TR classification scheme, despite changes included in its latest edition, remains a "fundamental barrier" to understanding women's sexuality (Wood *et al.*, 2006). It has identified the three most serious distortions of women's sexuality produced by the biomedical model, as the *presumed sexual equivalence between men and women*, endorsed by the traditional models of sexual response, and identical classifications system of sexual disorders for both men and women. Secondly, *the disregard of the relational context of sexuality* by the assumption that genital and physical difficulties can be measured and treated without regards for the relationship within the sex occurs. The final distortion is *the levelling of differences among women* not taking into consideration that all women are *not* the same, and women differ in a variety of ways such as their values, approaches to sexuality, social and cultural backgrounds, and their sexual needs and satisfactions (Tiefer, 2001; Wood *et al.*, 2006).

To address these distortions, the New View Working Group proposed the development of a classification system for sexual concerns based on women's real-life experiences (Tiefer, 2001; Hicks, 2005; Wood *et al.*, 2006), in which women identify their own sexual problems. Furthermore, they suggested that women's sexuality should be considered within broad, multidimensional framework that reflects the vast group of aetiologies, based on the insights of feminist clinicians and theorists and identified through clinical practice and/or research (Wood *et al.*, 2006).

The group suggested replacing the term "sexual dysfunction" with "sexual problems", which they defined as "*discontent or dissatisfaction with any emotional, physical, or relational aspect of sexual experience*" (Kaschak & Tiefer, in Wood *et al.*, 2006; Hicks, 2005). Importantly, this definition avoided categorising any one pattern of sexual experience as "normal" (Tiefer, 2001). No sexual problem (e.g. arousal or orgasm) was singled out in the categorisation, and the general term "sexual problems" encompasses the broad spectrum of different "phase" problems. This definition acknowledged the findings that women are less concerned about physical arousal than subjective (emotional) arousal, and the sexual complaints are more focused on the absence of emotional intimacy or relationship satisfaction than on the lack of physical sensations.

The New View Working Group advocated the development of sexuality theory, research, education, and practice that is meaning-centred rather than function-centred, and grounded in humanistic rather than in biological foundations (Tiefer, 2001). The New View framework (Hicks, 2005) was an attempt to see sexual experiences *from the woman's point of view*, to incorporate what sexual problems women themselves articulate and to embrace women's concerns most completely.

Four comprehensive and interrelated areas were identified as the major contributors to women's sexual problems (Tiefer, 2001; Hicks, 2005):

- a. socio-cultural, political or economic factors;
- b. partner and relationship issues;
- c. psychological conflict and personal history; and
- d. medical and physical conditions.

The new classification formulated by the New View Working Group is provided in Table 2.2.

**Table 2.2 Women's sexual problems: a new classification (shortened version)**

<p><b>1. Sexual problems due to socio-cultural, political or economic factors:</b></p> <ul style="list-style-type: none"><li>a. Ignorance and anxiety due to inadequate sex education, lack of access to health services or other social constraints (e.g., lack of information about how gender roles influence men's and women's sexual expectations, beliefs and behaviours);</li><li>b. Sexual avoidance or distress due to perceived inability to meet cultural norms regarding correct or ideal sexuality (e.g., anxiety about one's body, sexual attractiveness or sexual responses or shame about desire and fantasies).</li><li>c. Inhibitions due to conflict between sexual norms of one's subculture or culture of origin and those of the dominant culture.</li><li>d. Lack of interest, fatigue, or lack of time due to family or work obligations.</li></ul> <p><b>2. Sexual problems relating to partner and relationship:</b></p> <ul style="list-style-type: none"><li>a. Inhibition, avoidance, or distress arising from betrayal, dislike, or fear of partner, partner's abuse or couple's unequal power, or arising from partner's negative patterns of communication.</li><li>b. Discrepancies in desire for sexual activity or in preferences for various sexual activities.</li><li>c. Ignorance or inhibition about communicating preferences or initiating, pacing, or shaping sexual activities.</li><li>d. Loss of sexual interest and reciprocity as a result of conflicts over commonplace issues such as money, schedules, or relatives, or resulting from traumatic experiences, e.g. infertility or the death of a child.</li><li>e. Inhibitions in arousal or spontaneity due to partner's health status or sexual problems.</li></ul> <p><b>3. Sexual problems due to psychological factors:</b></p> <ul style="list-style-type: none"><li>a. Sexual aversion, mistrust, or inhibition of sexual pleasure due to past experience of physical, sexual or emotional abuses; general personality problems with attachment, cooperation or entitlement; depression or anxiety.</li><li>b. Sexual inhibition due to fear of sexual acts or of their possible consequences, e.g. pain during intercourse, pregnancy, sexually transmitted disease, loss of partner, loss of reputation.</li></ul> <p><b>4. Sexual problems due to medical factors:</b></p> <ul style="list-style-type: none"><li>a. Pain or lack of physical response during sexual activity despite a supportive and safe interpersonal situation, adequate sexual knowledge, and positive sexual attitudes. Such problems can arise from:<ul style="list-style-type: none"><li>i. Numerous local or systemic medical conditions affecting neurological, neurovascular, circulatory, endocrine or other systems of the body.</li><li>ii. Pregnancy, sexually transmitted diseases, or their sex-related conditions.</li><li>iii. Side effects of many drugs, medications, or medical treatment.</li><li>iv. Iatrogenic conditions.</li></ul></li></ul>
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Apart from identifying the four comprehensive and interrelated areas as contributing factors to women's sexual problems, new definitions were formulated as an outcome of the work group. These will be discussed next.

## 2.3.6 ICAFUD revised definitions of women's sexual dysfunction

### 2.3.6.1 Sexual dysfunctions

The latest changes to the DSM-1V-classification notwithstanding, the search for more accurate definitions is continuing. The International Committee of the American Foundation of Urological Disease (ICAFUD) hosted a conference in 2003 (Basson *et al.*, 2005; Basson, 2005). More than 2000 experts from 60 different countries contributed towards the conference proceedings, which were published on the Web on Psychiatric Times (2003).

The delegates criticised the DSM-1V- TR for a number of reasons, and mainly focussed its linear model of human sexual response, which depicts relatively *discreet phases* of sexual responding, namely an awareness of *sexual desire* to *arousal* to *orgasmic release* and finally *resolution*. The diagnostic categories reflect this linear and genitally focussed model (Basson, 2005), which is at variance with research findings of women's sexual functioning (Basson, 2002b; Basson *et al.*, 2005; Basson, 2005). The *phases of sexual response overlap* (instead of following in succession), e.g. desire and arousal may coincide and compound one another (Everaerd & Both, 2000; Basson *et al.*, 2005). Furthermore sexual fantasies could be employed *during* sexual activity, rather than an indication of sexual desire *prior* to sex (Basson, 2005).

The proceedings included a set of revised and expanded definitions that attempted to address the dissatisfaction with those in the DSM. These ICAFUD definitions emphasised assessments that took cognisance of the context within which a woman reported problematic sexual experiences, and on her subjective sexual experience (Basson *et al.*, 2005).

Subsequent to the conference, ICAFUD published a summary of the major categories of women's sexual dysfunction (Table 2.3) (Basson, 2005; Basson *et al.*, 2005).

**Table 2.3 Categories of Women's Sexual Dysfunctions** (Basson *et al.*, 2005)

1	Sexual desire/interest disorder
2	Combined arousal disorder
3	Subjective sexual arousal disorder
4	Genital arousal disorder
5	Persistent sexual arousal disorder
6	Orgasmic disorder
7	Vaginismus
8	Dyspareunia

This classification model differs from the DSM-IV-TR in that *the phases overlap* (as per the Sexual Response Cycle model (Basson, 2000; Section 2.2.5.2). In other words, it is not only the first-mentioned category that may have features of desire problems, but also the arousal phase, when desire is not being evoked by stimulation (i.e. no responsive desire is experienced). This categorisation allows for distinguishing between “spontaneous” and “responsive” desire, and consideration of “subjective sexual arousal” (which is an important component in the sexual interaction, as this may lead to responsive desire) as proposed by Basson (2001, 2002a, 2002b, 2004, 2005) and Everaerd and Both (2000). Subjective sexual arousal occurs when a woman agrees to, or instigates, sex (no matter the reason), and she begins to focus on sexual stimuli, experiencing physiological arousal, which can in turn trigger the desire for sex (Basson, 2005). Thus, even if sexual desire is absent initially, it can be stimulated through sexual activity – also known as “subjective sexual arousal”. “Sexual satisfaction” results when the stimulation continues for a sufficiently long time, and when the woman stays focussed on enjoying the sensation of sexual arousal. Sexual satisfaction does not necessarily include orgasm (and so differs from the traditional model).

### 2.3.6.2 Sexual desire disorders

The diagnostic criterion for the DSM-IV-TR Hypoactive Sexual Desire Disorder is an “absence” of desire *for* sexual activity or absence of spontaneous desire. The norm of desire is based on the occurrence of spontaneous /innate desire in men (Basson, 2005). However, it is normal for most women to not retain this initial ability for spontaneous desire, and in longer-term relationships the women rather has a preparedness/receptivity to deliberately *choose* to experience sexual stimulation. Desire may only be triggered *during, rather than prior to*, the sexual activity as response of sexual stimulation (Basson, 2004).

Therefore, in the new definitions the lack of initial or spontaneous desire does **not** constitute by itself female sexual dysfunction, but the absence of *responsive* desire might indicate a disorder.

There is more than one disorder of relevance to this study in the ICAFUD definitions. They are the following (Basson, 2005; Basson *et al.*, 2005:293):

**Table 2.4 Disorders of relevance in the ICAFUD definitions**

1	Sexual desire/interest disorder
2	Combined arousal disorder
3	Subjective sexual arousal disorder
4	Genital arousal disorder

These are explained in more detail below.

The importance of subjective sexual arousal is reflected in the new definitions, and the underlying conception of a circular sex-response cycle facilitates assessment and diagnosis (Basson, 2005).

*(a) Sexual desire/interest disorder*

*“Absent or diminished feelings of sexual interest or desire, absent sexual thoughts or fantasies, and a lack of responsive desire. Motivations (here defined as reasons/incentives) for attempting to become sexually aroused are scarce or absent. The lack of interest is considered to be beyond a normative lessening with life cycle and relationship duration”.*

The key to diagnosis is the lack of responsive desire. Minimal spontaneous sexual thinking, fantasising or desire prior to sexual activity does not necessarily constitute disorder. Disorder is present when motivation to be sexual, for any reason, or sexual stimulation does not cause arousal and concurrent desire to continue.

*(b) Combined sexual arousal disorder*

*“Absence of or markedly diminished feelings of sexual arousal (sexual excitement and sexual pleasure) from any type of sexual stimulation as well as complaints of absent or impaired genital sexual arousal (vulval swelling, lubrication).”*

The diagnosis follows a lack of sexual excitement from any type of stimulation (erotic material, stimulating the partner, stimulation of erroneous zones). There is no awareness of reflex genital vasocongestion. The revised definition now focuses on subjective experience, given the variable correlation between genital vasocongestion and subjective sexual arousal, (so the lack of awareness is an important indicator).

*(c) Subjective sexual arousal disorder*

*“Absence or markedly diminished feelings of sexual arousal (sexual excitement and sexual pleasure) from any type of sexual stimulation. Vaginal lubrication or any other signs of physical response still occur.”*

When, despite lack of subjective arousal from any type of stimulus, the woman and her partner do note lubrication and/or genital swelling, then the criteria of the diagnosis is met. External lubricants are not required for comfortable sexual intercourse.

*(d) Genital arousal disorder*

The diagnosis follows when the woman remains able to be continuously subjectively aroused from nongenital stimuli (erotica, stimulating the partner, kissing, receiving breast stimulation). Sexual excitement from genital stimulation is reduced and reported. Sexual sensitivity of the congested genital tissues has been lost in some women (even with the congestion developing to a normal degree), with the loss of awareness of genital congestion. They retain, at least for a period of time, sexual interest and motivation given their arousability from nongenital stimuli.

### **2.3.6.3 Aetiology**

A range of causes is also provided for each subtype, which link with the factors influencing sexual functioning outlined in Chapter 3. The idea being that women’s sexuality is highly contextual, and thus contextual factors should form part of the diagnostic framework. These include:

- *interpersonal and contextual factors*, such as aspects in the relationship, issues with mental and physical health;
- *personal psychological factors*, such as past negative sexual experiences, emotional instability, sexual distractions and neuroses, and;
- *biological factors*, such as depression, side-effects of medication, and hormonal deficiency have to be considered.

The following factors therefore have to be considered when making a diagnosis:

- Current life context, with interpersonal, environmental, sexual and social precipitating and perpetuating factors.
- Medical factors, such as past and present medical and surgical entities.
- Psychosexual development, with factors such as past sexual abuse.

The revised definitions consider the many reasons women choose to agree to or to initiate sexual activity. The importance of subjective sexual arousal is reflected in the new definitions, and the underlying conception of a circular sex-response cycle facilitates assessment and diagnosis (Basson, 2005).

### **2.3.7 Review**

The notion, encapsulated in the DSM, that any deviation from the traditional human sexual response cycle constitutes a sexual dysfunction has been widely challenged by experts on women's sexuality. In general, the criticisms centre on the presumed sexual equivalence between men and women, and the disregard of contextual factors that can affect sexuality, particularly in women. The concern is that this neglect of causative influences leads to false diagnoses of sexual dysfunction and prejudices the treatment of sexual problems. Alternative definitions, specifically for women's sexual disorders, have been developed in an attempt to correct the perceived shortcomings in current diagnostic references such as the DSM. As yet, however, these have not been incorporated into the DSM. This raises several dilemmas for clinicians involved in managing sexual problems, as sexual desire problems are not sufficiently accounted for in the DSM. The clinician needs to therefore be well versed in the latest developments to be able to have an understanding of the client's issues, by keeping abreast of the latest literature and research findings.

Controversy exists over the views of male dominance also in the field of sexuality, and a contentious issue remains the view of what is to be considered "healthy" versus "sick" in the realm in sexuality, and the debates continue, as the next section will allude to.

## **2.4 REVIEW OF THE CONTROVERSY SURROUNDING ISSUES OF WOMEN'S SEXUALITY**

### **2.4.1 Female sexuality viewed as secondary**

Women's sexuality has long been viewed with negativity and suspicion, and considered of little importance. In the Victorian era, for instance, women who admitted to enjoying sex were in danger of being hospitalised for insanity (Bancroft, 2002). In other cultures women's enjoyment of sex is controlled by physical mutilation, such as clitoridectomies (Bancroft, 2002).

Early research on human sexuality also focussed on men, often to the detriment of women (Bancroft, 2002). As an example, by the early 1980's "nerve-sparing" procedures had been developed for prostrate operations to preserve penis erectile functionality, however, in 2008 no such nerve-sparing procedures had been developed for women who undergo pelvic surgery, such as a caesarean section or hysterectomy. Indeed, according to Berman and Berman (2001) urological procedures to preserve women's sexual sensation are at least 50 years behind those for men. Only of late some of the focus is now switching to women.

#### **2.4.2 Role of the pharmaceutical industry**

In the early 1990s there was a surge in research aimed at a pharmacological research cure for impotence in men, which resulted in the discovery and manufacture of Sildenafil, also known as Viagra. Viagra remains one of the highest selling drug on the market today, and it and its successors generate huge profits for the pharmaceutical industry (Rosenthal, 2000; Nurnberg, Hensley, Heiman, Croft, Debattista & Paine, 2008). Early on, critics warned that the resultant close-knit relationship between the pharmaceutical industry and the sexology field raised serious ethical, political, theoretical and research questions (Tiefer, 1996; 2000) and cautioned against the increasing medicalisation of sexuality.

The early focus on men's sexuality mean that there was an absence of clear definitions in the realm of female sexuality, which in and of itself hampered research. This has been rectified in recent years, which have seen an increase in focus on female sexuality (Bancroft, 2002). The Consensus Conference in 1998 and the advent of a clearer classification and associated definitions (Basson, 2005) has also led to increased physiology and pharmacology research on women sexuality, and the race to find the equivalent of Viagra for women is on (Richardson, Goldmeier & Kocsis, 2005; Nurnberg, *et al.*, 2008)

This is not necessarily good news. Tiefer (2001) and Moynihan (2003:45) contended that the new definitions are tantamount to inventing female sexual dysfunction. Moynihan (2003:45) challenged the Consensus Conference as the " *freshest, clearest example of corporate sponsored creation of a disease*", accusing "cohorts" of researchers of working with colleagues in the pharmaceutical industry "*to develop and define a new category of human illness*". Moynihan (2003) pointed out that in order to build pharmaceutical markets for women, companies required a clearly defined medical diagnosis, which would facilitate

medical trials. The fact that the pharmaceutical industry funded the meetings to derive these definitions does not help ease concerns of nepotism, nor does the obvious profitability of the men's sexual dysfunction "industry", and the promise of similar markets for women.

### **2.4.3 The bio-medical conceptualisation of women's sexual desire**

As seen with the critique lodged against the DSM, the biomedical model locates the source of sexual desire in the physical body whilst this excludes the context of the women's lives, such as partners, and other life priorities (Wood *et al.*, 2006). The "biomedical paradigm" furthermore posits sexuality and the desire for sex as intrinsic, natural and universal (Tiefer, 1988, in Wood *et al.*, 2006), and promote the distinction between "normal" and "abnormal", and "high" and "low" levels of sexual desire, when quite possibly these are a continuum, and subject to a multitude of influences. Such labelling presupposes that all women should experience sexual desire similarly regardless of age, relationships or culture – basically a "one-size-fits-all" model (Wood *et al.*, 2006; Wood, Mansfield & Koch, 2007), and Sugrue and Whipple (2001, in Wood *et al.*, 2006) for this reason argued against the use of the DSM in that it in their view inaccurately pathologises what many women would consider to be natural and normal. Usher, (in Wood *et al.*, 2006) is quoted as follows: "*Women clearly internalise these definitions of 'normal' sexual functioning and as a result refer themselves for help, thus reinforcing the notion of pathology and of the need for expert intervention*". Furthermore, the belief that they are abnormal may account of the high levels of concern amongst women apparently seeking sex therapy to "cure" their lack of sexual desire, whereas it may be a healthy and functional response to stress, tiredness or their partners behaviour patterns (Bancroft, in Moynihan, 2003).

Research grounded in the biomedical paradigm explains aging women's sexual desire in terms of "deteriorating" function and "deficient" levels of hormones. This disease-oriented approach posits women's bodies as "deficient", thereby creating the need for medical and pharmaceutical intervention, typically via hormone therapy (Moynihan, 2003). If sexual desire is seen as being controlled only by hormones, it can then be "treated" with hormones only (e.g. Goldstein & Brandon, 2004; Berman & Berman, 2001), thus creating the impetus for pharmaceutical companies to develop "Viagra-type" drugs for women.

Tiefer (1995) criticised the norm of the prevailing medical model that there is a "correct genital performance" in sex on the grounds that it neglects other factors that contribute to the

complexity of women's sexual problems, and thus runs the risk of oversimplifying (and therefore mistreating) sexual difficulties (Tiefer, in Moynihan, 2003:47). She added that "*the medical model is severely limited in dealing with problems of sexuality because of its mind-body split, biological reductionism, focus on diseases rather than people, and reliance on norms*". Wood *et al.* (2006) concurred, as the "medicalisation" of female sexual desire, reduces individuals' behaviours or habits to products solely of physical health.

Bancroft (in Moynihan, 2003) believed the term "dysfunctional" to be highly misleading as the inhibition of sexual desire in many situations is a healthy and functional response for women faced with stress, tiredness, or threatening patterns of behaviour by their partners. He cautioned that the danger of portraying sexual difficulties as "dysfunction" is that this is likely to encourage drugs to change sexual function, when the attention should be paid to other aspects of women's lives. Women might end up thinking that they have a "malfunction" when they do not. Also Wood *et al.* (2006) also cautioned against the limitations and biases inherent in the terms like "deficient", "disorder" and "dysfunction" that affect notions about the nature of sexual desire.

Laumann, Paik and Rosen (1999) indicated that 43% of women were sexually dysfunctional, a figure that is widely cited in the media and scientific literature (by for example Dennerstein & Leher, 2002; Leiblum, 2002; Moynihan, 2003). Moynihan (2003:46) expressed scepticism and described the article by Laumann *et al.* (1999) as "*one of the milestones in the making of the new disorder*", given credence by the fact that two of the authors disclosed links to a pharmaceutical company, and serious questions hang over the accuracy of the 43% (Leiblum, in Moynihan, 2003). Indeed, in Moynihan (2003) even Laumann conceded that of the women making up the 43% are normal, and that their sexual problems are a reasonable responses to challenges and stress.

On the issue of the label of "sick" when sex is a low priority in a person's life, Everaerd and Both (2001) commented that finding sex unimportant is not regarded as "unhealthy". Wood *et al.* (2007) supported this notion that the diagnosis and treatment is inappropriate when women do not consider their level of desire to be problematic. Women choose to avoid sex for various legitimate reasons, and when they choose to do so, this should be seen as a legitimate option.

## 2.5 SUMMARY

This chapter presents an overview of the development of models of human sexual response, and pointed out how these yielded enhanced insights of sexuality. The HSRC (Masters & Johnson, 1966) provided a base on which subsequent theories could be built, resulting in improved models that more accurately portray the complexity and gender-specificity of human sexual responses. Whereas the early models focused on biological/genital motivation for sex, alternative models were developed which focussed on the greater importance of psychological and emotional reasons, in particular for women. Of significance is the development of the Sex Response Cycle model (Basson, 2005), which provides insights into the difference between innate and responsive sexual desire in women, and thereby enhances a greater understanding of women's sexual experiences as a whole. This model forms the base of contemporary classification and definitions of sexual problems.

Also highlighted in this chapter is the broader field of sexual dysfunctions, and then the focus turned to sexual desire disorders in specificity. With regards to Hypoactive Sexual Desire Disorder, the traditional models and the DSM-classification were covered in more detail, as it directly relates to the focus of this study. The DSM classification received criticism, and addressing some of these shortcomings, the newer, women-centred definitions were explored. As was seen in the last part of the chapter, also the formulation of the new definitions received criticism in specific for appearing to be "creating" female dysfunctions in lieu of financial gain of pharmaceutical companies. Notwithstanding the critique, these definitions are of particular significance for a fuller comprehension of women's sexuality as they more accurately reflect women's experiences (Hicks, 2005).

The next chapter will highlight factors that contribute to the experience of sexual desire, in the context of broader culture, the individual and the relationship.

## CHAPTER 3

### FACTORS AFFECTING SEXUAL DESIRE

Chapter 2 highlighted the earlier views of human sexual response, and some of the particular feminist concerns related to the use of these early and fairly simplistic models as the yardstick for clinical diagnoses. In this chapter, I expand on these concerns through, first, exploring views on the *nature* of sexual desire and, second, exploring the influence of the *social and cultural context* thereon. Interpersonal and social situations, and the role of societal pressure and social scripts are discussed and the main contributing factors, i.e., *physiological, psychological and relationship factors* in sexual desire are broadly categorised and described. For the earlier work (pre-1998), I have relied heavily on the seminal work of Regan and Berscheid (1999) who synthesised and collated a wide array of interdisciplinary theories, methods and data about sexual desire into a single volume.

#### 3.1 CHARACTERISTICS OF A STATE OF SEXUAL DESIRE

##### 3.1.1 A complex construct

Kaplan referred to the lack of understanding on how the brain translates neural activity into desire as “*mysteries*” (Kaplan, 1979:10). Leiblum and Rosen (1988:vii) too stated that sexual desire is “*an extraordinarily complicated aspect of human life*” and alluded to the fact that sexual desire cannot begin to be understood without at least a multifaceted approach. This is chiefly because there is no practical methods by which manifestations of sexual desire can be measured objectively. Indeed, Bancroft (1989:71-72) felt that “*of the various aspects of human sexual experience, sexual desire remains perhaps the most resistant to conceptual analysis*” and “*when we investigate sexual desire we should not expect to reduce it to its basic ingredients*”. Schnarch, (1997:134) suggested that sexual desire was “*the most complex form of sexual motivation among all living things*”. Levine (2002; 2003:285) asserted that clinicians might conceptualise sexual desire, and that scientists might attempt to quantify it, but sexual desire remains a “*slippery concept*”.

There is however little doubt that any attempts at understanding sexual desire should include consideration of the complex interplay of cultural, biological, intrapsychic and interpersonal

factors that exert an influence on its manifestation (e.g., Lief, in Leiblum & Rosen, 1988c; Seigraves, 1988a; 1988b; Levine, 1995; Basson, 2000; Levine, 2003; Hicks, 2005).

### 3.1.2 Psychological and physiological conceptions

The distinctions between physiological and psychological underpinnings of sexual desire appear to be arbitrary, and there is general agreement among researchers that its manifestation indicates an overlap of physical and psychological forces.

The concept of “desire” in earlier works of the 1950s (e.g., Heider & James, as cited in Regan & Berscheid, 1999) was defined as a *psychological* state that reflects the awareness that one wants to attain a “*currently unattainable*” goal, the fulfilment of which is associated with pleasure. Verhulst and Heiman (1988:245) also viewed “sexual desire” as solely “*an emotion*”, devoid of physiological response, which “*causes the person to look for sex*”. Building on these definitions, Regan and Berscheid (1999) defined “sexual desire” as a psychological state that is subjectively experienced by the individual as an awareness that he or she wants or wishes to attain a presumably pleasurable sexual goal that at the time is not available to them.

Most researchers, however, seem to agree that sexual desire is the product of *both* physical and psychological factors (e.g. Levine, 1987; Bullard, in Leiblum & Rosen, 1988c; Stein, in Bertram, 2000). Leiblum and Rosen (1988:5) viewed desire as “*a subjective feeling state*” that may be triggered by internal (e.g., fantasy or genital vasocongestion), and external cues (e.g., a candlelight dinner with an interested partner), and which may or may not result in overt sexual behaviour. Kaplan (1979:10) meanwhile stated that sexual desire is “*experienced as specific sensations, which move the individual to seek out, or become receptive to, sexual experiences*”. These sensations are experienced as sexual interest or/and openness to sex, genital sensations, and feeling sexy, “horny” or restless, which cease after sexual gratification (orgasm). In her later works, Kaplan (1995:15) has suggested that sexual desire/lust is “*an urge*” that is neither simply a subjective sensation, nor a merely mental event, thereby acknowledging the interplay between physiology and psychological factors not previously captured in her tri-phasic model (see Section 2.2.3.2).

Levine described sexual drive as one component of sexual desire, which is evidenced by “*genital tingling, tumescence, or lubrication*” (Levine, 1987:36). In later articles, Levine

(1995; 2002) added the psychological and cognitive components of *longing* for something we do not currently have, and an *interest* in behaving sexually, including *biological underpinnings*. He concluded, “*sexual desire is the sum of the forces that incline us toward and away from sexual behaviour*” (Levine, 2002:39).

Schwartz and Masters (1988) believed that sex is a natural function and that desire, like other components of sexual response, flows “naturally” in the absence of significant blockages. Although Schwartz and Masters (1988) equated desire with other “natural appetites” such as hunger or thirst, they described the manifestation of desire in psychological terms: “*sexual desire manifests itself as an attraction to a person the individual perceives as appealing*”, which can evolve into a casual or a committed relationship. “*Once a pair-bond has been established, sexual desire is a natural way of expressing the sense of intimacy that develops within the relationship*” (Schwartz & Masters, 1988:230).

### **3.1.3 Scope and dimensions of sexual desire**

A person may experience different levels of sexual desire at different times. Lief (1977) wondered whether there were unknown genetic or constitutional factors that leave some people at the low end of sexual desire, similar to any other dimension such as height, or intelligence. Kaplan (1979, 1995) too noted a distribution scale of sexual appetite, with low and high libido at the opposing poles, as did Levine (2002, 2003) who stated that an individual might experience desire in varying frequencies and intensities.

Regarding low libido, Michael *et al.* (in Levin; 2002) reported that 33% of women interviewed said that they were uninterested in sex (as opposed to only 16,5% of men). The qualitative experience of sexual desire may vary from intensely positive to intensely negative. Levine (2002, 2003) suggested the following spectrum:

*Aversion – Disinclination – Indifference – Interest – Need – Passion*

Regan and Berscheid (1999) noted a selection preference for sexual desire with respect to the desired objective (which sexual activity) and the desired object (which person). Furthermore, a person may experience diffuse desire, perhaps leading to masturbation or casual sex, or their desire may be directed towards a particular person.

Levin (2002:4) and Goldstein and Brandon (2004) referred to women's sexual desire as being "multivariate" in quality, in that, depending on the hormonal cycles, it varies from being passively "surrendering" or "open to sex" to actively "capturing and enveloping" or "seeking sex".

### 3.1.4 Sexual desire differs from sexual arousal

Some authors view the "phases" of desire and arousal as separate and distinctive from one another (e.g., Masters & Johnson, 1966; Chapter 2), others describe an interrelationship between desire, arousal and sexual activity as interconnected but discrete phases (Kaplan, 1979), and yet others view them as overlapping (e.g., Basson, 2000).

For instance, Kaplan (1979) asserted that sexual desire is an appetite or drive, produced by the activation of specific neural systems in the brain, while the excitement (i.e., arousal) and orgasm phases involve the genital organs. Lief (1995), also distinguished desire from arousal, and proposed that the arousal/excitement phase is separated into two components – psychologic (arousal) and physiologic (vasocongestion). He illustrated this separation using an example of an impotent male who might have strong arousal but no physiological response, and argued that women might equally experience the full range of physiological sexual responses, without feeling "aroused". This touches on the subject of "subjective" arousal, which is explained in more detail below.

Regan and Berscheid (1999) described "sexual desire" as a psychological state, *different* from physiological-genital arousal, which may occur without conscious awareness. They identified "subjective sexual arousal" as awareness that one is genitally and physiologically aroused, and contend that sexual desire is easily confused with subjective sexual arousal, as both are subjective experiences. The difference is that whereas *sexual desire* implies the *wish* to obtain a sexual object, an interest in sexual activities and desire to engage in sexual behaviour, *subjective sexual arousal* is the *awareness* that one is experiencing certain *physiological and genital reactions* such as an erection, lubrication or elevated heart rate. Subjective sexual arousal is assessed via perceptions of genital changes/sensations, and a self-rating of sexual arousal using terms such as "passionate", "lustful", "horny", "turned-on", "sensual" or "sexy" (e.g. Adams *et al.* in Regan & Berscheid, 1999). The two phenomena can occur concurrently, but sexual desire does not necessarily lead to physiological or genital reactions. Physiological-genital sexual arousal, subjective sexual arousal, sexual desire and sexual

activity can, and frequently do, co-occur (Regan & Berscheid, 1999). For example, seeing an attractive person may cause an urge to have sex, which in turn may cause physiological arousal, when experienced subjectively, may increase desire, which may result in actual sexual behaviour.

Basson emphasised that *desire and arousal coincide* and compound one another, and that the phases of women's sexual responses "overlap" (Basson *et al.*, 2005:291). Like Regan and Berscheid (1999), Basson points out that the even though the traditional view is that vaginal lubrication represent arousal, this does not necessarily constitute a "subjective" state of arousal, as women tend to focus on how mentally exciting they find a stimulus rather than on their physical responses (genital arousal). As a result they may well be unaware of any physical changes taking place (see Lief, 1995). Both and Everaerd (2002) also believe that sexual desire and arousal are interrelated, in that the stronger the arousal grows, the stronger the wish to have sex. The activation of the sexual system by sexual stimuli resulting in arousal and desire may take place either unconsciously, or may be consciously engaged.

When describing "desire" Levine (2002:40-43) listed synonyms as: "*wish, want, crave, long, yearn, hanker, ache, request, interest, plea, need, and aspire*", and stated that people feel their desire in their bodies. He noted that *sexual desire is often indistinguishable from sexual arousal*, in that desire is often only "early" arousal stimulated by neuroendocrine events, interpersonal stimuli or fantasy. He deduced that sexual desire contains biological, psychological, and cultural elements (Levine, 2002; 2003), also acknowledging the interplay between these components. In contrast, "lust" is described as intense *sexual arousal* that is "*unfettered by ordinary psychological, social and moral complexity*" (Levine, 2003:283).

Thus, the consensus view among modern researchers is that the responses of arousal and desire overlap and are often indistinguishable from one another. Furthermore, desire can vary in both form and intensity.

### **3.1.5 Sexual desire differs from sexual activity**

As pointed out previously, the occurrence of sexual activity does not necessarily imply a desire for sexual activity (e.g., Leiblum & Rosen, 1988b). A large body of research indicates that people engage in undesired sexual activities for a multitude of reasons, such as to avoid hurting their partner's feelings or to express feelings of closeness, (e.g. Beck *et al.*, 1991;

Regan & Berscheid, 1999; Tiefer, 2001; Wood *et al.*, 2006). Beck *et al.* (in Levin, 2002), for instance, found that 97% of women they interviewed reported engaging in sexual behaviour without desire. Levin (2002) indicated that some 30% of experienced orgasmic women have never experienced spontaneous sexual desire.

Similarly, a lack of sexual activity does not necessarily reflect lack of interest in sex as a variety of reasons may also result in self- or partner imposed abstinence, including culturally imposed proscription against intercourse such as prohibition of sexual activity during menstruation, or sex before marriage (Regan & Berscheid, 1999).

Sexual behaviour also depends on partner availability and willingness. Even an available partner (such as in marriage) does not imply that the partner is willing to engage in sexual intercourse (Levine, 2002), regardless of the sexual desire in the other partner.

Sexual activity (even if started in the absence of sexual desire) can ignite sexual desire through sexual arousal (Basson, 2000; Everaerd & Both, 2000). Thus, sexual desire can follow sexual arousal. This concept of “responsive” desire has already been mentioned and is elaborated on in the next section.

In summary, sexual desire does not necessarily result in sexual intercourse, and sexual activity does not necessarily imply the presence of sexual desire.

### **3.1.6 Spontaneous and responsive sexual desire**

The notion of spontaneous (or endogenous) desire has its origin in the drive theory (Kraft-Ebbing, 1886, in Regan & Berscheid, 1999; Freud, 1949; Kaplan, 1979; Stuart, Hammond & Pett, 1987). Kaplan (1979) argued that a “normal” person experiences spontaneous sexual desire, and has the capacity for arousal throughout their life. Levine (1987; 1988), on the other hand, saw sexual desire as the integration of three elements, *viz.*: drive, wish and motive, of which the endogenous sexual drive component is evidenced by spontaneous manifestations of genital excitement, mostly in adolescents and young adults. Schwartz and Masters (1988:240) asserted “*the hungers for food, sex, for affection, and for intimacy are all expressions of natural appetites...*”, i.e., that sexual functioning is the same as other natural functions. They supported the viewpoint that desire exists in all individuals and emerges “spontaneously” in all loving relationships.

Hawton (1985:30-31) disagreed, however, suggesting rather that: “*some women lack spontaneous interest in sex but are able to respond to their partners’ approaches and experience arousal and orgasm*”. The contemporary understanding of sexual desire, particularly in women, is that it is often responsive (Basson, 2001) and that a lack of spontaneous desire is not pathological (Goldmeier, 2001). Some women “spontaneously” experience sexual desire, especially in the earlier stages of relationship, but with time this fades to be replaced by responsive desire (Basson, 2000:53; see Sexual Response Cycle model in Chapter 2, Section 2.2.5.2).

Levin (2002) proposed two desire phases: the first phase being a *spontaneous* desire phase created endogenously which occurs before the excitation phase (in accordance with the classical concept by Kaplan), and in the second phase sexual desire is *activated by sexual excitation* (in accordance with Basson). Thus, in accordance with their views (Levin, 2002), female desire can be spontaneous and/or initiated from physical excitation.

Both and Everaerd (2002), on the other hand, claim that sexual desire (in women) is always responsive, although it may be experienced as spontaneous. They claim that individuals may initially not be conscious that they are processing sexual stimuli, but their body responds with, for example, changes in the genitals. When (and if) these responses exceed the perceptual threshold, the result is an awareness of sexual desire and arousal. Thus, in their view, spontaneous desire is actually a response to sexual motor effects. Therefore, desire is never spontaneous, and all sexual feelings are driven by reactions to stimuli.

It appears therefore that desire can be evoked spontaneously, and/or as a result of physical and/or psychological stimulation or factors.

### **3.1.7 Review**

Sexual desire a complex and multifaceted construct. Although it is strongly linked to biology, it is more than a physiological drive and cannot be separated from the psychological influences. Furthermore, for women at least, desire and arousal overlap, and cannot be separated. Desire has quantitative (high and low libido) and qualitative (different ways of experiencing desire) dimensions, and can be either spontaneous (e.g. biologically driven) or

responsive (e.g., in reaction to external stimulation). Sexual desire and sexual activity can exist without one another.

Davis (2001:131, in Wood *et al.*, 2006) remarked that women's sexual problems are "*notoriously multifactorial in aetiology*". In the next sections, I provide an overview of the literature on the contributing effects of cultural context, personal psychology, physiology, and relationship dynamics on sexual desire and experience.

## **3.2 CULTURAL FACTORS INFLUENCING SEXUAL FUNCTIONING**

### **3.2.1 Socialisation and cultural norms**

In terms of *cultural context*, a wide range of socio-cultural, political and economic factors influence women's sexual functioning (Tiefer, 2001; Hicks, 2005), including (but not limited to):

- ignorance and anxiety resulting from inadequate sex education and poor access to health services;
- lack of vocabulary to describe sexual experiences or needs;
- lack of information about biology and life-stage changes;
- lack of information about how gender roles influence sexual expectations, beliefs and behaviours;
- inadequate access to information and services for contraception and abortion, STD prevention and treatment, sexual trauma, and domestic violence contribute to possible sexual problems (Hicks, 2005).

The *process of socialisation* moulds an individual's standards, skills, attitudes and behaviours to conform to those regarded as desirable and appropriate for his or her role in society (Hetherington & Parker, 1979). Socialisation prescribes the thoughts, behaviour and feelings of males and females, including those related to their sexuality. What is considered "appropriate", behaviour tends to be very specific to one's cultural environment, particularly as it pertains to gender roles (Hetherington & Parker, 1979; Westheimer & Lopater, 2005).

The influence of socialisation and sexual scripting (Tiefer, 2001; Hicks, 2005) in sexual avoidance or distress arises from a perceived inability to meet cultural norms regarding "correct" or "ideal" sexuality. This may include anxiety and shame about one's body, sexual

attractiveness or sexual responses, and confusion or shame about one's sexual orientation or identity, sexual fantasies and desires.

Like any other social behaviour, the ability to participate in sexual relationships is learned (Tiefer, 1995). Sexual interaction bonds individuals partly because of its pleasurable, intimate and self-disclosing nature. Most societies have created sexual customs with boundaries to regulate sexual behaviour (e.g. sexual relations within marriage) and sexuality. For any given society, these define what is considered normal or abnormal, or taboo (Reiss, in Regan & Berscheid, 1999). In most societies, monogamy is the primary model of the committed bond (Westheimer & Lopater, 2005) and, as such, committed relationships, specifically marriage, are seen as the legitimate domain for engaging in sexual behaviour. This brings with it the notion of sexual entitlement as part of conjugal rights (King, 1999). As neither partner can legitimately have extra-marital sexual relationships, the withholding of sex from one partner can, and often does, form the basis for complaint about low sexual desire in the other partner (Verhulst & Heiman, 1988). Although many researchers oppose the idea of sexual entitlement in marriage or other committed relationships (e.g., King, 1999), if not satisfactorily negotiated, difficulties around unrewarding sex or unfulfilled sexual needs can lead to the break-up of the relationship (Westheimer & Lopater, 2005).

Of particular relevance to this study is that the concept of low sexual desire is based on a cultural view of "normal" sexuality that presupposes that partners *should* feel some amount of desire for each other, otherwise something is deemed "wrong" (Regan & Berscheid, 1999).

### **3.2.2 Religious teachings**

The *influence of religion* on sexual relationships between individuals, in particular those that preach sexual conservatism (e.g., Le Roux, 1986), can be profound. Lustful thoughts are often portrayed in religious teachings as sinful and adulterous, whereas abstinence and virginity are revered (Kaplan, 1974; Hawton, 1985; Perel, 2007). Kaplan (1974:174) drew attention to society's equating of sex with sin, which she felt led to a denial in childhood, of a need or desire for sexual pleasure. In her view, this was in part as result of a "*relentless assault with painful associations and consequences, especially during the most critical childhood years*" with the message that it is "*dangerous, nasty, hostile, dirty, disgusting and immoral*" to give expression of to sexual urges (Kaplan, 1974:175). These repeated negations of early sexual

pleasure can result in inappropriate control of sexual impulse, and conflict, guilt and alienation from sexuality (Hawton, 1985).

### **3.2.3 Gender scripts**

Script learning is a by-product of early social and emotional development (Rosen & Leiblum, 1988c:170), which includes “*expectations about appropriate gender-role conduct, familiarity and comfort with bodily functions and nudity, tolerance for intimacy and dependency, and attitudes to sexual morality*”. Scripts of male-female differences in sex roles and behaviour evolve, and are internalised and modified, throughout adolescence and adulthood. Conventional heterosexual scripts emphasise female passivity and acquiescence to male initiation and direction.

Traditionally, male scripts have been built around the supposed voraciousness of male sexual appetite, leading to the understanding that men are always available and desirous of sexual encounters, and should orchestrate sex (Zilbergeld, 1999). Conversely, the messages women receive about their sexuality are usually overwhelmingly negative. The factors influencing women’s conceptualisation of sexual desire, including parental guidance in repressive/conservative households, has the affect that many women distance themselves from the experience of sexual desire (Wood *et al.*, 2007). Women also learn to become sexual objects in seeking boys and men’s attention (Wood *et al.*, 2007).

These double standards are often supported by the media (Westheimer & Lopater, 2005), where men are portrayed as free to act as sexual agents while women who do the same are viewed as “sluts”. Women (and men) internalise the sexual double standard and the notion that, for women, sex must be rooted in love, whereas men need (and are permitted to have) sex to fulfil their needs. Barbach (2000) questioned the assumption that men should be the authority on sex and should “give” the woman sexual satisfaction, as well as other expectations created by societal scripts, such as that simultaneous orgasm should occur during thrusting virginal intercourse and that female genitals are dirty and repulsive (Hite, 1976, 1987; Barbach, 2000), on the grounds that these hamper women’s expression and experience of sexuality.

The result of socialization and social scripts is that men and women have different understandings of sexuality (Regan & Berscheid, 1996, 1999). They more or less agree about

what sexual desire is, but have differing views of the *goal* and *object* of desire. Men seem more likely to have a recreational or body-centred orientation, believing sexual desire is aimed at sexual activity. Women appear to be more likely to adopt a relational or person-centred approach, citing love or emotional intimacy as the goal of sexual desire (De Lamater, in Regan & Berscheid, 1999; Tallis, 2004).

From a feminist perspective, women internalise socio-cultural assumptions that privilege men's sexual needs (Wood *et al.*, 2007). In so doing they suppress their own sexual wishes and needs in sexual decision-making ("sexual agency"), relinquish control over their bodies and lose their sense of self. Wood *et al.* (2007) argued that in this way, women move from being sexual *subjects* (women who are in control of their bodies and sexual desire) to becoming sexual *objects* (for use by others, specifically men). They demonstrated that women's reported experience of sexual desire tended not to include mention of fun, pleasure, stress relief or relaxation. Girls learn that sex is done *to* them, whilst boys learn to desire and obtain sex. Girls learn to be passive in sex, and that sex serves boys' needs and interests, not those of girls' (e.g., Barbach, 2000).

### **3.2.4 Scripts relating to appearance and age**

Socio-cultural scripts also dictate the appropriateness of an object of desire (i.e., what is considered attractive or sexually mature, as opposed to ugly or immature), the ways in which desire should be communicated, in which life cycle it ought to be experienced, how much is appropriate, at what age and when, and the places, settings and even the time of day when it is appropriate to feel or act on desire (Regan & Berscheid, 1999).

It is "commonly acknowledged" that puberty is the height of sexual interest for men (Kaplan, 1979; Regan & Berscheid, 1999) and that, for women, sexual interest peaks in their mid-thirties. These perceptions support scripts that view sex as the prerogative of the young and attractive, that sex should cease when procreation is no longer possible and sexual performance should cease after middle age when people are less attractive than before (Hawton, 1985; King, 1999; Regan & Berscheid, 1999; Comfort, 2003). Pervasive stereotypes persist depicting older person as having little interest in sex or being asexual, and as sexually unattractive and unable to perform sexually. Koch, Mansfield, Thereau and Carey (2005) found that middle-aged women lost their sense of control over their sexuality when they

perceived themselves as less attractive as they aged, as this affected their self-esteem and their view as a sexual being.

### **3.2.5 Scripting prescribing sexual conduct**

Scripts provide the *cognitive organisation* of sexual interactions (Gagnon & Simon, 1977:6, in Rosen & Leiblum, 1988c; 1995), defining the situation as sexual, naming the actors, and directing the behaviour. They determine the circumstances under which sexual activity is to occur (the “when and where”), those persons and objects with whom it is acceptable to engage in sexual activity, the range of sexual behaviours (the “what”) and the motives for sexual interactions (the “why’s”) and function as a “code” for directing sexual actions and anticipating the partner’s response (Regan & Berscheid, 1999).

Simon and Gagnon (1986, in Rosen & Leiblum, 1988c) described how scripting focuses on the *contextual nature of sexual conduct*, providing two essential dimensions of sexual interaction: inviting participation or setting the stage, and providing a framework for the emotional experiences attaches to these behaviours. For example, falling in love can provide justification for first intercourse, and the sense of being desired may motivate sexual interaction even if it is not gratifying.

These scripts of sexual conduct can also at times put unrealistic demands on the relationship (Hawton, 1985).

### **3.2.6 Scripting prescribing sexual feelings**

Sexuality is not an inherently significant aspect of human behaviour. Rather, sexual phenomena become significant because they are assigned meaning by society (see Wood *et al.*, 2007 in this regard). It is thus scripts that determine the emotional reactions toward, and meanings attributed to, sexual experiences. This assignation of meaning to the significance of particular kinds of sexual encounters raises expectations of sexual desire and the emotions that will be evoked by sexual situations (Morin, 1995; Regan & Berscheid, 1999), which often leads to disappointment. Hence the common refrain after a first sexual encounter – “is this how it should be, is this *it?*” (after Ellison, 2000). The expectations of partners, which are often built on the same social scripts, may also lead to pressure to feel in a certain way in a sexual situation (Regan & Berscheid, 1999).

There is also cultural pressure to behave properly, and remain positive and avoid friction in relationships. This pressure is intensified by the belief that sexual response should be innate, since it supposedly represents a biological drive (Apfelbaum, 1988). Thus, those who do not respond automatically with arousal feel humiliated and inadequate, while those who do, feel pride. Tiefer (1995) and Barbach (2000) found that many women expect that satisfying sex should occur “naturally” and that they should inherently know how to respond sexually.

### **3.2.7 Review**

In western society, values and norms dictate appropriate behaviour, including sexual behaviour, so that people can live harmoniously. Certain taboos prevail, such as those against incestuous relationships or sexual relations with children, as do other constraints such as the notion that sex should occur within a committed monogamous relationship, usually marriage. While they no doubt have benefits to society, the cultural frameworks that dictate when and how sex should take place can also complicate sexual relations between individuals, particularly, if one of the parties does not or cannot respond “appropriately”. They also dampen any natural spontaneous experience of sexual desire.

Society’s messages about women’s sexuality tend to be negative, which makes it difficult for women to be positive towards sex. Gender roles also create false expectations, and pressure to respond in certain ways. Society frowns upon unattractive and older people enjoying sexual relations, as if this is just the prerogative of the young and beautiful. In the light of such negativity and prejudice it is no wonder that after a few years of marriage people find it difficult to maintain a sexual relationship.

## **3.3 PSYCHOLOGICAL FACTORS INFLUENCING SEXUAL DESIRE**

Following on from the previous section, many factors within an individual may affect their experience of desire, including culturally-imposed notions of gender-identity and religious orthodoxy. Other factors may also play a part, such as depression, age, previous sexual encounters, fear of pregnancy or fear of loss of control over sexual urges, obsessive-compulsive personality disorder, phobias or aversions, and masked sexual deviations (LoPiccolo & Friedman, 1988; Hicks, 2005). Depending on which factors are relevant, they can either enable or inhibit sexual desire.

### **3.3.1 Childhood influences on sexual desire**

Individual histories, learning and experiences play a major part in shaping sexual desires, preferences and fantasies. Early erotic experiences are highly influential in shaping adult sexual destiny. Money (1986) used the term “love map” to describe the mental template of each person’s sexueroptic fantasies and erotic practice, while Morin (1995) similarly wrote of “peak erotic experience” in reference to early erotic experiences linked with desire in later life by association, shaping sexual preferences and idiosyncratic erotic stimuli. A person’s first sexually arousing experiences may become imprinted on and shape his/her erotic programme (Kaplan, 1995). As such, these experiences exert significant influence on the development of an idiosyncratic experience of sexual desire. Of course, these experiences are not always positive, and can lead to the development of a flawed experience of sexual desire.

The societal pressures and values encountered in childhood also exert an influence over adult experiences of sexual desire. Girls, in particular, are subjected to a multitude of messages, positive and negative, regarding the appropriate place for sexuality in their lives, some of which they will internalise (Morin, 1986; Wood *et al.*, 2007). Accordingly, factors such as parenting, religion and the media influence how they will view and conceptualise sexual desire when they reach adulthood.

A child’s experience of the family’s attitudes towards sexuality has a profound effect on psychosexual development (Hawton, 1985). In many families sex is never discussed as a taboo subject, relaying the message that sex is wrong and shameful. Negative messages might even be openly expressed, resulting in inhibited sexual responsiveness and guilt feelings.

Childhood sexual experiences, especially incest, are far more common than previously recognised (Hawton, 1985; Higson-Smith, Lambrecht & Jacklin, 2005). Childhood sexual abuse and trauma is linked to a decrease in sexual desire in adulthood (Bass & Davies, 1988; Sgroi, 1982; Waterhouse, 1994; Trudel, Landy & Larose, 1997) because this often leads to depression, which in turn is associated with diminishing desire (e.g. Levine, 1987; APA, 2000). Hawton (1985) mentioned that adult female rape victims are at risk of developing problems concerning phobic aversion and sexual desire.

### **3.3.2 Life stages and social context**

Sexual desire manifests and is understood differently in different adult life phases and social situations. For instance, as a person moves from being unattached to becoming engaged, getting married, becoming a parent, having an affair, getting divorced, becoming widowed, getting married and so forth, so their motivations for sex change (Levine, 2002; Hicks, 2005). While young and in search of a life partner, there might be an intense need for an intimate connection, which may be celebrated with exuberant sexual behaviour, particularly early in the relationship (Levine, 2002). Similarly, when the couple wants to get pregnant, sexual motivation sparks the desire for frequent sex. After childbirth, factors such as exhaustion, the stress of coping with a new baby, and some physical discomfort after the birth itself, often result in a reduced interest in sex in women (Hawton, 1985). Wood *et al.* (2007) and Træn, Martinussen, Oberg & Kavli (2007) noted that young mothers women often feel rushed, overwhelmed and busy, and the distraction of tasks, worries and other life events (e.g. food preparation, nappy changes, visits from friends and relatives) makes them tense and less interested in sex. Despite the cultural expectation to continue regular and frequent sexual behaviour throughout marriage, one or both partners' sexual desire lessens (Levine, 2002).

Partner loss can induce the need for sex (Levine, 2002), and many people act out frustration and other feelings through engaging in sex in the midst of divorce. It is also a well-documented phenomenon that newly-divorced people seek out sexual encounters (Rice & Rice, 1986).

### **3.3.3 Emotional state**

Mood and desire are intricately connected (Regan & Berscheid, 1999). Emotions play a vital role in the induction or suppression of sex drive, and that if an individual is happy, sex drive is likely to rise, whilst while stressed and angry, it will plummet (King, 1998; Træn *et al.*, 2007). Women who have mood swings during the course of their menstrual cycle reported varying levels of sexual desire when their mood is low (DeAngelo, 2001). There is also a correlation between certain types of mania (such as in bi-polar disorder) and increased sexual desire (APA, 2000), and a great deal of time and effort has been spent exploring the links between depression and sexual desire (Hawton, 1985; Beck, 1995; Kaplan, 1995; Rosen & Leiblum, 1995; King, 1999; Leiblum & Rosen, 2000; Schnarch, 2000; Basson, 2005). Impaired sexual desire has been found in the majority of patients with depressed mood,

depression, and anxiety lead to impaired interest in sex (Hawton, 1985; Trudel *et al.*, 1997; Regan & Berscheid, 1999; APA, 2000; Basson, 2005).

Other findings claim that not only positive or loving feelings, but also intense feelings of anger, guilt, anxiety and closeness that can act as aphrodisiacs (Money, 1986; Everaerd & Laan, 1995). Paradoxically, barriers to intimacy may at times also increase the attractiveness of the incentive, and amplify desire. Morin (1995:73) called this the “erotic equation”:

$$\textit{“attraction + obstacles = excitement”}.$$

Basson (2002) concurred that anxiety increases vasocongestion in the genitalia, even though this may not necessarily be subjectively experienced as an aroused state. Negative emotions such as guilt, embarrassment or shame might preclude the experience of subjective sexual excitement, therefore affecting the ability to become sexually aroused and to feel desire.

Simply put, sexual desire is unpredictable, complex and personalised, and any emotion that results in arousal, can also be a turn-off.

Kaplan, (1979:37) in turn, argued that *all* sexual dysfunctions, including desire problems, are caused by anxiety, which may have many origins such as deep unconscious conflict, considerable hostilities, and fear of rejection, vulnerability, or power struggles. Anxiety is evoked when sex is anticipated, or when the initial sensations of erotic desire are experienced. The person then defends against the anxiety by suppression, deliberate distraction with asexual thoughts, or by focussing on the negative aspects of their partner or the situation as a deliberate “turn off” (Kaplan, 1995).

The suppression of desire may also be appropriate for example when in dangerous situations or when the partner is abusive, unavailable, unattractive, or when sexual activity is disappointing (Kaplan, 1979, 1995). The inhibition of desire is seen to be pathological *only* when it occurs in an “inappropriate” situation, such as when the person suppresses desire for a caring, attractive and loving partner.

Apfelbaum (1988) distinguished between “performance” anxiety which may arise when the individual fears not being able to perform sexually, whilst “response” anxiety arises when the individual does not feel desirous or aroused sexually when feeling under pressure to do so in

the sequence of events leading to sex. Such a woman may fake orgasm, responding to the pressure by her partner to be responsive. She might do this also due to her own personal pressure to affirm her own womanliness. Even so she might still end up feeling that she is a failure as she has the “wrong” reaction to sex, which contributes to perpetuate her anxiety.

Træn *et al.* (2007) established that stress was a common cause of reduced sexual desire in both sexes, but men, in contrast to women, may use sex as means of diversion and recreation from stress.

### **3.3.4 Effect of self-esteem**

A poor body image may be responsible for a decline in sexual interest in women (Berman & Berman, 2001; Goldstein & Brandon, 2004; Carey, Koch, Barthalow, Mansfield & Thereau, 2005). Habitualised negative thoughts about the self also correlate with reduced desire in women (Træn, *et al.*, 2007). Basson (2002b, 2005) also stressed the role of women’s sexual self-concept as positive self-view will result in processing sexual stimuli into arousal and a willingness to engage in further activities, whilst negative a self-view may preclude or hinder development of desire and a continuing positive sexual experience.

### **3.3.5 Role of fantasy and thoughts**

Kaplan (1995:46) used the terms “*sexual desire*” and “*sexual fantasy*” interchangeably, as she was of the opinion that “*sexual fantasies are...mental representations of a person’s most ardent sexual wishes and desires*”. As such, mental representations, or erotic fantasies, emerged as important determinants in sexual desire (Money, 1986; Levine, 1987; Morin, 1995; Barbach, 2000).

Leitenburg and Henning (1995, as cited in Westheimer & Lopater, 2005) found that people who report frequent sexual fantasies generally report fewer sexual problems. These sexual fantasies heighten pleasure and promote arousal. Their content also reflects the person’s sexual value system in ways that their overt sexual behaviour may not. Fantasies are often linked to the early erotic experiences (as per Money, 1986; Morin, 1995) or with people other than a present partner. Some women (Friday, 1973, Ogden, 1999) report elaborate sexual fantasies that, no matter how erotic, may be perceived by others (and themselves) “socially

unacceptable” (such as rape fantasies, being a prostitute, or bestiality). These fantasies are thus mostly not shared with the present partner (Morin, 1995; Perel, 2007).

Levine (1987, 2003) and Barbach (2000) noted that during sexual activities fantasies, memories of past erotic experiences and concentration on the pleasurable sensations, especially the genital area, help women to become aroused, in line with the Sexual Response Cycle proposed by Basson (2002, 2005; Section 2.2.5.2). Moreover, Levine (1987) noted how voyeuristic stimulation (hearing of, reading about or seeing the sexual excitement of others) has the ubiquitous power to generate sexual arousal in that it involves transient fantasy, and suggested that desire in mid-life is largely stimulated by our memories of past excitements (Levine, 2002).

In fact, cognition may be actively and purposefully engaged in by the individual to enhance sexual desire and arousal. Levine (1987, 2003) pointed out that people with weak and/or infrequent drive manifestations may *decide* to behave sexually for idiosyncratic reasons. They may use sex to make them feel loved, valued, important, vital, energetic, connected, or masculine or feminine. Conversely, young people with supposedly high desire and spontaneous arousal may choose *not to* engage in intercourse for a variety of reasons, such as fear of pregnancy, religious beliefs or deference to parental wishes. Memories, or expectations of negative outcomes, may also have a harmful influence on sexual desire or may hinder sexual functioning and arousal, particularly those of negative sexual experiences, such as those where the partner was abusive or overly coercive or where intercourse was painful (Sgroi, 1982; Bass & Davies, 1988; Herman, 1997; Barbach, 2000; Basson, 2005).

Kaplan (1995) and Træn *et al.* (2007) found that thoughts in general are an important factor in sexual desire, in that partners who reported a higher level of habitualised negative thinking about their partner, also reported loss of sexual desire.

### **3.3.6 Review**

The development and maintenance of women’s sexual persona is influenced by a plethora of factors, which ultimately determine her personal views and her sexuality in any particular social situation (Hicks, 2005). During childhood her early sexual experiences may provide a “footprint” for the development of future eroticism, whilst trauma may have a negative influence. Upbringing contributes the individual’s views on sexuality as does the norms and

values in the specific society in which the individual grows up. With maturity, the influence of other life stage factors come into play such as motherhood, and the daily responsibilities of women equally has an effect on their availability and responsiveness sexually. The women's mood and emotional state also may influence the openness to sexual experiences, and her fantasies may play an important role in enhancing the arousal state of the sexual experience. The way the women feels about her self also is a contributing factor on her experience of sexual desire.

Apart from the psychological aspects, the role of biology must also be taken into account in the experience of sexual desire, as will be highlighted in the following section.

### **3.4 PHYSIOLOGY AND SEXUAL DESIRE**

#### **3.4.1 Physical health**

It is common sense that a person's physical well-being will have a profound effect on their interest in sex, and that any pain or illness will dampen it (Kaplan, 1995; King, 1998; Leiblum & Rosen, 2000; Bullard, 2000; Goldstein & Brandon, 2004). Good physical health is a precondition for sexual functioning, as sex is a physical activity dependent on physiological changes (as pointed out in Chapter 2 with the explanation of the physiological changes during sexual activity).

A plethora of medical conditions affect sexual expression, pain or lack of response during sexual activity. These include local or systemic medical conditions, pregnancy, sexually transmitted diseases or other sex-related illness, and the side effects of medical treatments or drugs (Tiefer, 2001; Hicks, 2005). For instance, fibrosis, high blood pressure, high cholesterol or coronary heart disease may diminish the flow of blood to the pelvic region and reduce sexual sensation (Berman & Berman, 2001). Endometriosis, fibroids (problems with the tissue in the uterus), vaginal and urinary tract infections and pelvic floor disorders are all known to reduce sexual desire (Berman & Berman, 2001). Regan and Berscheid (1999) and Levine (2002, 2003) also cite a wide range of research on people who experienced illnesses such as diabetics, cancer, Parkinson's disease, and anorexia nervosa and who reported decreased sexual desire.

Spinal cord injuries or any surgery that damages the nerves leading to the genital areas can result in a loss of sexual sensation, and a reduced ability to become aroused (Hawton, 1985; Berman & Berman, 2001). Hence, some women who have had caesareans or hysterectomy report sexual problems afterwards. Women also report lack of sensation from straddle injuries (e.g. a fall off a bicycle; Berman & Berman, 2001).

### **3.4.2 Medications and drugs that affect sexual functioning**

A wide range of medication can affect sexual functioning (APA, 2000; Regan & Berscheid, 2001). Antihypertensive medication (for blood pressure, or beta-blockers prescribed for anxiety), antidepressants, sedatives, narcoleptics are suspect, and controversy still surrounds the possible effects of birth control pills (Berman & Berman, 2001). Alcohol, marijuana, opiates and heavy smoking may too lead impaired to sexual interest (APA, 2000).

### **3.4.3 Ageing**

Hawton (1985) and Westheimer and Lopater (2005) noted that many women lose interest in sex when ageing, some of which may not be a result of age *per se*, but rather attributable to changes in their appearance or an increased frequency of physical illness. Koch *et al.* (2005) supported this notion. However, sexual appetite is known to change with age (Kaplan, 1979:60; Regan & Berscheid, 1999; Levine, 2002, 2003; Træn *et al.*, 2007). Kaplan (1979) proposed that women's sex drive peaks at around the age of 40, after which it declines steadily. While it is true that most studies support Kaplan's contentions, Basson *et al.* (2005) noted that some studies contradict this and indicate that age has a minimal effect on sexual desire, and that sexual desire may even increase after 50.

### **3.4.4 Hormones and neurotransmitters**

Notwithstanding the importance of other factors, it is widely acknowledged a functional nervous system and adequate levels of the reproductive hormones are prerequisites for sexual functioning (Leiblum & Rosen, 1988b:ix; Kaplan, 1995). The reproductive hormones that exert the strongest influence on sexual functioning in women are oestrogen, testosterone and progesterone (Kaplan, 1995; Goldstein & Brandon, 2004), but others, such as the neurotransmitters, serotonin, dopamine and the receptor oxytocin, also have a role; as do other sensory stimuli like smell and taste.

Oestrogens promote the development of female secondary sex characteristics, such as breasts, and are also involved in the thickening of the endometrium and other aspects of regulating the menstrual cycle ([www.wikipedia.com](http://www.wikipedia.com)). They are also linked to the development of behaviour such as nurturing (Kaplan, 1995). Oestrogen “turns on” the sexual drive – the woman may *want* sex (Goldstein & Brandon, 2004) and makes her more sensitive to sensual stimulation (King, 1998), such as touch, erotic smells and sights. This effect means that oestrogen also heightens the significance of sensual aspects of the relationship, such as the way her partner speaks to her, his grooming and hygiene.

During menopause in women there is decreased production of oestrogens, androgens, progesterone and prolactin (Northrup, 2004; De Angelo, 2002), which may be accompanied by a drop in sexual desire in these years. Oestrogen prevents and relieves vaginal symptoms (such as dryness or lack of elasticity) that may result in painful sexual intercourse, which may also contribute to diminish interest in sexual activity. Most studies, however, remain inconclusive about the effect of menopause on sexual desire (e.g., Regan & Berscheid, 1999; Richardson, *et al.*, 2005).

Progesterone is a reproductive hormone involved in the female menstrual cycle and pregnancy, and has inhibiting effects on sexual response (King, 1998). Fluctuations in levels of progesterone during certain menstrual phases may affect sex drive, however, there is no single pattern in sexual interest that has emerged from the research (King, 1998), with some women reporting no difference, others have an increase, and yet other women report more than one peak (Regan & Berscheid, 1999; Levin, 2002).

With the increase in progesterone in pregnancy, there may be a decrease in sexual desire (Regan & Berscheid, 1999). After birth progesterone acts to increase prolactin, which is the hormone responsible for breastfeeding (Goldstein & Brandon, 2004). Prolactin also acts as an antagonist to oestrogen and dopamine, which may be associated with low sexual desire, and postpartum depression (Goldstein & Brandon, 2004). The exact influence that prolactin has on sexual desire remains inconclusive, however (Regan & Berscheid, 1999).

Testosterone is a steroid hormone from the androgen group, and present in significantly higher levels in men where they play a vital role in the maturation of the male genitalia and of male secondary characteristics (Bancroft, 1989; Kaplan, 1995). In both men and women,

testosterone plays a key role in sexual functioning. With testosterone deficiency, males lose their sex drive, ejaculatory and erectile functions (Kaplan, 1995; Northrup, 2004).

In the female body, testosterone begin to exert an influence during puberty, peaks in the mid-twenties where after there is a steady decline. A proportion of testosterone changes to oestrogen, but about a quarter remains, which is thought to have a profound impact on women and their sexual desire (Kaplan, 1995; Goldstein & Brandon, 2004). Testosterone is responsible for sexual assertiveness, it stimulates the need to masturbate and for orgasm, and causes the nerves in the clitoris and nipples to become sensitive (Goldstein & Brandon, 2004), so that a decline in sensitivity and a diminished interest in masturbation might be signs of testosterone deficiency (Berman & Berman, 2001). A number of clinicians propose that, as in the case of men, this loss of sexual interest can be reversed by testosterone replacement (Kaplan, 1995; Riley, 2000; Berman & Berman, 2001; DeAngelo, 2002; Goldstein & Brandon, 2004; Northrup, 2004).

The “cuddle chemical” oxytocin functions as inducers of uterine contractions and milk ejection. Oxytocin is secreted by both sexes during sexual stimulation and orgasm, and associated with affectionate behaviour and pair bonding (King, 1998; Goldstein & Brandon, 2004; Tallis, 2004; Davidson & Rosen, cited in Kaplan, 1995). Serotonin and dopamine are neurotransmitters (chemicals that are used to relay, amplify and modulate signals between a neuron and another cell; [www.wikipedia.com](http://www.wikipedia.com)) synthesized in the central nervous system. The levels of these in a person’s body influence the intensity of feelings and emotions of that person.

Dopamine and serotonin determine how a woman experiences her sex drive (Leiblum, in Leiblum & Rosen, 1988:ix). Relatively low levels of serotonin are thought to facilitate a “*calm, warm sociability that promotes continued intimacy*” (Crenshaw, as cited in Goldstein & Brandon, 2004:78). A more seductive sex drive has been traced to high levels of dopamine and oxytocin while increased level of dopamine motivate the pursuit of pleasure providing an emotional high (Goldstein & Brandon, 2004).

Individuals who are “in love” have obsessional behaviour combined with (low) levels of serotonin which would also imply high levels of sex drive comparable with those who suffer from, for instance, obsessive-compulsive disorder (Tallis, 2004) The obsessional qualities

associated with being in love may have evolutionary origins, as this obsession would have (and possibly still does) facilitated pair bonding, thereby ensuring procreation and joint parenting (Tallis, 2004). The flooding of the bloodstream with serotonin resulting from the use of antidepressants known as selective serotonin reuptake inhibitors (SSRIs) eliminates sexual desire in up to 50% of patients (Weeks & Winters, 2002).

Evidence has been offered to suggest that humans respond positively to ancient aromatic aphrodisiacs, the so-called human sex pheromones (Berliner, as cited in Kaplan, 1995; Goldstein & Brandon, 2004). For instance, Tallis (2004) noted that smell is an important factor in relation to sexual attraction, and described research pointing to a positive sexual response by women to male armpit sweat (!) Equally, it has been suggested that various other smells may also act as a repellent, and could be important in the on-set of desire disorders (Kaplan, 1995).

As was the case for hormones, after evaluating studies dealing with pheromones and human sexual desire, Regan and Berscheid (1999) concluded that the evidence for a human sex pheromone remains speculative.

### **3.4.5 Review**

Biology plays an important role in sexuality, and without sexual apparatus and endocrines, sexual activity cannot take place. A healthy physical body is more conducive to experiencing desire, whilst factors such as illness, pelvic trauma and medications taken for physical conditions may have a negative effect. There appears to be a decline in the occurrence of sexual desire with age.

The exact extent and significance of the influence exerted by hormone and pheromones on sexual desire remain unknown (Bancroft, 1989, 2002; Tiefer, 1996, 2001; Moynihan, 2003; Goldstein & Brandon, 2004; Cook, 2005; Wood *et al.* 2006), largely because the relatively few scientific studies of the effects of androgen replacement therapy have rendered contradictory results (Basson, 2005; Davies, Davidson, Donath & Bell, 2005). Nonetheless, there is general agreement that hormones exert *some* kind of an influence and, given the demographics of this study, (*viz.* being middle-aged women), means that the participants represent women who's hormone levels *may* have reduced with age, possibly affecting their sexual desire.

Several researchers (e.g. Stuart, Hammond & Pett, 1987; Weeks & Winters, 2002) have, however, emphasised that regardless of the role they play, androgen levels alone are not sufficient to explain fluctuations in sexual desire, and other factors such as the socio-cultural context, marital satisfaction and levels of intimacy also play important roles.

### **3.5 RELATIONSHIP FACTORS INFLUENCING SEXUAL DESIRE**

*“Because sexual desire is most often directed towards another person, it is inextricably woven into the fabric of the relationship”* (Stuart *et al.*, 1987:93). Women’s sexual experience in contemporary relationships frequently begins for reasons *other* than desire, such as to enhance emotional closeness with their partner, foster acceptance, develop a bonding commitment or to express love (Basson, 2000, 2002a, 2002b; Træn *et al.*, 2007).

Brezsnyak and Whisman (2004) contend that many theories of sexual desire disorders have emerged that consider interpersonal factors both as outcomes and casual determinants of low sexual desire. These interpersonal factors include social-developmental characteristics of individuals, relationship determinants, and societal based beliefs and discourses that “good” sex is central to a “good” marriage (Brezsnyak & Whisman, 2004), and these factors will be explored in the next section.

#### **3.5.1 Evolutionary perspectives**

Reproduction is essential for the procreation of a species. From an evolutionary perspective, therefore, the production of viable offspring from a physically and genetically fit partner (Regan & Berscheid 1999) was the ultimate purpose of sexual encounters between humans. As physical appearance, in particular facial symmetry, is presumed to indicate genetic fitness and health it has presumably long been an important determinant of desirability. Physical beauty is also associated with socially desirable personality characteristics, and attractive individuals are often viewed as more likeable and well adjusted (Westheimer & Lopater, 2006). There is strong evidence to support the notion that physical attractiveness (mostly focussed on the facial features) is an important factor in arousing sexual desire in both males and females (Regan & Berscheid, 1999).

Apart from facial features, other attractiveness criteria include height (men prefer shorter women, and women taller men) and weight (overweight people are often considered unattractive). In general, however, extremes in stature are generally out of favour, and balanced features are successful in the beauty and desirability stakes (King, 1998; Regan & Berscheid, 1999; Tallis, 2004).

Tallis (2004) agreed that beauty seems capable of creating instant desire, but referred to the phenomenon of beauty being “in the eye of the beholder” where a person in love sees past the imperfections of the loved one. Such an effect may have developed to ensure survival of the species, as this may have been limited if only attractive persons reproduced. Tallis (2004) also observed that candlelit dinners might hide imperfections such as facial asymmetries, which would heighten the chance for a sexual attraction.

It seems however likely that, while physical beauty may be a key determinant in short-term relationships, in long-term-relationships other fitness criteria, such as emotional fitness, may apply. Indeed, there is general agreement that women are attracted to men who can provide for their immediate needs through social position, and material possessions, and their future need, and those of their children, through potential resource-accruing ability (Regan & Berscheid, 1999).

### **3.5.2 Effect of the environment**

Men and women have long made use of ambience in both seduction and stimulation of their own sexual desire. Whether or not they hide facial asymmetries, candle lit dinners, and other romantic settings, remain a popular prelude to sexual encounters (e.g., Wood *et al.*, 2007).

Other, possibly less romantic, settings are also used to stimulate desire. For instance, extraneous arousal, such as watching stimulating film material, may enhance sexual desire for another person (Regan & Berscheid, 1999). This propensity to generate desire through film or printed media is commonly used as a therapeutic measure, and sex therapists may encourage the use of stimulating material and/or fantasies to trigger desire (Barbach, 2000).

### **3.5.3 Effect of partner's offensive behaviour**

Offensive behaviours by a partner can have a profound effect on the woman's sexual feelings. Kaplan (1995) defines unattractive sexual behaviour as counter-courtship manoeuvres that spoil the partner's appetite for sex, such as insensitivity, hostility, obnoxiousness and temper tantrums. These behaviours create a downward spiral of reciprocal anger along with a hostile environment that is incompatible with lovemaking. Basson (2001) stressed the role of sexual stimuli in invoking or enhancing desire, such as respect and physical affection.

Poor personal hygiene or excessive weight gain also has a destructive influence on sexual attraction (Hawton, 1985; LoPiccolo & Friedman, 1988). Kaplan (1995) warned that if partners "*sit around ... in dirty underwear, don't brush their teeth ....*", they should not expect to evoke desirous feelings in their other half.

### **3.5.4 Role of emotions**

Both men and women recognize sexual desire as an important feature of the experience of being in love (Hendrix, 1993; Caretomuto, 1989; Regan & Berscheid, 1999). Without this passionate element, a stable affectionate love is described as "companiate" (companionable) (Tallis, 2004). Sexual desire alone, however, is not sufficient to engender romantic love, and other positive (companiate) feelings must be present for a person to remain in love with another. Sexual desire may awaken these positive feelings, which conversely, may awaken desire (Tallis, 2004).

Tallis (2004) was in accord that strong sexual desire is reflective of the romantic stage of relationship. When sexual desire fades, a person is no longer in a state of romantic love. In the same way, sated, and therefore diminished, desire may leave lovers feeling disappointed and disillusioned (Tallis, 2004).

Women generally emphasise the emotional aspects of sexuality, and display a tendency to focus on the quality of the relationship of which sexual activity is only one part. Consideration, warmth and physical demonstrations of love, when present in a relationship, enhance women's sexual desire (Hendrix, 1994; Leiblum & Rosen, 1988c; Basson, 2001). Men, on the other hand, put more emphasis on the sexual act and the physical pleasure they derive there from (Træn *et al.*, 2007). This difference in emphasis can lead to

misunderstandings between men and women, for instance, women may seek emotional intimacy in a non-sexual way through hugging or touching, whereas men may interpret warmth indicated by touching and lingering eye contact as sexual interest (Regan & Berscheid, 1999). Women may be hurt and frustrated when a partner misreads this close interpersonal contact as a cue to take the cuddling to the sexual level (Wood *et al.*, 2007).

Other issues of emotional intimacy, such as fear of closeness, different perspectives on optimal closeness and inability to fuse feelings of love and sexual desire also affect sexual desire (LoPiccolo & Friedman, 1988). Some authors assert that lower levels of connectedness may diminish sexual desire (King, 1998; Ellison, 2000; Brezsnayak & Whisman, 2004; Basson, 2005), while others (e.g. Perel, 2007:25) argue that too much intimacy can impede desire. Schnarch (1991, 1997, 2000) wrote extensively on the intricacies and complexity of emotional connectivity, and the necessity for partners to maintain a separateness from one another in order to be independent, fully-developed human beings; while at the same time holding on to each other in a process of “differentiation”. Only when successful in this, argues Schnarch, can they retain the emotional closeness necessary to sustain sexual desire in long-term relationships (compare also Morin, 1995; Hendrix, 1993; Lobitz & Lobitz, 1996).

Negative emotions towards a partner, such as anger stemming from interpersonal conflict or betrayal, dislike, or fear evoked by issues such as partner abuse or unequal power in the relationship, reduces sexual desire (e.g. Kaplan, 1979, 1995; Hawton, 1985; Stuart *et al.*, 1987; Leiblum & Rosen, 1988; Donnelly, 1993; Trudel *et al.*, 1997; Davies *et al.*, 1999; APA, 2000; Tiefer, 2001; Basson, 2002b, 2005; Dennerstein & Leher, 2004; Brezsnayak & Whisman, 2004; Hicks, 2005; Westheimer & Lopater, 2005; Træn *et al.*, 2007; Wood *et al.*, 2007). These may manifest in low sexual desire as an unconscious attempt to equalise the power dynamics and regain control in an unbalanced relationship (Brezsnayak & Whisman, 2004).

### **3.5.5 Relationship duration and sexual novelty**

Duration affects various aspects of a couple’s relationship, including levels of emotional intimacy, and time can result in boredom with sexual activities. Westheimer and Lopater (2005) noted the negative effect of “habituation” (which is a decrease in effect of stimulation over a time period) on the sexual activities in long-term relationships.

With regards to sexual boredom, Kaplan (1995:37) suggested that humans are genetically programmed to feel lust only with new partners, and that they become sexually sated in long-term relationships. This is not a new notion, as Money (1986) suggested that humans are serially monogamous and that desire can only remain high for the first few years of a relationship. Thereafter, desire fades unless the couple has a baby, rekindling their passion for another period. Polygamists frequently cite the decline in desire in long-term relationships, the erotic appeal of sexual novelty and the high incidence of extramarital affairs, to support their lifestyle choices (Kaplan, 1995; Morin, 1995). Levine (2002) suggested that familiarity diminishes sexual interest, and that whilst long-term relationships allow the couple to explore a variety of various exciting sexual activities, after some time they have done everything that they feel comfortable with. He calculated that many faithful individuals could count on an average of 3,000 sexual experiences with their life partner, and that along the way the longing for the novelty of a new partner triggers infidelity (Levine, 2003:283). Also King (1998:259-260) noted that whilst in love, the couple expands their sexual repertoire, but only temporarily, before its “shrinks” back, and “*after a few years, a bit of desultory foreplay and unenthusiastic intercourse is all a couple have left to offer each other*”. This state of affairs does not bode well for continued sexual desire in longer-term relationships.

### **3.5.6 Sexual technique**

Poor sexual technique, or a limited repertoire of sexual techniques, specifically ineffectual stimulation, may lead to diminished desire in woman in that there is no great incentive to engage in sexual activities that are unfulfilling or unpleasant (Ellison, 2000; Basson, 2005). Sexual scripts also create unrealistic expectations, for instance, Hite pointed out that 70% of her participants indicated that they do not reach orgasm through thrusting intercourse alone, but many couples still hold the view that simultaneous orgasm is the ideal encounter (Hite, 1976, 1987). Consequently, many men (and women) do not make use of other techniques to arouse their women partners.

Hawton (1985) and Kaplan (1995) showed that, for women, foreplay is an important contributor to sexual enjoyment and that a sexual problem may manifest or persist because the couple engage in little or no foreplay. The result is that the woman derives less and less pleasure from sexual activity, and increasingly engages in sex for her partner’s sake. The compounding effects of conventional heterosexual scripts that emphasise female passivity and male orchestration of sex (Zilbergeld, 1987; Rosen & Leiblum, 1988:170) and a reticence to

communicate sexual preferences may mean that the man does not know how best to stimulate his woman partner (Verhulst & Heiman, 1988; Wood *et al.*, 2007), which can lead to frustration and serve to perpetuate the situation (LoPiccolo & Friedman, 1988; Hawton, 1985; Verhulst & Heiman, 1988).

### **3.5.7 Gender differences in sexual desire**

Kraft-Ebing (1886, in Regan & Berscheid, 1999:56) stated that “*man has beyond doubt the stronger sexual appetite of the two*”. Earlier authors, such as Kinsey (1953:44) viewed desire as fundamentally different in men and women, with women experiencing sexual interest intermittently and men having an “*incessant and invariant sexual appetite*”. Others (Kaplan, 1979; Zilbergeld, 1987; Leiblum & Rosen, 1988c; Bancroft, 1989; Baldwin & Baldwin, 1997; Levine, 2002) support that the sexual urges of males are more compelling than for females and more readily accessed through a large variety of external and internal prompts (Leiblum & Rosen, 1988, Levine, 2002, 2003). Female sexual desire is therefore seen to be more variable than for males, and also more easily suppressed or eradicated by social circumstance and fluctuates in response to the menstrual cycle, pregnancy, menopause, and fatigue (Træn *et al.*, 2007). Leiblum and Rosen (1988c:13) hypothesised that the pathway between desire and execution was longer for woman than men, with more “*byways, detours an obstacles*”.

Gender differences in sexual appetite have a decided influence on couples’ sexual lives. As men place a higher value on sexual activity, they are most frequently the ones who express dissatisfaction with the frequency of sexual intercourse in their relationships (Bresznyak & Wisman, 2004; Dunn, Croft & Hackett, 2000). Some women also feel that sex is an obligatory task in marriage, and engage in unwanted or unsatisfying sex (Weeks & Winters, 2002; Wood *et al.* 2007) with all the negativity that follows. In general, different levels of desire between a woman and her partner results in reduced marital satisfaction (Davies *et al.*, 1999).

The discrepancy in the genders’ need for sexual relations also led to Verhulst and Heiman (1988) to perceive low desire as a problem of “synchronisation of the sexual rhythms” in a relationship rather than a “dysfunction” attributed to one of the partners. Low sexual desire is described as “*indicating unsatisfactory individual coordination and/or interpersonal synchronisation*” (1988:242-245). This view emphasised that low sexual desire is a *complaint* about subjective experience of dissatisfaction (an emotion) that reflects an imbalance of

interaction, rather than a *disease* with an anatomical localisation. More recently, King (1998:7) also avoided the term sexual dysfunction, focussing instead on discrepancies in desire (referring to this as DD or “desire discrepancy”) between men and women.

### **3.5.8 Negotiations and communication**

Several studies have indicated that while husbands may be dissatisfied with a low frequency of sexual activity in their marriage, their wives do not necessarily share their concerns (Davies *et al.*, 1999; Dunn, *et al.*, 2000). Clearly these differences in perception, if left unresolved, may lead to marital problems.

Communication about sexual issues is often complicated by the fact that many people are offended by direct references to sexual desire and feel that these are inappropriate. The resultant inadequate sexual negotiations may contribute to sexual difficulties (Tiefer, 2001) and/or end in the couple’s sexual withdrawal from one another (Tiefer, 2001; Clement, 2002; Levine 2002; Hicks, 2005).

The general level and quality of communication between partners can also influence their sexual interest in one another. Women, who feel that they can communicate easily about any topic, including sex, tend to be more interested in sex (Clement, 2002), as the ability to openly communicate can facilitate their sexual desire (Weeks & Winters, 2002; Wood *et al.*, 2007), with the negation of drive discrepancies, and differing needs for sexual activities.

Even when there is good communication between partners about their levels of sexual desire, this does not necessarily include discussion of their reasons for engaging in sex. Levine (1987, 2002) and Basson (2002a, 2005) noted that individuals in a couple agree to have sex for a wide variety of reasons, which may be quite different for each person and are often not made known to the other. Motivation for engaging in sex may include a need for self-soothing, a desire or willingness to please the partner, to conceive a child or for non-sexual aims, such as for material gain, manipulation or because of loneliness. Consensual sexual intercourse merely implies a willingness from both parties to engage sexually, for their own reasons.

### 3.5.9 Relationship satisfaction

The most significant influence on their sexual desire cited by women is the quality of their relationships with their partners (Stuart *et al.*, 1987; Trudel *et al.*, 1997; Apt, Hurlbert, Pearce & White, 1996, in Brezsnayak & Whisman, 2004; Basson, 2005; Wood *et al.*, 2007). Furthermore, the relationship as an influence on their experience of sexual desire receives most of the attention in women's discussion on the topic (Basson, 2001).

Egalitarian couples report the highest levels of marital satisfaction and of sexual desire for both husbands and wives (Brezsnayak & Whisman, 2004). They also tend to be more attentive towards one another and place more importance on the shared aspects of relationship. Being happy in the relationship and with a partner enhances the experience of increased intimacy, sexual desire and sexual activity (Donnelly, 1993; Brezsnayak & Whisman, 2005). Brezsnayak and Whisman (2004) point to the association between marital satisfaction and sexual desire: sexual desire may be seen as an expression of satisfaction with a marriage, and conversely, marital dissatisfaction directly produces low sexual desire for one's partner (Verhulst & Heiman, 1988; Træn *et al.*, 2007).

Conversely, low marital satisfaction can reduce motivation for sexual intimacy, and may even promote sexual withholding. Thus, marital distress is both a *causal* determinant and an *outcome* of low sexual desire. Lack of desire over time can lead to dissatisfaction and to frustration, and this reciprocal cycle may lead some couples into a pattern of escalating sexual dysfunction (LoPiccolo & Friedman, 1988).

Low sexual desire may cause a withdrawal from the dissatisfying relationship, either with one partner intentionally withholding sexual activity, or otherwise presenting with low desire as a safer way of expressing dissatisfaction (MacPhee *et al.*, 1995, in Brezsnayak & Whisman, 2005). As sexuality is seen to be an important part of the marital relationship, the existence of low sexual desire may create frustration and dissatisfaction with the relationship.

Basson (2005) expanded on this theme, suggesting that women, especially those in long-term relationships, initiate or agree to sex for a variety of reasons aside from sexual desire, but an emotionally and physically positive outcome after a sexual encounter, or feeling emotionally close to their partner during sexual activity, would increase sexual responsiveness (see

Chapter 2). She has also repeatedly stressed the importance of emotional intimacy in the experience of sexual desire (Basson, 2001; 2002b; 2005).

Recent theoretical and clinical frameworks (e.g. Rosen & Leiblum, 1995; Schnarch, 1997; Gehring, 2003; Swart, 2004) stress the importance of shared experience, positive affect and mutual acceptance in relationships in fostering sexual desire. Certainly it seems that, for most women in long-term intimate relationships, sexual satisfaction is closely linked to feeling attuned to and connected to their partners (Ellison, 2000).

### **3.5.10 Review**

Relationship factors are a vital determinant in the experience of sexual desire. While evolutionary perspectives may account for some of the “mating” behaviour of humans, most women cite the quality and nature of their relationships as key factors in shaping their sexual desire. The behaviour of partners can either enhance or reduce sexual desire. Generally speaking, negative emotions reduce sexual desire, but an array of negative feelings might enhance desire under certain circumstances (Morin, 1995).

Sexual desire in a relationship seems to diminish over time, possibly as a result of emotional merging, habituation or boredom, or all three. Poor sexual techniques or unrealistic expectations of sexual skills, may also lead to disappointment. Discrepant sexual desire between partners not openly communicated and negotiated tends to decrease relationship satisfaction. Some evidence suggests that partners that view their relationships as fulfilling have more desire for one another and more frequent sexual encounters.

## **3.6 SUMMARY**

This chapter explored the concept of sexual desire to create an understanding of its complexities. Sexual desire is both a physiological and a psychological construct, which varies in quality and capacity. The origins of sexual desire are also complex. At times desire can be spontaneous and, at others, a response to external stimuli.

Culture and social scripts dictate much of our sexuality, including behaviours and feelings in sexual situations. As these scripts are not always reasonable or realistic, they can lead to

sexual problems, the roots of many of which can be found in confusion and misunderstanding between men and women.

Factors within the individual, referred to here as psychological factors, also influence sexual desire. Early messages about sex and sexual experiences, traumatic experiences, and age and life circumstances, all contribute towards a woman's psychological makeup, which in turn contributes to her experience of sexual desire.

The vital roles of a healthy body in promoting the experience of sexual desire were highlighted, including the debilitating effects of illness or injury. The contributions of hormones to sexual desire were also addressed, although the evidence for links between hormones and sexual desire is contradictory.

Sexual interactions frequently take place within the context of a relationship, thus interpersonal factors also play a role in the development of sexual desire. Evolutionary traits, physical attraction, love, environmental setting and relationship satisfaction all influence sexual desire in some way. Duration of the relationship is also an important contributor, as is communication in addressing natural discrepancies in sexual desire in long-term relationships.

In summary, it is clear that women's sexual functioning is dependent on a plethora of factors, particularly sensitive, and therefore, accordingly, sexual desire problems may emerge from a multitude of factors (Wood *et al.*, 2006).

## CHAPTER 4

### RESEARCH METHODOLOGY

#### 4.1 INTRODUCTION

The discoveries in the biochemistry and pharmacology of the human sexual response of the last decade have tended to focus on males, with research in female sexuality and sexual dysfunction lagging significantly. The reasons for this include (Goldstein & Rosen, 2002):

- the greater complexity of female sexuality, and the paucity of accepted theories or models that properly explain sexual response in women;
- deficiencies in the available measurement approaches, for instance, few reliable and validated self-report instruments have been developed and little agreement exists on domains of measurement for response or satisfaction;
- a lack of agreement among experts concerning diagnostic criteria and classification of sexual dysfunction on women;
- the relatively poor funding of women's sexuality compared with that of men.

There is thus a clear and identifiable need for additional research into issues related to female sexual responses, which necessitates consideration of both the biology of female functioning and the subjective sexual experience of women (Slowinski, 2001; Lavie & Willig, 2005).

#### 4.2 THE NEED FOR QUALITATIVE RESEARCH

To date, much of the research that has been done on female sexuality has been *quantitative* and, at times, has led to questionable results (Moynihan, 2003). Tiefer (2001) called for research and services driven by women's own needs and sexual realities, and cautioned against that which was motivated by commercial interests. The "New View" group, of which she is a central part, deliberately avoided quantitative approaches and, instead, adopted a social constructionist view in promoting qualitative research that avoids the need to define "successful or normal sexual experience" (Tiefer, 2001). The New View report is regarded as a valuable step in the recognition of the complexity of female sexual experience, in that it deals with female sexuality as part of an integrated whole (Hicks, 2005).

Research based on quantitative studies indicates that lack of desire is *the most common complaint* amongst women (e.g., Davies *et al.*, 1999; Pridal & LoPicollo, 2000; Basson, 2002a:357; Basson *et al.*, 2005). The percentage of women who present with this problem ranges from 33% (Cook, 2005; Hicks, 2006) to 67% (Basson, 2002b), with a fair amount of variation in between, *viz.*: 38% (Rosen, Taylor, Leiblum & Bachman, in Swart, 2005); 33%-39% (Basson, 2002a:357); 43%. (Laumann, *et al.*, 1999), and 52% (Hawton, 1985).

Not all researchers agree with these figures, however. Moynihan (2003:46), for instance, questioned the quantitative research methodology used to derive the numbers, accusing the researchers of being bias in their sampling methods. Even Laumann himself (in Moynihan, 2003) granted that the 43% of women presenting with low desire in his study included many women for whom lack of desire may have been a perfectly reasonable response to personal challenges and stress. The prevalence of self-reported sexual difficulties (“disabilities”), as opposed to a clinician’s careful diagnosis, is also strongly correlated with communities where women are free to acknowledge their own sexual needs and pleasure, such as in Britain, the United States and Sweden (Basson *et al.*, 2005). Basson *et al.* (2005) also cautioned that the individual interpretation of the words “sexual interest” and “desire” in questionnaires (for example those developed by Derogatis & Melisaratos, 1979; Rosen, *et al.*, 2000; and Derogatis, Rosen, Leiblum, Burnett & Heiman, 2002) could affect the outcome of a study.

According to Basson (2005), the prevalence of low sexual desire is largely unknown, and she explained that in much of the past research, low sexual desire was included under the broader term “hypo-active sexual desire disorder”, which is an older term that describes women reporting an absence of spontaneous or initial desire. In the new definitions (Hicks, 2006), however, lack of desire does not in and of itself constitute sexual dysfunction. Thus, the estimated prevalence of 30-50% of hypo-active sexual desire disorder in women may be misleading, and these numbers may well drop significantly if and when lack of spontaneous or initial sexual desire no longer constitutes a disorder (Basson, 2005).

Predictably, therefore, there is considerable disagreement among researchers on how best to assess the presence, and intensity, of sexual desire, and which parameters denote “normal” versus “hypoactive” levels of desire (Beck *et al.*, 1991). With respect to the complexity of assessment, Bancroft (1989) commented, “*of the various aspects of human sexual experience,*

*sexual desire remains perhaps the most resistant to conceptual analysis*". He added: "...when we investigate sexual desire we should not expect to reduce it to its basis ingredients" (Bancroft, 1989:71-72), alluding to the intricacy to conceptualise "desire".

Survey reports (for example those of Kinsey *et al.*, 1948,1953) have tended to focus on sexual behaviours, such as the frequency of masturbation, rather than subjective states, like sexual desire (Beck *et al.*, 1991). This study therefore will use *qualitative* methods of enquiry to tap into the participants' subjective states. This is in line with the aim of this study, which is to gain a better understanding of the *subjective* experience of women who clinically present with low sexual desire.

### **4.3 THE USE OF LITERATURE IN QUALITATIVE STUDIES**

Creswell (1994, 1998) provided guidance on the use of literature in qualitative study reports. He suggested that, depending on the design, published literature and theory could be incorporated before or after the collection of empirical data, and the decision on this lay with the researcher. When the appropriate place is being considered, the decision is based on an understanding of the audience for the project. Creswell (1994) offered three placement options, *viz.*:

1. in the introduction, (providing a useful backdrop and framing the research problem);
2. in a separate literature review (in line with traditional qualitative research), and;
3. in the final section of the report, where it can be used to compare and contrast with the results/themes emerging from the study.

Although Creswell himself favoured placement in the final section, he was clear that the literature could be used in any or all of these locations. Furthermore, Grinnell (1998:275) suggested that the researcher should gain as much knowledge as possible before the interviews as it forms the basis for the decision what aspects of the respondents' experience are to be explored.

A qualitative study should be exploratory – "*the researcher seeks to listen to informants and build a picture based on their ideas*" without prejudice from preconceived ideas of their own (Creswell, 1994:21). Thus, regardless of its placement, the literature should be used inductively, i.e., it should not give rise to leading questions by the researcher. Creswell also

recommended that literature should be used sparingly in the beginning to convey an inductive design, “*unless the qualitative design type requires a substantial literature orientation at the outset*” (Creswell, 1994:21), as was applicable in this study.

In this study, the literature has been incorporated in all three of the placement options provided by Creswell (1994):

#### **4.3.1 Providing a backdrop**

In the introduction, the related literature is discussed briefly in order to provide an orienting framework for the study and the approach adopted (Fouche & Delpont, 2002). This early review demonstrates the paradigm and the assumptions underlying the general research question.

#### **4.3.2 Presented in a separate section**

A two-part literature review on issues pertaining to sexual desire was presented in order to provide the audience with the research context of the study (as per Creswell, 1994:24), as women’s sexual desire has not been extensively researched in South Africa. Furthermore, the literature review serves to demonstrate familiarity with related research, identify gaps in current knowledge and demonstrate that the study fills a need. The intention was to also learn from other researchers as to how they theorised and conceptualised research issues, and be guided by their empirical findings (Mouton, 2001).

#### **4.3.3 Assimilated in the final section**

In the analysis and discussion, the literature has been used to compare and contrast with the results/themes emerging from the study. Fouche and Delpont (2002) noted that the literature review could be used as a control after the data were collected. Comparing the results of this study with those of other studies and the existing body of theory, enhances the trustworthiness of this study (Leedy, in Fouche & Delpont, 2002; De Vos *et al.*, 2002, 351).

## 4.4 CHOICE BETWEEN QUANTITATIVE AND QUALITATIVE DESIGN

Based on the merits of a qualitative versus quantitative research (Section 4.2), a qualitative paradigm was selected for this study. In addition, Creswell (1994:4) recommended consideration of four issues in the choice of a design type, namely:

***Ontology (the issue of what is real):*** Creswell (1994) pointed out that multiple realities exist in any given situation, such as that of the researcher, the individual in the study and the reader interpreting the study. The quantitative researcher views reality as “objective”, and as something that can be measured independently by using a questionnaire or an instrument. By contrast, the qualitative researcher views reality as something that is constructed by all of the participants in the study.

***Epistemology (the relationship of the researcher to the topic under investigation):*** Whilst the quantitative researcher remains distant and independent to control for bias and objectivity, the qualitative researcher interacts with the participants of a study.

***Axiology (the role of values in a study):*** The quantitative researcher keeps personal values out of the study and reports on facts only. The qualitative researcher, on the other hand, admits to the value-laden nature of the study. There is an active report on values and biases.

***Rhetoric (the language of the research):*** In quantitative studies the language used is impersonal and formal, and use is made of concepts and variables based on well-defined and accepted definitions. The language in qualitative may be first person and personal, informal and based on definitions that evolved from the study.

The afore-mentioned were all given due consideration in the decision to adopt a qualitative paradigm. I chose a qualitative design, as I wanted to explore the participants’ reality through my own interaction with them. I also admitted to the role of my own values and biases, and have incorporated a section on reflexivity (see Section 4.14.4). I also made use of fairly personal and informal language throughout the dissertation.

#### **4.4.1 Methodology**

The processes of quantitative and qualitative studies also differ. The quantitative methodology uses *deductive* logic wherein hypothesis and theories are tested in cause-effect order, with valid and reliable instruments. This is a static design in which concepts, variables and hypothesis remains fixed throughout the study, and the intent is to develop generalisations that contribute to theory and that enables one to better predict, explain and understand phenomena. In qualitative methodology *inductive* logic prevails. Categories emerge from the research participants, providing context-bound information leading to patterns or theories that help explain phenomena. The accuracy of the data can be assessed using techniques such as verification of the information with the informants (“Heron’s Co-operative enquiry”), “member checks” or “triangulating” among different sources of information (Creswell, 1994; Heron, 1996; Babbie & Mouton, 2001:275, 277; Shaw, 2001, Smith, 2003). (See Section 4.14 for a further discussion on the trustworthiness of the study).

Merriman (1988, in Creswell, 1994) mentioned further considerations for the choice for qualitative methodology, such as that qualitative researchers are primarily concerned with process, rather than outcomes; interested in meaning, and how people make sense of their lives; the researcher is the primary instrument for data collection and analysis, and; the research is descriptive in that the researcher is interested in the understanding gained through the process.

Consequently, in accordance with the qualitative approach, I used inductive logic to arrive at the results and conclusions.

#### **4.4.2 The exploratory nature of the research**

A further factor in favour of the qualitative approach was that I aimed for understanding based on in-depth inquiry. In qualitative research, the aim is discover what happens, how it happens and why it happens the way it does (Henning, 2004). As sexology is a relatively unstudied field in South Africa (Fourie, 1984; Smit, 1997; Craig, 2002; Robinson, 2005) this study aimed at breaking new ground, yielding new insights and comprehension (as per Babbie & Mouton, 2001), and as such it could be termed exploratory research.

Exploratory research aims to gain insight into, among other things, a phenomenon or an individual (Fouche, 2002:108) in order provide a clear and detailed account of actions and representations of actions so to improve understanding of our world. This type of inquiry necessitates the examination of the qualities, characteristics or properties of a phenomenon for better understanding and explanation.

Henning (2004:6) explained that the qualitative researcher makes meaning from the data through examination of the bigger picture, and uses this to convert empirical information into a so-called “thick description”. This thick description should provide an account of the phenomenon that is coherent, offers facts and empirical content, interprets the information in the light of other empirical information, and forms the basis of a theoretical framework that locates the study. The researcher is the main instrument of research and makes meaning, which will be presented as findings. The advantage of qualitative research is that the researcher is free to utilise “slumbering variables” (Henning, 1995 as cited in Henning, 2004:8), which are those properties of the phenomenon not observable to the naked eye for which the sensitised research instrument (the researcher) is needed to “zoom” in on detail, so that the whole picture becomes important. In this way the “thick description” gains substance as the data becomes richer. It was in this way that I was able to tap into information not gained by quantitative research, by virtue of being able to explore any statements in the interviews for more clarity, and obtaining more detailed descriptions.

#### **4.5 APPROACH OF CHOICE**

There are different approaches associated with qualitative paradigms, such as (Creswell, 1994):

- ethnography;
- grounded theory;
- case studies, and;
- phenomenological studies.

Of these, I chose the phenomenological approach and, in so doing, embarked on a **qualitative study with a phenomenological approach**. I also chose a particular approach of phenomenology, namely Interpretative Phenomenological Analysis (IPA) (Smith, 1994). An

overview of the phenomenological approach is provided next, and also IPA is explained in more detail in the following section and in Section 4.5.2.

### **4.5.1 The phenomenological approach**

Phenomenological research aims to clarify situations lived through by persons in everyday life, which phenomenologists call the “life world” (Giorgi & Giorgi, 2003). The aim of phenomenological research is to capture as closely as possible the way in which a phenomenon is experienced within the context in which the experience takes place. In the **phenomenological analysis**, human experiences are examined through the detailed descriptions (“lived experience”) of the people being studied, in an attempt to discern the psychological essence of the phenomenon (“meaning”). This analysis seeks to reveal the meaning that comprises the phenomenon within the context of the person’s lives, i.e. the “what we do or why we do what we do” (Shaw, 2001; Giorgi & Giorgi, 2003).

This method involves studying a small number of subjects through extensive engagement to develop patterns and relationships of meaning (Shaw, 2001; Smith, 2003). There are four basic steps to the phenomenological approach: *bracketing*, *analysing*, *intuiting* and *describing*. The first three of these address problem formulation and the selection and gathering of accounts of people’s experiences. The fourth step is concerned with the analysis of the accounts (Lemon & Taylor, 1997; Giorgi & Giorgi, 2003).

#### **4.5.1.1 Bracketing**

According to Lemon and Taylor (1997:230) bracketing is the “*fundamental process*” of the phenomenological method. It refers to a concerted attempt on the part of the researcher to suspend previous knowledge, preconceptions or biases about a phenomenon in order to appreciate how others experience it (Moustakas, 1994; Giorgi & Giorgi, 2003). This suspension is called “phenomenological reduction”. Although complete reduction is impossible, the conscious attempt to suspend preconceptions or biases raises an awareness of any such subjectivity and the influence that it could have on interpretation of study results. Lemon and Taylor (1997) asserted that prior to any data collecting, researchers must engage in a process of self-reflection to identify their preconceptions and biases.

Accordingly, in this study, I engaged in this self-reflection through the process of reflexivity (Shaw, 2001; Willig, 2001), which is addressed in Section 4.14.4.

#### **4.5.1.2 Analysing**

Analysing refers to the gathering of the accounts of an experience to form a coherent whole, as was done in Chapter 5. Lemon and Taylor (1997) explained that when an individual analyses their own experiences, it involves a process of memory and self-reflection, but when applied to the experiences of others, it requires a series of choices about which experiences should be included and which methods should be used to record them. These decisions should follow from the understanding of the researchers presuppositions, gained in the bracketing phase.

I analysed the interview transcripts in accordance with the principles of IPA, and as the experience of low sexual desire was the focus of the study, it constituted the analytical focus. The research interests led me to ask certain questions during data collection, which took the analytic process in a certain direction (as per Osborn & Smith, 1998:67, in Willig, 2001). Osborn and Smith noted that the results of such analysis are necessarily a “*co-construction between participant and analyst in that it emerges from the analyst's engagement with the data in the form of the participant's account*”.

#### **4.5.1.3 Intuiting**

Intuiting is an “attitude of mind”, in which the researcher, having bracketed his or her own preconceptions, looks at the experience with “*theories held at bay*” (Oiler, in Lemon & Taylor, 1997:232). It is an attempt to feel what it would be like to live in the informant's world. One of the benefits of intuiting is that it results in the inclusion of the subjective experience that is absent from more traditional scientific approaches, and which is increasingly being seen to be essential in developing a real understanding of human knowledge and behaviour.

Thus, to do justice to the experience of the participants of this study I was required to seek to live their experiences as if they were my own, i.e., applying “intuiting” (Lemon & Taylor, 1997).

#### 4.5.1.4 Describing

The term “describing”, as opposed to “analysis”, emphasises the story-telling component of the phenomenological approach (Lemon & Taylor, 1997). In describing, the researcher draws together insights derived at, and tests these against the descriptions of the experience, revealed by the participants’ quotes, to arrive at the so-called “thick description” of a phenomenon referred to in Section 4.2. The aim is to coalesce the individual experience of the informants into a (reduced) model (Lemon & Taylor, 1997) that explicates their shared experiences.

#### 4.5.2 Interpretative phenomenological analysis (IPA)

IPA is a relatively recent phenomenological approach developed specifically within psychology by Dr J.A. Smith of Birkbeck University, London, in the United Kingdom ([www.bbk.ac.uk/psyc/staff/academic/jsmith](http://www.bbk.ac.uk/psyc/staff/academic/jsmith)). IPA has been adopted by many other health professionals and is currently widely used (Giles, 2002). I belong to an international e-mail linked study group ([ipanalysis@yahoogroups.com](mailto:ipanalysis@yahoogroups.com)) where issues pertaining to IPA research are discussed and support offered. The senior members of the study group include Dr Smith and other authorities, such as Dr R. Shaw (2001).

**IPA aims at developing an understanding of lived experience, and with how participants make sense of their personal and social worlds, and the meanings particular experiences, events, and states hold for them** (Smith & Osborn, 2003). This addresses the first aim of the study, namely to gain a better understanding of the subjective experience of women who present with low sexual desire. IPA is capable of addressing in-depth questions regarding the nature of individuals’ experiences, and wishes to explore the individual’s personal perception or account of an event/state (Smith, 1994; Smith *et al.*, 1999; Willig, 2001, Giorgi & Giorgi, 2003). According to Shaw (2001:48), “*The focus is very much on the uniqueness of a person’s experiences, how this is made meaningful, and how these meanings manifest themselves within the context of the person both as an individual and in their many cultural roles, for example as a parent, sibling, employee, student, friend, spouse*”.

IPA considers that even though trying to get close to the participant’s personal world, the researcher cannot do this directly or completely. Access to the reality of another is both dependent on and complicated by the researcher’s preconceptions, which are required to

make sense of that others world through a process of interpretative activity. Thus, a two-stage interpretation process (or double hermeneutic) is involved in which the participants are trying to make sense of their own world, and the researcher is trying to make sense of the participants making sense of their world (Smith, 1994; Smith *et al.*, 1999; Smith & Osborn, 2003). Hence the term “*interpretative* phenomenological analysis” is used to include these two facets of the approach (Smith *et al.*, 1999; Shaw, 2001).

#### **4.5.2.1 Benefits of using IPA**

The benefits of IPA includes that it is flexible and open-ended in its data-collection methods, allowing participants to discuss aspects of their experiences that may be unexpected by the researcher (Shaw, 2001). This has the advantage that it could, potentially, lead to the uncovering of constructs not previously developed. As such, IPA is an exploratory tool that is data-driven. Another valuable benefit of IPA is its capacity to investigate human experiences within their cultural context, as it emphasises that contextual factors that are at work within an individual’s life, which may directly or indirectly play a part in the meaning-making process (Shaw, 2001). IPA thus seeks to capture subjective, unshared aspects of experience (idiosyncrasies) and the shared aspects of experience that are constructed by external forces within the context of contemporary culture.

#### **4.5.2.2 Limitations of IPA**

IPA has drawn some criticism, chiefly that from Willig (2001); although Smith (2008) felt that the “limitations” raised by Willig would better termed “questions” or “issues”. Nonetheless, Willig’s limitations, together with the counter explanations provided by Larkin (2008) and others are provided here for completeness, and because they highlight some of the potential difficulties in presenting IPA results.

##### *(a) The role of language and eloquence*

IPA is heavily reliant on the participants’ ability to express their views and the researcher’s ability to record them correctly. Willig (2001) points out that language constructs, rather than describes, reality and the same event can be described in many different ways using many different words. She contends that an interview transcript tells us more about the eloquence of the participant than about the experience they describe. Willig (2001) also questioned

participants' ability to use language in a way to capture the subtleties and nuances of their physical and emotional experience.

Larkin (2008), however, contends that IPA does not claim to directly access another person's experience but rather claims to access an *account* of their experiences, as described by them. He also argues (as supported by Smith & Osborn, 2003) that the IPA analytic process is based on a close engagement with a participant's language use, with the stated aim of interpreting not only the meanings of the words themselves, but also the added meaning provided by the context of a participant's life world.

#### *(b) Explanation versus description*

Willig (2001) contends that IPA only describes the lived experience of participants, but does not attempt to explain it, which disregards the cause of the origin, thereby limiting any understanding of a phenomenon. Kvale (1996) and Smith *et al.* (1999) concur that the rich descriptions generated of how participant perceived the world, do not tend to further our understanding of why such experiences take place.

Larkin (2008) also agrees that IPA is *not* explanatory, but states that this is true of all qualitative psychology, and as such he does view this as a limitation of IPA. He argues that IPA is explicitly interpretative: developing from a "descriptive" core the analysis proceeds to engage interpretatively. This interpretative process allows IPA to engage with the results of other (more explanatory) techniques even though it does not offer explanations itself. Lemon and Taylor (1997) claim that the phenomenologist approach provides a perspective that cannot be achieved through other means and, as such, this approach is a useful framework for understanding experience.

## **4.6 AIM OF THE STUDY**

The focus of this study was to describe the experience of women, who do not want to have sexual relations, using a qualitative design type with a phenomenological approach, resulting in a thick description of lived experience. The aim was to explore each woman's thoughts and feelings on her understanding of her avoidance of sex, whether she herself is distressed by this and if so, why, and whether her avoidance has an impact on her relationship, or *vice versa*. The phenomenon was further contextualised by incorporating the role of society in

providing sexual scripts (which are prescriptions of how women should behave sexually), and the implication of the findings for practitioners and therapy.

## **4.7 THE RESEARCH QUESTION**

The first challenge for the researcher in preparing to conduct a phenomenological study is to arrive at a topic and question, which have both social meaning and personal significance (Moustakas, 1994). Usually, the question arises from an intense interest on the part of the researcher in a particular problem or topic.

In IPA, research questions are usually framed broadly and openly, and there is no attempt to test a predetermined hypothesis. The aim is rather to explore, with flexibility and in detail, a particular phenomenon (Smith & Osborn, 2003).

Accordingly, the central question in this study was:

**“What are the experiences of a woman who presents with low sexual desire?”**

## **4.8 PARTICIPANTS**

I avoided the diagnostic criteria (Chapter 3) in my approach to studying the phenomenon of low desire. The main criteria for inclusion in this study were that the participant should be a woman with low or no desire to have sexual relations with her partner (see Section 4.8.2).

### **4.8.1 Sample size**

IPA attempts to say something in detail about a particular group's perceptions and understandings, rather than make generalisations. Accordingly, IPA studies have small samples sizes (Smith & Osborn, 2003).

Smith and Osborn (2003) indicate that sample size is dependant on several factors, such as, the richness of the individual cases and the constraints of the study. They suggest five or six participants as a reasonable sample size, but studies have been published with samples sizes of between one and 15 (Smith & Osborn, 2003). Prof. Dr. J.A. Smith recommended that a

doctoral dissertation should have between eight and 12 participants (Prof. Dr. J.A. Smith, Brisbeck University, London, personal communication via, ipanalysis@yahoogroups.com, (retrieved on 12 November 2007).

In this study, one of the constraints were that it proved difficult to find willing and suitable participants, due to the personal nature of the subject under discussion. This, plus the advice received from Prof. Dr. Smith, led me to decide on 10 participants for this study.

#### **4.8.2 Recruiting participants**

In the words of Creswell (1994:148), “...*the idea of qualitative research is to purposefully select informants that will best answer the research question*”.

Accordingly IPA researchers seek out a fairly homogenous sample, and through purposive sampling find a closely defined group for whom the research questions are relevant (Smith & Osborn, 2003). In keeping with the IPA method, I therefore made use of “purposive sampling” (Singleton *et al.*, 1988:153, as cited in Strydom & Venter, 2002; Willig, 2001), which allows for the selection of “typical” persons for inclusion in the study (Grinnell, 1998:251). In the first instance, I sought women who experienced a lack of sexual desire, and within this included other criteria in order to identify a homogenous group of these women. Thus, the full set of criteria was:

- female;
- low or no desire to engage in sexual relations with the partner;
- in a relationship for more than two years;
- professed intention to continue the relationship;
- between 35 and 55 years of age.

Grinnell (1988; 1998) cites unwillingness to participate in a study and an inability to contact selected respondents as two of the problems that arise with small sample size. These difficulties affected the process used to obtain participants for this study. Although colleagues working in the field of sexology (SASHA members) and colleagues such as doctors and gynaecologists identified possible respondents, they were understandably reticent to put their clients in contact with me, lest they compromise their own relationship with these clients. When it became evident that I was unlikely to gather the required 10 participants through

referrals from colleagues, I put notices up at the offices of six colleagues (see Addendum D) asking for volunteers. A colleague also kindly distributed these notices at a talk by Dr Marlene Wasserman (also known as “Dr Eve”) on low sexual desire. In the event, only one person (a present client of mine) offered to be a participant after seeing my notice at her doctor’s surgery.

I eventually resorted to “snowball sampling” (Baker, 1988:159 as cited in Strydom & Venter, 2002). This way of sampling is useful when one is interested in a particular group of limited size, and knows only a few people belonging to that group (Grinnell, 1998:253). In utilising snowball sampling, participants identify other possible participants who are then approached in order to make up the sample.

Taking cognisance of the fact that women were understandably reticent to discuss such an intimate issue as the one being researched, particularly with a stranger, I decided to approach someone who trusted me, where I could rely on an existing open relationship between us to “break the ice”. I approached a friend who I knew was experiencing low sexual desire toward her partner, and who agreed to be the first participant. She then assisted in recruiting the second and third participants. The fourth participant heard about the study through mutual friends and offered to participate. She referred another two women to me, who, after lengthy telephonic discussions, both decided that the topic was too sensitive and declined to be part of the study. I then recruited three other participants who were ex-clients of mine who had presented with low sexual desire in the past. (I took care to select only ex-clients with whom I had a solid relationship, so as not to taint their therapy experience). The eighth participant was the present client who responded to my notice and she recruited the ninth participant. The tenth was a present client.

Recruitment was based on voluntary participation and informed consent (Addendum A).

### **4.8.3 The participants**

All the participants were heterosexual, white, middle class, South African women, whose mother tongue was either English or Afrikaans. They were from similar socio-cultural contexts. They were all raised in Christian households with Calvinistic teachings, they attended Christian-National government schools and all but one of them had tertiary

education. They all live in Cape Town and surrounds, with their husbands/male partners. (In reproducing the data in Chapter 5 I have used “husband” and “partner” interchangeably as the purpose of this dissertation both indicate the male person they with whom they live, regardless whether they are legally married or not).

The following is a summary of relevant information for each of the women who participated in the study to assist the reader in an understanding of their life world (after Smyth, 2004, and Herbst, 2006). In accordance with the principal of confidentiality pseudonyms have been used to protect the identity of the participants. In selecting pseudonym I chose names that resembled the participant’s actual name, so that they evoked the same mental image. For instance, “Berta” is a conservative sounding name, as is the real name of the participant.

**Jana** is 47 years old, Afrikaans speaking and married to her high school sweetheart. She has two children at high school. She is attractive and athletically built, but presented as shy and insecure. She has a postgraduate diploma, and worked for a few years until her first child was born. She is currently a homemaker, and she spends her free hours reading, doing art, and keeping fit by attending gym. Her husband is a successful businessman. Their relationship is under strain, as Jana feels unsupported by her husband. She became upset by the details she provided in the interview and presented as wounded.

**Paula** is 46 years old, Afrikaans-speaking, and is in a long-term relationship with a colleague. Paula presents as independent and stated she would not marry her partner, a colleague in her business. She was married twice before and has a child from each marriage. One child is still at school and the other has left home. Paula holds a Masters degree, and is successful in business. She presented as attractive, well groomed, confident and ambitious. At times during the interview, however, she also presented as vulnerable.

**Karla** is 45 years old, but looks much younger than her age. She is petit, neatly dressed and takes great care with her appearance. Three years ago she married a professional man whom she had been dating for many years. The couple has no children. Karla has a post-graduate degree but recently resigned her job in middle management for a state department. Presently she does contract work, and spends the rest of the time as a homemaker. The couple is Afrikaans speaking, conservative in their outlook, and active members of the Dutch Reformed Church. Karla presented as polite, but formal and cautious.

**Gwen** is 50 years old, English speaking and married for 30 years to a man who is 15 years her senior. He husband is now retired. The couple has two grown children. Jenny has a post-graduate degree and works as a consultant at a small non-government organisation. Gwen presented as a down-to-earth, spiritual person who searches for deeper meaning and fuller understanding of issues. She took great care in the interview to present concise and well thought through ideas. She presented as warm and caring.

**Dora** is Afrikaans speaking, 47 years old, and married her first love. The couple has three adolescent children, and the eldest suffers from depression. She is slightly built and has a young dress-sense. Dora has a post-graduate qualification but has not worked since her first pregnancy. Her husband is manager. The impression was gained that their relationship is superficial and unfulfilling. Dora presented as friendly and talkative, but anxious - she chain-smoked during the interview, and bites her nails. This interview was the shortest of the ten conducted, and Dora's focus was more on her child's depression.

**Berta** is 46 years old and also Afrikaans speaking. She married 21 years ago and the couple has two adolescent children. Her husband is a well-known artist. Berta presented as flamboyant, attractive and well groomed with colourful modern clothes and an abundance of jewellery. She has an exceptionally good sense of humour and is a good narrator, so we laughed often during the interview. She never worked since her marriage, and has issues of inferiority for not having tertiary education. She is popular at parties for being good fun. Berta is actively involved in the children's schools and extramural activities. The rest of the time, she socialises, or shops for clothes, jewellery and other goods. She recently started painting and produces art of high quality.

**Cathy** is 40 years old and is English speaking. She has been married for 18 years and the couple has two children. Her husband is a successful businessman, who excels in sport, but who is dedicated to his family and his wife. Cathy is an attractive, somewhat reserved woman with an understated sensuality who was casually dressed, and presented as comfortable and relaxed during the interview. She is compelling and is popular with their friends, even though she appears cool and distanced. She has a diploma but does not work and spends her time with her children and their activities, and with other non-working mothers. The couple had been in marital therapy a few years ago, and some of their marital problems were addressed.

Cathy carries sadness for both her and her husband because the marriage has shortcomings, and she has a deep sense of failure as a spouse.

**Theresa** is 35 years old and is an Afrikaans-speaking sales-representative. She is a charming and vivacious individual, with an appealing laugh and bubbly personality. She has been married since she was 21 years old to a geologist, and the couple recently had their first child. Theresa has a secretarial diploma, but enjoys the adrenaline rush of sales, for which she has won many awards. Theresa puts a lot of effort into her appearance and is very attractive. Her marriage went through a rough patch a few years ago when she was unfaithful but her gentle, patient husband took her back with open arms. She particularly enjoys entertaining and socialising.

**Anna** is 51 years old and is bi-lingual. During the interview, she alternated between Afrikaans and English in a colourful manner. She has been married for 25 years. She and her husband, a lecturer in music, have three children, and live an atypical lifestyle. Anna is a qualified librarian and worked for a few years to put her husband through University. She then started her own successful clothing design business, which she has run for the past 20 years. She presented as a voluptuous, artistic, chic woman who dresses with flair. She has a dry sense of humour. She is interesting and intelligent, and confidently presented clear views on most matters.

**Linda** is 38 years old, is Afrikaans speaking, and has been married for 14 years. The couple have three young children. Her husband is a computer programmer, and Linda has a diploma in photography has not worked since the birth of the first child. She is a pleasant, sparkling and animated woman, who presented as light, cheerful and full of the joys of life. Linda is an athletically built woman presents as much younger person in her T-shirt, shorts and bare feet. She often laughed heartily during the interview and made light of the issues. She is actively involved in the church and the community, and is a lively, sociable person with whom it was a pleasure to spend time.

## **4.9 DATA COLLECTION**

A *semi-structured interview schedule* (Addendum B) was used in face-to-face interviews, which were tape-recorded and transcribed.

### **4.9.1 Semi-structured interviews**

There are several means of data-collection used in IPA, such as written, audio or video accounts (Shaw, 2001; Willig, 2001:54), however, semi-structured interviews are most used, as they allow the participants to provide a fuller, richer accounts than are possible with a standard quantitative instrument (Willig, 2001). The semi-structured interview format also takes into consideration the intimate and personal nature of the subject under research (Lavie & Willig, 2004). The rapport established between the researcher and participant fosters a deeper understanding and can offer access to the more private and intimate details (after Lavie & Willig, 2004).

Tiefer (1995:201) suggested that “*sex research should raise up women’s diverse voices, not impose a pre-existing paradigm through questionnaires or measurements*”. The choice to use semi-structured interviews was partly based on this recommendation as they allow for an informal, interactive process, and utilise open-ended comments and questions (Moustakas, 1994). This also allows the researcher considerable flexibility in probing interesting areas that emerge, and for the introduction of unanticipated answers, which can be further probed with “funneling” techniques by which a general item is followed up with more specific probing questions (Grinnell, 1998:276; Smith & Osborn, 2003) to produce richer data. My practical clinical experience also meant that I was confident I would be able to draw the women out should interesting details emerge.

At the start of each interview, I explained why I wanted to tape-record the session, how I would use the resultant recording (as recommended by Willig, 2001; Smith & Osborn, 2003) and obtained each participant’s permission to do so. Tape recording the interview (rather than taking notes) helps the interview to run smoothly, creates space for the parties to establish rapport and ensures that all the nuances are captured for later analysis, and, if necessary, re-analysis (Smith & Osborn, 2003).

### **4.9.2 Constructing the interview schedule**

I relied on Smith and Osborn (2003) for assistance in constructing the interview schedule. In summary, they suggest the following actions:

- determine the broad range of issues to be covered in the interview;
- arrange topics in an appropriate sequence. In this instance, I left the most sensitive topics to later in the interview when the participants were more relaxed;
- determine appropriate questions relating to each area of interest;
- plan questions that can be used to further explore answers, in case these are necessary.

I studied the guidelines on question construction and interview techniques of Moustakas (1994), and Smith and Osborn (2003), and used these to augment my clinical experience where necessary and appropriate (Addendum B). Producing a schedule beforehand forces the researcher to think of difficulties that may be encountered, as with the wording of a question of sensitive topics, and to give thought of how the difficulties might be handled, which would allow the researcher to more confidently and preparedly proceed with the interview (Smith & Osborn, 2003).

I also took cognisance of the possible errors in collecting and processing data from “non-probability sampling” with a small number of participants, as pointed out by Grinnell (1988; 1998) and was mindful to avoid these by careful construction of the interview schedule. Grinnell (1988:255) noted that these errors include: error of intended and unintended response (lies or misperceptions), interviewer bias, poorly worded questions in the interview schedule, and partial responses to questions.

#### **4.10 DATA PRESENTATION**

I interviewed the participants in their mother language, i.e., seven in Afrikaans and three in English). The interviews were tape-recorded and later transcribed by myself in the same language in which they were conducted, as per the recommendations of Smith and Osborn (2003). I then had to make a decision about the *translation* from Afrikaans to English and the most advantageous *presentation* of the data specifically with reference to original and translated text. This process proved to be quite a challenge.

I sought guidance on whether or not it was advisable to translate the Afrikaans interviews into English and, if so, on the best approach to use. I was advised that IPA allows considerable flexibility with respect to language and depends on the preference of the

researcher (Dr J.A. Smith, Brisbeck University, London, personal communication, ipanalasis@yahoo.com, 11 February, 2008).

Herbst (2006) and Appelt (2006) grappled with the same problem of translation from Afrikaans to English. Their sample populations were from a particular cultural community who speak an idiosyncratic Afrikaans. Appelt (2006:65) referred to the “*parochial language of the Cape Flats*” and Herbst (2006:84) to the “*idiomatic, unique and descriptive Afrikaans words and phrases used*” by their participants. Herbst first presented a citation in English, followed by the original Afrikaans text, in order not to lose the “inimitable” Afrikaans used by the specific cultural group she interviewed (Herbst, 2006:107). Upon reading her dissertation, however, I found the presentation cumbersome and lengthy, and I eventually only read the English translations. Appelt (2006:65) included only selected words in the original language, in italics and brackets, when she considered the translated version to have lost part of the “implied” meaning. In my opinion, this was a much more accessible and readable text (as was the motivation for Lavie & Willig, 2004, in their decision to translate from Hebrew to English).

The difference between Herbst and Appelt’s participants and those in this study, however, was that those in this study were middle-class, tertiary trained, bi-lingual, Afrikaans-speaking women, living in Cape Town. This meant that their Afrikaans did not pose the same challenges in the translation.

Furthermore, in my opinion the English translations in this study (where applicable) formed part of my meaning-making and interpretative role in the analysis (see Section 4.11). The IPA approach recognises that the person’s thoughts are not transparent in interview transcripts, but that the analytic process should interpret, enhance and translate the understanding captured in their thoughts. This requires the researcher to engage in an interpretative association with the transcript, which is obtained through a sustained engagement with the text and a process of interpretative activity (Smith *et al.*, 1999; Smith & Osborn, 2003). IPA holds a symbolic interactionist position by recognising that meanings are negotiated within in a social context, and with the researcher playing the interpretative role (Lavie & Willig, 2004). Therefore, I view the translation of the text as an additional level of interpretation.

Furthermore, translation into another language aside, Willig (2001:25) makes the well-taken point that “*all types of transcription constitute a form of translation of the spoken work into something else. An interview transcript can never be the mirror image of the interview*”.

Based on the afore-said, I then decided to translate the text, and was left with several options of where to place the original (Afrikaans) text. In the interest of trustworthiness and in order for the reader to judge the translation, I decided to include the original text in the thesis, beneath the relevant English translations. I resolved that this option would make for easier reading and present the subtleties of the communicative interaction between the interviewee and myself in the appropriate context.

Thus, in summary:

- I transcribed the interviews exactly as spoken;
- I included pauses, interruptions, volume of speech and laughter as “transcript notations” (after Willig, 2001) in as readable a format as possible (after Giles, 2002; Annexure E);
- I provided the original Afrikaans transcript, in smaller font, below the English translation.

#### **4.11 DATA ANALYSIS**

Interview transcripts were subjected to detailed qualitative analysis, which involved identifying, and eliciting of key themes and developing these into “thick descriptions” (Fade, 2004) in the writing up phase (see Section 4.12).

There are four stages of analysis of the individual transcripts. These are (Willig, 2001; Lavie & Willig, 2005):

1. Familiarisation with the transcripts through reading and re-reading each one: at this stage the researcher produces notes reflecting initial thoughts and observations.
2. Identification and categorisation of the central themes that emerge, thus capturing the essential quality of what is represented by the text.
3. Introduction of structure by grouping similar themes.
4. Production of a table of structured themes, together with quotations that illustrate each.

The last stage of the analysis is the integration of cases. Having produced summary tables of each individual participant, these are integrated into an inclusive table of master themes that reflects the experiences of the group of participants as a whole, culminating in writing up of the data (Smith *et al.*, 1999; Shaw, 2001).

In a move beyond exploration and description towards understanding, the analysis requires an explanation of the participants' "lived experiences". Henning (2004:7) noted in this regard "*It is in the articulated interpretation that the understanding and that explanation of the phenomenon lie – not in the presentation of organised and rearranged data*".

IPA demands that the researcher plays an active role in making sense of the accounts collected, rather than engage in passive analysis (Shaw, 2001; Willig, 2001; Giles, 2002; Smith, 2003). This is because it is the *interpretation* of the transcript that draws together a cohesive meaning from the individual accounts (Giorgi & Giorgi, 2003; Shaw, 2001; Smith *et al.*, 1999; Smith, 2003). Meaning (to understand and to make sense of the experience) is central, and the aim is to *understand* the content and complexity of those meanings, rather than to measure its frequency. To clarify, in the words of Smith and Osborn (2003:45), "*'understanding' ... captures these two aspects of interpretation-understanding in the sense of identifying or empathising with and understanding as trying to make sense of*". IPA thus has a commitment to the exploration of meaning and sense-making.

During data analysis, I engaged in continued reflexivity and self-monitoring, in order to prevent bias (Lemon & Taylor, 1997; Shaw, 2001). Furthermore, in view of the fact that Shaw (2001) cautions that the researcher should not go beyond what is said by the participants, I also remained mindful not to add my own story to those of the participants.

#### **4.12 WRITE UP**

Giles (2002:217) noted that one of the features of a qualitative report is the "use of large, detailed chunks" of data, in the interest of the reader to be able to evaluate whether the interpretation makes sense and addresses the research question. This makes this section "typically much longer" due to the inclusion of the data, and the accompanied detailed commentary. The write up should provide convincing a description of the nature and quality of the participants' experience of the phenomenon being researched (Willig, 2001). One can

either present the “results” and “discussion” in separate sections, but I opted for the option of presenting both in a single, albeit long, section (Giles, 2002; Smith & Osborn, 2003).

The presentation of the results can be supported by the inclusion of a table of themes (Willig, 2001), as I have in Table 5.1.

This write-up outlines the meanings inherent in the participants’ experience, and translates the themes into a narrative account. The themes are explained, illustrated and nuanced, and considered in relation to the existing literature. The table of themes forms the basis of the narrative argument, which is interspersed with citations from the transcripts to support the case, distinguishing between what the respondent said and the analyst’s interpretation of it (Lemon & Taylor, 1997; Willig, 2001; Smith & Osborn, 2003).

Finally, the concluding section of an IPA report also addresses implications for future research, and can in addition inform recommendations for improved practice, particularly in the areas of health and counselling practice (Willig, 2001).

#### **4.13 ETHICAL CONSIDERATIONS**

The focus of this research is an intensely private matter for individuals and their partners. As such, I endeavoured to ensure that the participants did not feel violated in any way, and made certain that my actions were ethical at all times. Ethical standards were applied through:

- informed consent;
- guaranteed confidentiality;
- debriefing the respondents;
- adhering to the code of conduct of the social work profession and that of private practitioners.

The provisions for these formed part of the proposal for this research and were approved by the University’s Ethical Committee prior to any data collection (See Addendum C). They included:

Written consent for the interview (Addendum A): None of the participants objected to my tape-recording their interview.

Guaranteed confidentiality: I have used pseudonyms altered identifying data, to avoid the participants being recognised should they disclose that they took part in the study.

Interview technique: During the interviews I used my clinical skills to provide a safe space for the participants. I listened attentively to foster empathy, indicating understanding by nodding and provided warmth and acceptance using body language. I deliberately refrained from engaging in a therapeutic role, however, as I did not want my involvement to contaminate the data.

Debriefing sessions: I offered two debriefing sessions to participants free of charge, either with myself or a colleague (Grinnell, 1988:255). None of the participants made use of the formal opportunities for debriefing. However, all of them used the time after the interview to informally debrief and to discuss feelings that had arisen during the interview.

## **4.14 VALIDITY AND RELIABILITY OF THE STUDY**

Creswell (1994) stresses the importance of addressing the concepts of validity and reliability in a qualitative plan.

### **4.14.1 Reliability**

“Replicability” (or reliability) has the function that another researcher is able to conduct the same study using another sample, obtaining near-identical results (Giles, 2002). Qualitative research has been labelled unscientific (Morgan, in Giles, 2002) because it’s difficulty to replicate, making it difficult to ensure that researchers do not make false claims. Giles (2002) agrees that this is a possible weakness of qualitative studies, but points out that since qualitative research is not aimed at establishing facts, findings can only ever be disagreed with, and could never be proven “false”.

While a homogenous sample is a requirement of IPA, the selected group of privileged middle-aged white heterosexual women, might in itself leave the study open to critique. Addressing reliability through a similar study with a more diverse group may well result in

the emergence of other themes. In this regard, the description of the methods used, and descriptions of the selection of the participants provided herein enhance the chances of replication (as per Creswell, 1994), thereby enhancing trustworthiness (Creswell, 1994).

#### **4.14.2 Generalisability**

The small sample size may limited generalisability, or so-called “external validity”, of the outcomes of the study (Creswell, 1994). Pidgeon and Henwood (1997) suggested that, in qualitative research, it is more appropriate to refer to “transferability” than “generalisability” as sampling is not done statistically. “Transferability” refers to the application of the findings of the study in similar contexts or settings (De Vos *et al.*, 2002).

While this may be true, the intent of qualitative research is not to generalise findings, but to form a unique interpretation of events (Creswell, 1994:158). Pidgeon & Henwood (1997:271) argued that if the researcher reports fully on the contextual features of the study, and provides rich and dense information sensitive to diverse levels of abstraction, it “*will in itself suggest its own sphere of relevance and application*”. Similarly, Giles (2002) suggested that it is enough that the findings of a study resonate with readers (being “in tune” with the experience) so that the readers are able to identify with the experience, and that the findings should be sufficiently sound and understandable as to suggest practical application (as also supported by Lemon & Taylor, 1997).

#### **4.14.3 Credibility**

The other limitation of qualitative research is the more problematic question of validity, or accuracy of the information (“credibility”, according to De Vos *et al.*, 2002; or “internal validity”, according to Creswell, 1994). Giles (2002) argues that no amount of documented data will convince a sceptic, who simply disagrees with the interpretation of data, but techniques to reduce bias are vital in qualitative methodology, and the researcher must remain faithful to the participants’ accounts. To enhance trustworthiness the qualitative researcher has to apply measures such as “triangulation” (Shaw, 2001; Tindall, 1994 in Giles, 2002), or “member checks” (Creswell, 1994; Babbie & Mouton, 2001) to press validity claims. As I chose the latter I will explain the method as follows.

Heron's Co-operative inquiry (Heron, 1996; Heron, in Shaw, 2001) is essentially the same process as doing "member checks" (Creswell, 1994:158; Babbie & Mouton, 2001:275) and involves study participants in the analysis by reporting the findings back to them. I asked the participants to scrutinise the analysed data to confirm whether it actually reflects what they said during the interviews (see as an example Addendum F). They were given the opportunity to confirm or challenge my interpretation of their accounts. The participants all indicated that they were satisfied that the transcribed data reflected their input, and only one suggested a minor change, which was incorporated in the findings.

Another ways to address validity include the use of reflexivity (Shaw, 2001; Willig, 2001; Giles, 2002), as I have done in the next section.

#### **4.14.4 Reflexivity**

Reflexivity demands that the researcher examines carefully her own personal and professional reasons for asking the research question. Reflexivity includes the process of the researcher's "*scrutiny of ...her own research*" (Willig, 2001) and "*experience, decisions and interpretations in ways that bring the researcher into the process and allow the reader to assess how and to what extent the researcher's interests and positions influenced inquiry*" (Charmaz, 2006:188). According to Giles (2002) the value placed on reflexivity in a particular study is a measure of how objective the researcher is attempting to be.

Reflexivity demands that the researcher exercise reflexive awareness at each appropriate point in a study (Giles, 2002; Thompson, [ipanalysis@yahoogroup.com](mailto:ipanalysis@yahoogroup.com), 13 June 2008) and comprises:

- *Personal reflexivity*, which concerns personal interests and values as they may affect the research process. This may include a description of how the researcher came to be interested in the topic, and of the particular biases and/or expert knowledge can affect the study.
- *Functional reflexivity*, which concerns the role of the individual researcher in directing and shaping the course of the study.

I included this section to allow the reader to evaluate and understand any inter-subjective dynamics between the data and myself (as per Biggerstaff & Thompson, in press, 2008).

#### **4.14.4.1 Personal reflexivity**

*I grew up in Stellenbosch, the second child of four, where my father was a University Professor. I attended in a girls-only school and, thereafter, Stellenbosch University for my first degree. I am from a conventional, Calvinistic background, and held strict religious beliefs, including conformist views on sexuality. I grew up to believe that sex before marriage is “sin”, but that somehow once married, it is a wonderful “gift” from God to be enjoyed (which I did not understand possible when one had to view it so negative before the marriage) and also the “right” of the man as head of the household.*

*At my first place of work as an unmarried young adult I often overheard my older colleagues discussing their sex life. It puzzled me to hear how they joked about their manoeuvres to avoid sex with their partners, how they depicted sex as being a boring chore, and of little personal value as they derived no pleasure from it. Then as a young mother attending play dates with other young mums, the discussion was much the same. They complained that they felt too tired at the end of the day to still accommodate their husbands’ needs, and by this time I could relate to what was discussed as my own avoidance strategies were already well practiced (!).*

*As I matured, I continued to hear from different women (be it friends, colleagues, or family members) how they habitually avoided sex, and in social situations this was joked about, or complained about by their husbands. I noticed this phenomenon of woman not wanting sex with their husbands being referred to in magazines, and the many magazines articles on how to “pep up” your sex life. I wondered why, if sex is such a wonderful and natural thing, is it necessary for popular media to advise people how to do it, and how to “revive” it?*

*Further studies in Psychology did not explain this conundrum, nor did my Masters in Clinical Social work, although it included semester courses in sexual health and marital therapy. At the Sexual Offences Court my interest in human sexuality deepened, as I became aware that the effects of sexual assault includes sexual difficulties in relationships. When employed at the Family Advocate’s Offices I also noted that marital failure was often attributed to problems around sexuality.*

*I commenced private practice in 1995 to spend more time in therapeutic intervention with a special interest in marital/couples counselling. My clinical experience resulted in increased awareness of the high incidence of sexual avoidance and the impact thereof on individuals and their partners.*

*I identified a need for more information in sex therapy per se, and joined SASHA (Southern Africa Sexual Health Association) during 2005 to attend monthly case discussions, workshops and lectures within a multi-professional group. In reading up on the phenomenon of low sexual desire, I noticed that often authors would identify the many reasons why women do not want to have sex, only to end with instructions on how to “do it” (without desire!). I grew increasingly uncomfortable with social scripts that govern society prescribing a “sexual norm” to women, when this norm is different to what seems to be experienced in real life. The media (television, films and popular magazines) tend to pressurise women into specific sexual behaviours. I found that textbooks on how to address this phenomenon of “low desire” in women are mostly written by men, and wondered if men can fully understand a woman’s perspective. I then decided to formalise my interest in the subject by doing a doctorate, in the hope of finding out what women themselves have to say about the topic.*

#### **4.14.4.2 Functional reflexivity**

*In the choice of the research subject, I was aware that by focussing on “low” desire, I might also err, like the societal script, by classifying as this as a “condition”, and I felt uncomfortable to group the women by this commonly shared experienced “problem”. There was, however, no other way to select potential participants except on the grounds of “low” desire. I was careful not to pathologise or label the phenomenon through the use of current clinical terminology, although for research purposes it was helpful to clarify and frame the “condition” by keeping clinical diagnosis in mind. I was also mindful that the wording of the interview questions not influence answers, by avoiding any inference that low or no sexual desire is abnormal or undesirable in any way.*

*Thus, my own background and view of the world has definitely played a role in the development of the interest in the topic, and the choice in research process. However, I have actively tried to use my awareness of this fact to ensure that the findings remain those of the participants’ (as per Shaw, 2001) and not mine.*

## 4.15 LIMITATIONS OF THE STUDY

No study is without its limitations, and this one is no different. The limitations of this study include those related:

- Recruiting the participants, and the homogenous nature of the group
- The elusive subject matter
- Probable error in the accounts
- The exploratory nature of the study.

Due to the sensitive nature of the research topic, I experienced initial difficulties in finding participants. At least one prospective participant felt that the topic might be too personal and she decided against participation, which I supported, as I thought she was too emotionally fragile to participate. I did eventually manage to find the ten participants needed.

Another limitation was the difficult and elusive subject matter – it is widely acknowledged that it is very difficult to define and categorise “sexual desire” and I found that the overlap with other disorders and other phenomena meant that, at times, it was difficult to clarify themes and categorise concepts.

When retrospective descriptions are obtained there is the double possibility of error (memory and perception of the original situation) or deceit on the part of the participant (Giorgi & Giorgi, 2003). But Giorgi and Giorgi (2003) also point out that in longer interviews, such as used in this dissertation, it is usually possible to detect contrived views. I did not detect any such contrivance in interviews with any of the participants'. Importantly, the epistemological claim in phenomenology is not aimed at objective reality, but at the experiential structure. In other words, how data is *presented* to the researcher is more important than how objective the data are.

Exploratory studies seldom fully answer research questions and, at best, “hint” at answers and give insights into methods that could provide more definite answers (Babbie & Mouton, 2001). I realised that in all likelihood this would also be true of this study but, as explained in the previous section, exploratory phenomenological research aims to describe the lived experience of participants, and not to explain it (Willig, 2001; Larkin, 2008).

## **4.16 SUMMARY**

In this chapter I outlined the research methodology in detail. I explained the reasons for my particular use of the literature, motivated my choice of Interpretative Phenomenological Analysis, and outlined its point of departure. I also discussed the need for reflexivity to curb bias.

I provided reasons to support the sample size, described the difficulties in recruiting participants, and detailed the procedures used. I also provided character sketches for each participant in helping the reader understanding their life-worlds.

I explained my choice of semi-structured interviews for data gathering and the process used to arrive at the questions posed in the interviews. I also explained the post-interview processes of transcribing, translating and analysing the data.

I outlined the procedures adopted to ensure ethical behaviour on my part. Finally I outlined some of the limitations of the study.

In the next Chapter I apply the research methodology as outlined in this Chapter. I analyse the empirical data, and write up the participants' accounts of the phenomenon of low sexual desire (as described in Sections 4.5.1.4 and 4.12).

## CHAPTER 5

### THE LIVED EXPERIENCE OF WOMEN'S LOW SEXUAL DESIRE: ANALYSIS AND DISCUSSION

In this chapter, I analyse and discuss the data collected in this study on the subjective experience of women of having low desire to have sexual intercourse with their partners. The relevant literature on the nature and experience of desire was consulted for comparison after I had analysed the data, in accordance with IPA (Shaw, 2001), and used to explain the themes and findings of the empirical study (after Giles, 2002), and to verify the research findings, thereby contributing to trustworthiness (De Vos *et al.*, 2002).

As the **aim** of this study is *to research women's experience of low sexual desire*, there was an attempt to clearly conceptualise the concept of sexual desire. "Sexual desire" is, however, a very complex construct, as noted by Leiblum and Rosen (1988:vii) who asserted that sexual desire is "*an extraordinarily complicated aspect of human life*", whilst Schnarch (1997:134) suggested that sexual desire is "*the most complex form of sexual motivation among all living things*". This chapter will first focus on exploring views on the *nature* of sexual desire.

Furthermore, to further advance the aim of this study, this chapter will also draw attention to sexual desire in the social and cultural context. Amongst others, interpersonal and social situations, and the role of societal pressure and social scripts will be described, again as it emerged as themes in the analysis of transcripts of participants' accounts.

With regards to the *method* of Interpretative Phenomenological Analysis, Smith *et al.* (1999:220) explained that the researcher would find in proceeding with analysing data that the method is adapted to the researcher's particular way of working, as was the case with this particular study. Qualitative analysis "*is inevitably a personal process and the analysis itself is the interpretative work which the investigator does at each of the stages*".

In the analysis I focused on the uniqueness of the participants' thoughts and perceptions, true to the phenomenological nature of IPA, which relies on the researcher's capacity to become immersed in the private world of each participant as a phenomenological insider. I made attempts to make sense of and interpret the participants' experiences to address the research question (Fadde, 2004).

The information gathered through interviews, were interpreted to extract themes relevant to the research question, (as per Smith *et al.*, 1999; Shaw, 2001; Lavie & Willig, 2005) by reading and rereading the transcripts of the interviews, and getting familiarised with the data. I marked interesting or significant information, and accordingly emerging theme titles emerged. I then made a list of master themes, and the original titles became sub-themes, which I clustered under several headings. The final step was to produce a consolidated table of themes and sub-themes for the group of participants as a whole.

The following sections are a translation of the themes into a narrative account, as per IPA (Smith, 1999; Smith, 2003), intermingled with verbatim extracts from the transcripts as support of the themes and sub themes. The Afrikaans citations were translated to English (Herbst, 2006), and I included the Afrikaans text by first presenting citations in English, followed directly by the original Afrikaans version underneath in smaller print.

Seven themes emerged from the data for the group of participants as a whole. These themes and their related sub-themes are listed in Table 5.1. They are each explained and discussed in the following sections.

**Table 5.1 A consolidated summary of the seven emergent themes from the data**

Theme #	Theme name	Related sub-themes
Theme 1	Perceptions of sexual desire	Components of sexual desire Dimensions of sexual desire Sexual desire versus sexual arousal Spontaneous and responsive sexual desire Sexual desire and sexual activity
Theme 2	Experience of sexual desire	Past experience of sexual desire Present experience of sexual desire Experience of situational sexual desire
Theme 3	Experience of sex life within the relationship	Declining sexual encounters Compliance with sexual encounters Experience of sexual relations with partner
Theme 4	Impact of low desire on self and/or relationship	Experience of impact on the individual Experience of impact on the relationship
Theme 5	Personal reasons for a decline in sexual desire	Health Menopause Ageing Self-concept Childhood history Life-stage factors
Theme 6	Relationship factors impacting on sexual desire	Romantic love and attraction Interpersonal behaviour Relationship duration/novelty Relationship satisfaction Discrepant sexual desire Power struggles Conflict, connectedness and intimacy Love-making techniques
Theme 7	Sexual desire with-in the socio-cultural context	Social scripts Comparisons with social group Parental influences Sex role stereotypes and gender defences Contextual factors

The seven themes that are reflected in the table will be discussed in the following sections.

## **5.1 THEME 1: PERCEPTIONS OF SEXUAL DESIRE**

When participants were asked to describe “sexual desire”, all of them expressed difficulty in conceptualising the term. They explained what they understood it to be, and some women described the experience of how it would feel.

### **5.1.1 Components of sexual desire**

Most of the respondents made the distinction between a physiological need and an emotional component in the way they view sexual desire.

Anna and Cathy highlighted the emotional aspects of sexual desire:

It is a desire to be physically intimate with somebody, and it is more emotional than physical (Anna).

Sexual desire is the desire ... deep down ... to have sex ... or looking at someone and feeling turned on ... Is that sexual desire? I think it is largely emotional (Cathy).

Dora identified the emotional component as feelings of “love”:

Desire goes together with love; it is not so much “lust”. There is also an emotional component (Dora).

*Begeerte gaan saam met liefde; dis nie soseer “lust” nie. Daar is ‘n emosionele komponent daarby (Dora).*

Similarly to these respondents Verhulst and Heiman (1988:245) viewed sexual desire as an emotional experience, devoid from anatomical localisation:..“*as an emotion*”, sexual desire “*is a feeling that causes the person to look for sex*”.

Paula highlighted the physical aspects of desire:

Desire is desire to have sex. It is more a physical thing that results from an emotional or an intellectual trigger (Paula).

*Begeerte is begeerte om seks te hê. Dis meer ‘n liggaamlike ding wat kom as gevolg van ‘n emosionele en intellektuele “trigger” (Paula.)*

Others like Linda and Karla stated that sexual desire has both emotional and physical components:

It is both emotional and physical (Linda).

*Dis is beide emosioneel en fisies(Linda).*

It is in the end a chemical thing. It is both emotional and physical. It is clearly more a physical need than an emotional desire; otherwise it would not have been called a “sexual desire”. Sex has to do with your body, and it is the physical manifestation of your feelings that begin with the holding of a hand, a kiss or an embrace, and hopefully ends in the sex act (Karla).

*Dis op die ou end ‘n chemiese storie. Dis beide emosioneel en fisies. Dis duidelik meer ‘n fisiese behoefte as ‘n emosionele begeerte, anders sou mens dit nie ‘n “seksuele begeerte” genoem het nie. Seks het te doen met jou liggaam en dis die fisiese uiting van jou gevoelens wat begin met die hou van ‘n hand, ‘n soen of ‘n omhelsing, en hopenlik eindig met die seksdaad (Karla).*

As with the aforementioned citations, Levine (2002) concurred that sexual desire is often a longing for something we do not currently have, and an interest in behaving sexually, but with biological underpinnings. As Karla explained, women cited love or emotional intimacy as the goal of sexual desire, in pursuit of relationship goals (DeLamater, in Regan & Berscheid, 1999; Tallis, 2004).

Gwen too mentioned the two components of desire as being physical and emotional. She referred to desire as “propelling”, which is in accordance with drive-theorists’ views. She made the distinction between desire for a person that she is emotionally involved with, and the more physical (lust) response when there is no emotional involvement.

It is a physical response. It is a pleasurable response and it feels as if your whole body is involved. It feels completely fired up an extraordinary energy which propels you whether you wish to go forward or not. In a sense it has almost an uncontrollable part to it, the younger you

are. Sexual desire is more physical. For myself I have never divorced the two ... no, that is not true ... [thinks long] ... because one can watch, not pornography, but a very moving and sexual explicit love story, and you... I can feel my bodily reaction to it. But I am not emotionally involved with these people. So in that sense it can be the same thing, but if it is me myself who feel desire for another person there clearly has to be a strong emotional bond. I don't feel desire for a stranger, unless it is ... (Gwen).

As Gwen did, Levine (1987:36) described the sexual drive as one of the components of sexual desire, and evidenced, amongst others, by physical responses such as “genital tingling”, “tumescence”, or “lubrication”. Gwen reiterated her idea that sexual desire is an “energy“, which builds on her previous citation that it is “*an extraordinary energy which propels you*”:

If you desire something, you want something, as opposed to just the warm close physical feeling, which is slightly sexual because you love your husband ... and the person is male, and you are female ... But desire carries an energy with it, which is not what I am saying ... [long pause]. I do see desire as having this propelling energy as opposed to just a warm and cosy feeling – this is sexual but just low sexual. So your physical response is just then warm and fuzzy, as opposed to “all the lights flashing”, as with desire (Gwen).

In accordance with Gwen's view that drive is a “propelling energy“, Schwartz and Masters (1988) believed that sex is a natural function, and that desire, like other components of sexual response, flows naturally in the absence of significant blockages. Even though Schwartz and Masters (1988) equated desire with other “natural appetites“ such as hunger for food (i.e., physiological state), they described the manifestation of desire more in psychological terms: “*sexual desire manifests itself as an attraction to a person the individual perceives as appealing. This attraction can evolve into a casual or a committed relationship. Once a pair-bond has been established, sexual desire is a natural way of expressing the sense of intimacy that develops within the relationship*” (1988:230).

Most researchers agree that sexual desire, being multifaceted, is the product of *both* physical and psychological factors (e.g. Levine, 1987; Bullard 1988; Stein, in Bertram, 2000). These views are supported by this research. Regan and Berscheid (1999:15) summarised that sexual desire is a “*psychological state subjectively experienced by the individual as an awareness that (s)he wants or wishes to attain a (presumably pleasurable) sexual goal that is currently unattainable. Sexual desire, like other states of desire, is different from, although undoubtedly associated with, bodily responses.*”

In summary, the distinction between physiological and psychological underpinnings of sexual desire appear to be arbitrary, and it would appear that its manifestation indicate an overlap of both forces. The participants stressed the importance of the role of emotions in the experience of sexual desire.

### 5.1.2 Dimensions of sexual desire

Apart from the distinctions made between physical and psychological desire, it was described in *quantity* (either high or low), and the particular experience differ also in experience (*quality*). Kaplan (1979; 1995) reported a distribution scale of sexual appetite, with low and high libido at the opposite ends of a continuum, like Paula explained:

Depending on many factors desire can strong or weak– it fluctuates (Paula).  
*Afhangende van baie faktore kan begeerte hoog of laag wees – dit fluktueer(Paula).*

Sexual desire not only fluctuates in quantity, but also in quality. In a previous section Gwen described different aspects of desire, such as “*propelling, completely fired up, an extraordinary energy, uncontrollable*” and Berta mentioned “*warm, excited*”, which indicates the range of differing qualities of experience. Also Jana mentioned that sexual desire could have a more playful quality, like with a one-night stand:

Sometimes it is plain physical ... It is another thing to be with some-one only once ... to have some “mystery” ... [laughs] (Jana).  
*Partykeer is dit plein fisies ... Dis ‘n ander ding om net een maal met iemand te wees, ‘n bietjie “mystery” te hê ... [lag](Jana).*

Also Theresa emphasised the compelling, lustful component of sexual desire:

It is to want to be with someone – the craving to have sex with him ... I **have** to! [laughs] Like with Paul. Remember, he also was a sex-mad person! [laughs] (Theresa).  
*Dit is om by iemand te wil wees – die lus om met hom seks te hê ... ek moet! [lag] Soos met Paul. Onthou, hy was ook ‘n seksuele mal mens![lag] (Theresa).*

Theresa’s comments of being “sex-mad” and attracted to a man she is not married to, reminds of Levine (2003) who described “lust” as “*intense sexual arousal unfettered by ordinary psychological, social and moral complexity*” (2003:283).

Another difference qualitatively is that desire can also be non-specific, rather than exact. Regan and Berscheid (1999) supported the notion of the existence of a qualitative dimension, regarding the specificity of the desired objective (e.g. sexual activity) and object (e.g. object or person). A person may have *diffuse* desire for sexual activity, and may therefore

masturbate or have casual sex with a willing participant, or otherwise desire may be directed to a *particular* person, as explained by Gwen:

If aroused by watching pornography you might want to masturbate when you are on your own, but you have no emotional connecting with that person (in the film). It is then just simply a physical release, as opposed to when you are in love with a person ... then you absolutely want to connect physically with *that* person (Gwen).

Gwen's explanation of the difference between having specifically a desire for a loved one, and diffuse sexual desire, also touched on the aspect of voyeuristic stimulation of sexual desire. Levine (1987) noted how hearing of, reading about or seeing the sexual excitement of others has the ubiquitous power to generate sexual arousal in that it involves transient fantasy. Fantasy, conscious or unconscious, may generate the earliest manifestations of desire.

In summary, sexual desire manifests itself within a range of low and high quantities and with differing qualities.

### **5.1.3 Sexual desire versus sexual arousal**

In their attempts to define sexual desire some of the respondents made mention of physical responses when experiencing sexual desire. Regan and Berscheid (1999:15) made distinctions between sexual desire, arousal and subjective sexual arousal. *Sexual desire* was described as a psychological state, "*clearly different from physiological genital arousal*". *Arousal* was defined in terms of specific physiological and genital events that may occur without conscious awareness, whereas *subjective sexual arousal* was awareness that one is genitally and physiologically aroused. Both and Everaerd (2002) believed that sexual desire and arousal are related – the stronger the arousal grows, that stronger the wish (or desire) to have sex. Basson *et al.* (2005:291) revealed that desire and arousal *coincide* and compound one another, and that the phases of women's sexual responses "overlap". As women tend to focus on how *mentally* exciting they find a stimulus rather than focussing on their physical responses (genital arousal), they might be unaware that they are physically aroused, and deny sexual desirous feelings despite genital lubrication. The citations of some of the women indicate the overlap of these occurrences.

Gwen described subjective (i.e. being aware of) arousal as distinct from desire, and referred to the overlap between physiological arousal and sexual desire:

If you watch a pornographic movie, your body responds, but you don't want that person but your bodily reaction is the same when you are in love with that person and want that person ... There is a complete emotional involvement with the person one desires as opposed to an involuntary physical response, like when you watch pornography (Gwen).

Gwen's distinction between arousal and desire is in accordance with the views of Regan and Berscheid (1999). They propose that sexual desire is easily confused with subjective sexual arousal, as both are subjective experiences. The difference is that sexual desire implies that one is interested in sexual activities and wishes to engage in sexual behaviour. On the other hand, subjective sexual arousal is the awareness that one is experiencing certain physiological and genital reactions such as lubrication. Both phenomena can occur concurrently.

Apropos of Gwen's mention of pornography, research suggests that extraneous arousal may enhance sexual desire for another person, for example, watching stimulating film material, which is then transferred onto the partner (Regan & Berscheid, 1999). This ability is commonly used as a therapeutic measure, and sex therapists may encourage the use of stimulating material or fantasies to spark sexual desire between couples (Barbach).

Berta's views point to the overlap between the emotional components of sexual desire and the physical aspects of an arousal state:

It is excited, erotic, romantic. It is both emotional and physical. It is warm and romantic. It is a desire, and it is different to being aroused. "Aroused" is more physical. Desire is more fantasy, and aroused is what happens to you physically. (Berta)

*Dis opgewonde, opwindend, eroties, romanties. Dis beide emosioneel en fisies. Dis warm, romanties. Dis 'n begeerte, en dis verskillend van om "aroused" te wees. "Aroused" is meer fisies. Begeerte is meer fantasie, en "aroused" is wat met jou fisies gebeur (Berta).*

Berta's descriptions correspond with Levine (2002:43), who stated: "*People feel their desire in their bodies*", and that sexual desire is often indistinguishable from sexual arousal. Similarly, the triphasic model of Kaplan (1979:9) described the interrelationship between desire, arousal and sexual activity as "interconnected but discrete" phases.

In summary, responses of arousal and desire overlap and are often indistinguishable from one another.

#### **5.1.4 Spontaneous and responsive sexual desire**

Anna said:

Arousal can follow, once you get into sexual activity, whether you are really into it or not; there may come a point where your body's physiological responses override emotional reluctance or resilience. Sexual arousal can sometimes occur spontaneously, and it can be triggered by an outside image, but it also does not necessarily translate into a desire to find a means to satisfy the response you have (Anna).

Anna's experience is explained by Hawton (1985:30-31), who indicated that "*Some women lack spontaneous interest in sex but are able to respond to their partners' approaches and experience arousal and orgasm*".

This distinction is also described by Basson (2002b) and Levin (2002), who state that some women "spontaneously" experience innate sexual need, especially in the earlier stages of relationship. In long-term relationships (such as the case with the participants) spontaneous desire does not seem to be experienced as readily, but responsive desire may be evoked "*by seeking stimuli necessary to ignite sexual desire*" (Basson, 2000:53).

Both and Everaerd (2002) asserted that when a person becomes aware of sexual feelings, s/he can voluntarily *react* in a manner depending on the particular situation. In this regard, Gwen explained experiencing an involuntary physical response, (leading to responsive sexual desire) when watching pornography, or when reading "a sexually explicit love story", and then may masturbate. Physiological sexual arousal, subjective sexual arousal, and sexual activity can, and frequently do, co-occur (Regan & Berscheid, 1999), as was the experience described by Gwen.

The majority of the participants described having had an active sex life in the beginning stages of their relationship, which tapered off drastically. Those who still participate in sexual interactions with their husbands do *not*, as described in the literature even experience responsive desire. In fact, they described not experiencing desire *ever* towards their husbands, and there are a multitude of reasons for this incidence, as will be pointed out in the further analysis.

In summary, some of the respondents indicated a distinction between spontaneous and responsive desire, and the occurrence of responsive desire in reaction to stimuli. The next section will focus on the experience of the respondents of sexual desire.

### 5.1.5 Sexual desire and sexual activity

Anna described that when experiencing sexual arousal it does not necessarily mean that there is a desire to find an outlet to satisfy the sexual response experienced. Gwen simply stated:

When having a sexual desire, it is not the same as the sexual act (Gwen).

Other respondents noted how an emotional need may lead to sexual activity:

At times the need is more to be cuddled, but then it ends up as sexual. The need is to be cuddled ... and sex stems from there (Jana).

*Somtyds is die behoefte meer aan "cuddle", maar dan eindig dit op as seksueel. Die lus is om ge-"cuddle" te word ... en seks kom dan van daar af (Jana).*

Sexual desire is to be attracted to a person and an eagerness to be intimate, at times not necessarily sexually, but also "closeness" (Karla).

*Seksuele begeerte is om aangetrokke te voel tot 'n persoon en graag intiem te wil omgaan, met tye nie noodwendig seksueel nie, maar wel ook "closeness" (Karla).*

The women believed in these instances that their sexual desire is aimed at enhancing emotional intimacy in the relationship, not at having sex (Tallis, 2004; DeLamater, in Regan & Berscheid, 1999). Regan and Berscheid (1996, 1999) found that men and women have different orientations towards sexuality. Whilst women cited emotional intimacy as the goal of sexual desire, the majority of men believed sexual desire is aimed at sexual activity (Tallis, 2004; DeLamater, in Regan & Berscheid, 1999).

From these afore-mentioned citations it becomes clear that the incidence of sexual activity does not necessarily imply that there was the desire for sexual activity. People engage in undesired sexual activities for many reasons other than sexual desire (e.g. Leiblum & Rosen, 1988, Beck *et al.*, 1991; Regan, as cited in Regan & Berscheid, 1999; Tiefer, 2001; Wood *et al.*, 2006), of which one is for intimacy reasons (Basson, 2005).

Then again, a lack of sexual activity does not necessarily reflect lack of sexual desire, as sexual interaction depends on partner compliance and accessibility (Levine, 2002). Even an available partner (such as a marriage partner) does not imply that the partner is willing to have sexual intercourse. As became clear in this study, an enormous range of reasons may prohibit sexual activity, including self- or partner imposed abstinence (Regan & Berscheid, 1999).

The reverse is also applicable - sexual activity (even if it proceeded without sexual desire of one of the participants) can ignite desire. This may increase sexual arousal and in turn the

desire to have sex. Thus, desire can follow sexual arousal, and the person can experience desire because of the engagement in sexual activity and by focussing on sexual stimuli or fantasies (Basson, 2000; Everaerd & Both, 2000, 2001).

In summary, sexual desire does not necessarily result in sexual intercourse, and sexual activity, conversely, does not necessarily imply the presence of sexual desire.

In this section the *perceptions* of the women were highlighted, and the next section will explore how they *experience* sexual desire.

## **5.2 THEME 2: EXPERIENCE OF SEXUAL DESIRE**

The women referred to experiences when they were younger (also before they got married), how the desire manifested in their present relationship, how it feels to have no desire towards their erstwhile sexual partners, and the experience of having strong sexual desire towards other men, but not towards their husbands.

To put their experiences in perspective, it has to be noted that both Jana and Theresa have suffered undiagnosed vaginismus<sup>1</sup>/dyspareunia<sup>2</sup> in their sexual relations with their husbands.

### **5.2.1 Past experience of sexual desire**

The respondents all have a history sexual experience either with their present partners or other partners. Linda, Karla and Berta experienced strong sexual desire as a teenager.

Earlier on there was sexual desire, as a teenager ... very typical. There was one guy that did it for me ... he *did!* [laughs]. But really, it was but only two or three men out of many boyfriends ... there were then the experience of deep desire and ... being kissed ... and that then your knees go lame (Linda).

*Vroeër was daar seksuele begeerte as tiener ... heel tipies. Daar was een ou wat dit vir my gedoen het ... hy hét! [lag]. Maar rêrig, dit was maar twee of drie mans uit baie boyfriends uit...daar was dan die ervarings van diep begeerte en ... gesoen word ... dan word jou knieë lam. (Linda).*

As a teenager it is all that you want, and all you can think about. In your twenties it is also like that. One is very aware of wanting to make love with your partner. In your thirties ... it also depends if I am very attracted to that person (Berta).

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<sup>1</sup> Vaginismus is the recurrent or persistent involuntary spasm of the muscles of the outer third of the vagina, which interferes with sexual activity. The manifestation of vaginismus could be lifelong or acquired, and either generalised or situational.

<sup>2</sup> Dyspareunia is the recurrent genital pain associated with sexual intercourse, not caused by a medical condition. The manifestation is either lifelong or acquired, and either generalised or situational.

*As 'n tiener is dit al wat jy wil hê, en al waaraan jy kan dink. In jou twintigs is dit ook so. Mens is baie bewus van wil liefde maak met jou partner. In jou dertigs ... dit hang ook af of ek baie aangetrokke voel tot daardie persoon (Berta).*

The citations by the participants are in line with Levine (1987) who stated that “horniness” is most dramatically manifested in adolescents, at which age the intensity of the drive is the strongest and the capacity to hide it is the weakest.

Some respondents experienced very high sexual desire in the early stages of their relationship, for example:

At twenty when we got married it was highly exciting, very vibrant, very busy ... everything I dreamed of. (Gwen).

I was very physical; I adored the man ... he was just so very beautiful. We together discovered sex ... and our bodies. (Paula)

*Ek was baie fisies; ek het die man bewonder ... hy was vir my so baie mooi. Ons het seks saam ontdek ... en ons liggame. (Paula).*

It was wild, warm, exciting. It was frequent – *too* frequent – like we all were in that sort of flush. (Anna)

*Dit was wild, warm, exciting. Dit was gereeld – óórgereeld - soos almal was in daardie soort flush. (Anna)*

In the first year of the relationship my desire was very very strong, very physical. We did it *all* the time! ... there was the being-in-love ... (Gwen)

Participants described being young adults, and being in love, at which stage there might be an intense need for intimate connections in search for a life partner (Levin, 2002). Early in romantic relationships this intimacy might be characterised by passionate sexual behaviour (Schwartz & Masters, 1988; Levine, 2002; Basson, 2005), when the sexual desire appears to be strong, spontaneous and linked to strong feelings of love.

In summary, the respondents indicated that they have experienced strong sexual desire when they were younger and in the beginning stages of the relationship, then the desire wore off.

### **5.2.2 Present experience of low/no sexual desire**

Paula, Gwen and Theresa said of their present experience of desire the following:

I have *no* desire at present, my sex drive is nil. He does not stimulate me *at all* (Paula).

*Ek het nou géén begeerte vir hom nie, my seksuele begeerte is nul. Hy stimuleer my gládnie (Paula).*

I have no desire presently – I do not want it **at all** (Gwen).

In the first few years we played more, had more sex, experimented more. But I have totally lost my desire for this in the past ten years. It is just *gone* [laughs] – I *really* do not want Karel to fiddle with me. I feel cold towards him – it just does not matter. There is *no* passion or desire (Theresa).

*In die eerste paar jaar jaar het ons meer gespeel, meer seks gehad, meer eksperimenteer. Maar ek het my lus daarvoor die afgelope tien jaar totaal verloor. Dis net wég [lag] – ek het rêrig nie lus dat Karel aan my moet karring nie. Ek voel koud teenoor hom – dit maak net nie saak nie. Daar is géén passie of “desire” nie. (Theresa)*

Linda, Jana and Anna expressed their indifference, or distaste in sex:

I *never* have desire...no shucks, very seldom ... I am *not* fazed. I just don't *want* to – **NO!** ....  
On a scale from one to ten it is a very small thing (Linda).

*Ek het nóóit begeerte nie... nee wat, bitter min... ek is min gepla. Ek wil net nie – NEE! .... Op 'n skaal van een tot tien is dit 'n baie klein dingetjie (Linda).*

No, *no* desire *at all*. (Jana).

*Nee, géén begeerte hoegenaamd nie. (Jana)*

Sexual desire is overrated...I see my divorced friends chasing after men for sex. I would rather eat my left eyeball (Anna).

On the one hand Cathy expressed positives about her husband, but she also expressed strong aversion to sex with him.

I have *no* desire for Chris. I don't *ever* desire him [laughs]. I feel I *love* him...sometimes... not as often as I should, but sometimes I do ... It is more the love like towards a brother, like a good friend ... I respect Chris. His intelligence, his good ability to think things through ... I *love* Chris, but I don't *desire* him at all....it's repulsive... (Cathy).

Regardless of the strength of their sexual desire in the beginning stages of their relationships, all of the the participants reported a decline over time. Levine (2002) mentions that, despite the “cultural expectation“ to continue regular and frequent sexual behaviour, one or both members' sexual desire lessens:

When I was young and newly wed, I definitely had more desire than now (Dora).

*Toe ek jonk en pasgetroud was, het ek beslis meer begeerte gehad as nou (Dora).*

... there are changes in the experience from the new, fresh, new relationship desire in the beginning, and as you get older ... stuff happens ... and comes in. I think you lose it (Cathy).

I have **no** desire to sleep with him. It is *still* not nice for me to sleep with him. (Theresa).

*Ek het geen begeerte om by hom te slaap nie. Dit is stééds nie vir my lekker om by hom te slaap nie (Theresa).*

As all the participants reported this decline that poses the question as to whether any long-term relationship is able to sustain a sexual relationship (after Money, 1986; Kaplan, 1995). Basson *et al.* (2005) noted a study by Klusman during 2003 that supported the notion of a normal reduction of desire with relationship duration.

The participants, such as Paula, Karla and Linda, indicated boredom with their sexual experiences. It appears that the familiarity that comes with longer relationships brings about a lessening in sexual desire, (Levine, 2002), because the novelty wears off. Apart from the effects of longer term relationships, there may be many other different causes that account for the increase in dissatisfaction with sexual experience, including life circumstances arising from social, relational, personal or physical causes, as will become clearer in the next sections (Hicks, 2005).

In spite of having no desire towards their partners, most of the participants described having a “good” relationship and wanting to remain in the relationship. But even so, these participants who loved their husbands, do *not* want to have sex with their husbands. These findings contrast with other studies indicating that low sexual desire is associated with decreased levels of relationship satisfaction (Trudel, Boulos & Matter, 1993; Trudel *et al.*, 1997, as reported in Breznsnyak & Whisman, 2004) and that desire was highest in those who report high levels of marital satisfaction. However, in the current study the high levels of marital satisfaction did *not* bring about high levels of desire.

The finding in the present study that there was a decline in sex drive also is in contrast with Kaplan (1979) and Levine (2002; 2003) who postulated that for females there is an increase in desire which peaks around the age of 40, after which it declines.

The respondents not only do not have any desire to have sex with their partners, their experiences vary on a spectrum, as identified by Levine (2002), who pointed out that sexual desire fluctuates along a spectrum including aversion, disinclination and indifference.

To sum up, the respondents mostly expressed good relationships with their partners, but in contrast with the prevailing options in the literature, this aspect did not maintain their sexual drive.

### **5.2.3 Experience of situational sexual desire**

Although these respondents declared unequivocally that they had no desire towards their partners, no less than six of them had had, or were in the process of having, extra-marital affairs, which they described as being passionate and lustful. Only two of the respondents, Dora and Karla, said they never experienced sexual desire lately. All the others reported experiencing varying degrees of sexual desire, but **not** directed towards their life-partners. The following citations demonstrate this clearly:

So I don't think I have a low sexual desire. With Chris I do. But I *do* have a sexual desire...I *do* find other men very sexually desirable ... desirous ... I don't Chris ... I *do* find other men attractive ... maybe [long pause – thinking] ... their unavailability ... the unknown ... their intelligence ... but Chris is that as well ... I don't know! But I turned to other men ... three times ... Maybe it is just that I am attracted to some-one *other* than Chris! (Cathy).

Berta, whilst attempting to describe the nature of desire, qualified:

I have no desire for Freek, but you see, it's difficult: I have a lover! It is dead, absolutely completely dead towards my husband, but very strong towards my lover. I have *no* desire whatsoever towards my husband, but I have a **constant** desire for my lover (Berta).

*Ek het geen begeerte vir Freek nie, maar jy sien, dis moeilik: ek het 'n lover! Dis dood ... Totaal-en-al dood teenoor my man, maar baie sterk teenoor my lover. Ek het geensins 'n begeerte teenoor my man nie, maar ek het 'n konstante begeerte na my lover (Berta).*

Although having had no desire for her husband, Anna started a relationship with a handsome man with whom the sex was “very exciting”. This passionate relationship lasted for close to a year. Also Berta vividly described the experience of, and her desire for, her lover as follows:

... when I hear his voice I am filled with desire ... his voice is out of this world and put me completely in another place ... totally ... and the way he answers ... his voice is very important ... it stimulates me!. It is also the way he dressed, and also his hair ... and certain body parts ... his groin ... it is very soft – like velvet. And his hands are beautiful, and soft, and when I feel his hands around my neck, it is fantastic. When I stand, and he stands behind me, and he puts his hands on me, then my knees go totally weak. And his hair is soft ... and his lips are soft ... and he is mad about kissing me... my husband does not kiss me ... his softness, the atmosphere ... and the moonlight evening. And in the night we spoon, which my husband and I never do. And when we wake up, then he asks whether he can make me tea. He is caring – those things make my knees go weak ... He is soft ... very soft ... (Berta).

*...as ek sy stem hoor is ek vol begeerte ... sy stem is ongelooflik ... sy stem sit my heeltemal op 'n ander plek ... totaal en al...en die manier waarop hy antwoord...sy stem is baie belangrik..dit wek my op!. Dis ook soos hy aantrek, en ook sy hare ... en sekere dele ... soos sy lieste ... dis baie sag – soos fluweel. En sy hande is mooi, en sag, en as ek sy hande om my nek voel, is dit fantasies. As ek staan, en hy staan agter my, en hy sit sy hands op my, dan raak my knieë totaal lam. En sy hare is sag ... en sy lippe is sag ... en hy is mal daaroor om my te soen...my man soen my nie ... sy sagtheid, die atmosfeer ... en die maanligaand. En in die nag dan lê ons lepel, wat ek en my man glad nie doen nie. En as ons in die nag wakkerword, dan vra hy of hy vir my kan gaan tee maak. Hy is versorgend – daai goed maak my knieë lam. Hy is baie sag ... baie sag ... (Berta).*

Gwen described her strong sexual desire towards her lover:

I *wanted* to have sex with Mike, but not with my husband, although I loved my husband ... I still do. My desire was low towards my husband, because it was all focussed on my lover. I did not want to sleep with my husband; I *wanted* to sleep with Mike. At forty with my husband it was already non-existent. At twenty when we got married it was highly exciting, very vibrant, very busy, everything I dreamed of. With my lover, it was all of these, and more so, as he took the initiative more. With him I wanted it three times a day ... it was a highly sexual thing – we did it all the time, all over: on the school grounds, in the lounge, on the beach ... it was fun! ... in the garden. I never experienced that before because I was married when I was so young.

Mike was not Gwen's only lover:

When I was 26, there was a guy I was absolutely besotted with ... we had sex seven times a day! Then there was the next guy ... and then other ... and then Mike, who was a sexual bomb, who just *loved* my body...(Gwen).

Many of the participants described their desire towards lovers as very active and enveloping, (as per Levin, 2002), and Goldstein and Brandon (2004) suggested that changes in hormonal levels may lead to heightened desire. It would appear however, that in these participants' experience, it was more the quality of the particular relationship and the arousing situations that created the excitement as apposed to their more sedate relationship with their husbands.

Theresa also has had more than one extra-marital affair, of which her husband has no knowledge. Theresa expressed strong desire experienced during affairs and towards a previous lover:

I felt a *craving* to have sex with him. It was *very* strong: morning, noon and night - any place ... farm ... dam ... any guesthouse ...! I have to laugh! *Any* place ... at first it was Johan, then Paul – I wanted to devour him sexually!. *Very* different to how I felt towards my husband ... But I always knew he would not remain faithful (Theresa).

*Ek was lús om met hom seks te hê. Dit was baie sterk: morning, noon and night- enige plek, plaas...dam ... enige gastehuis...! Ek moet lag! Enige plek ... eers was dit Johan, toe Paul – ek kon hom seksueel versind!. Baie verskillend teenoor hoe ek met my man gevoel het. (Theresa).*

Marazziti (in Tallis, 2004) noted that individuals with low levels of serotonin have high levels of sex drive, but also obsessional behaviour that is comparable with obsessive-compulsive disorder, very much like Theresa (and Gwen) described. The sexual games (e.g. being clandestine and having sex at a variety of different places) between Theresa and her lovers remind of Morin's notion (1995) that obstacles heighten desire. It appears that excitement and secrecy in these affairs were experienced as erotic and increased sexual desire (as per Regan & Berscheid, 1999; Perel, 2007).

Also Linda mentioned that she is sexually very attracted (“*baie turned on*”) to a man she sees at the gym, and that she finds him “*flippen awesome*”. She is very tempted by him and the prospect of some “good sex”. She also on occasions had experienced sexual desire towards other men in the past, even though *never* towards her husband.

I do not know why I find other men sexually attractive, and not Johan. Like the poor chap at the gym...! I do not know why this man's looks work for me ... If I see him, I am overcome and I cannot keep my eyes off him. And I can *go* there, but I don't. I just always think, “jiss, this man, just don't come near me” ... [giggles] ... but yes, I do desire him. It is a big temptation – I find this man flippen awesome (Linda).

*Ek weet nie waarom ander mans vir my seksueel aantreklik is nie, en nie Johan nie. Soos die stomme jafel by die gym ...! Ek weet nie waarom dié man se looks vir my werk nie...As ek hom sien, kan ek die horries vang en ek kan my oë nie van hom afhou nie. En ek kán daar gaan, maar ek doen nie. Ek dink net altyd, jis, die man, moet net nie naby my kom nie ... [giggel] ... maar ja, ek is lus vir hom. Dis 'n groot temptation – ek vind die man flippen awesome (Linda).*

The other situation wherein the participants experienced desire was in masturbation activities and fantasy. Most of the participants, including Cathy, Jana and Paula, reported that when they masturbated, they would fantasise about men *other* than their partners. Berta, like Cathy, mentioned that she never thinks about having sex with her husband, but that she fantasises about having sex with her lover nearly every day. She masturbates frequently, fantasising about her lover. Nancy Friday (1973) collated anecdotal evidence of women's vivid and

expanded erotic fantasies, which play an important factor in arousability and desire (Kaplan, 1995; Morin, 1995).

Therefore, the experience of low desire is *situational* for most of the participants, who experience, or have experienced, very strong desire for a lover. Only two participants described that they *in general* have no desire at present. These two however, like the other participants, did have desire before, and would fall in the category of having “acquired” low sexual desire (Lief, in Leiblum & Rosen, 1988) or “responsive sexual desire disorder” (Goldmeier, 2001), which has implications for intervention.

In summary, even if they do not have any sexual desire whatsoever towards their partners, most of the participants have strong desires towards other men, and experience sexual fantasies.

### **5.3 THEME 3: EXPERIENCE OF SEX LIFE WITHIN THE RELATIONSHIP**

While some of the participants simply refuse sex, others continue having a sexual relationship with their husbands, even though they have no desire to do so. These participants describe experience of these sexual encounters as unpleasant even when making a deliberate attempt to work at it. As a whole, sex was described something that has to be endured or tolerated rather than enjoyed, or satisfying their own desire.

#### **5.3.1 Declining sexual encounters**

In the face of a decline in their sexual desire, the participants had to negotiate changes in their sexual relationship with their partners. Some respondents, like Anna and Gwen, have no sexual relationship with their husbands. Gwen’s sexual interactions with her spouse lessened over a prolonged period, as did Anna’s. Gwen described how she agreed to sex in the past because she was “*sorry for him*” but that they slowly came “*to the same place*” where they understood and accepted that they would not continue to be sexual. They remain loving companions. She felt that her husband, like Bertha’s, did not want her sexually, and she eventually moved into her own room, (“*which was completely respected*”).

For Anna the lack of sex was a by-product of tension between her and her husband. The couple has had no sex for 13 years, and Anna describes it as a gradual tapering off, rather than a conscious decision at a particular time.

In our relationship there had been so many resentments ... and anger that had always remained unresolved, and so it just got the stage ... it was never a great “Eureka” moment of “never again”. It was a gradual insidious thing ... and then it just became impossible ... like when you have had an argument with a friend, and now it is two weeks, and then it is six weeks, and then more weeks, then a year. If you had tried to resolve the issue after six weeks you had stood a better chance in resolving it, rather than resolving it a year down the line – it is more difficult then.(Anna).

They only ever discussed the abstinence once:

I withdrew. He never even asked about it – I think he just got despondent of trying ... we never ever *ever* sat down and said, hey, what are we going to do about this. Never *ever*. I can only remember once that it was raised in an argument during which I said “we did not even have sex for five years, how can you want me to” ... whatever. This was the only time that it was raised (Anna).

*Ek het onttrek. Hy het nie eers daarna gevra nie – ek dink hy het net moedeloos geword van probeer.. ons het nooit óóit gesit en gesê, jis, what are we going to do about this. Nog óóit nie. Ek kan my net een keer herinner in ‘n argument waar ek gesê het ”we did not even have sex for five years, how can you want me to”...whatever. Dis die enigste keer dat dit opgekom het (Anna).*

Dora described a decline in sex over many years – in the last five years sex had taken place on average twice a year. She never initiates sex, because she never has a desire for sex. When Dora’s husband initiates sex, she mostly refuses:

I just say no, and that’s it. There is nothing he can do to get me to do if I do not want to (Dora).  
*Ek sê net nee, en klaar. Daar is niks wat hy kan doen om my te kry om dit te doen as ek nie wil nie (Dora).*

Linda and Paula’s partners are persistent when they decline sexual advances:

Sometimes I succeed in saying to him, “look here, I also have a say in this matter – **NO!** End of story, **NO!**”! [animated] I just think, shit, I also have a say in this matter. He will be okey about it, but he will *not* stop trying. He does not give up, he just does not stop! If I had said “no, not now”, then he will just carry on *until* I give in. No heck! [laughs], he doesn’t get put off (laughs). He cannot *understand* what my problem is...! (Linda).

*Ek kry dit partykeer reg om vir hom te sê, “kyk hierso, ek het ook ‘n sê in hierdie saak – **NEE!** einde van die storie, **NEE!**”! [geanimeerd]... ek dink net, shit, ek het ook ‘n sê in die saak. Hy sal orrait daarvoor wees, maar hy sal nie ophou probeer nie. Hy gee nie op nie, hy hou nie op nie! As ek gesê het “nee, nie nou nie”, dan sal hy net aanhou tót ek ingee. Nee wat, [lag] hy laat hom nie afsit nie [lag]. Hy kan nie verstáán wat my problem is nie...!(Linda).*

I tell him, “leave me alone”, but then it just gets too bad. He just carries on and on, then I just do it, then he leaves me alone again [laughs]. He always initiates – I *never* do. I sleep with him even if it means nothing. I never have an orgasm (Paula).

*Ek sê vir hom, “los my uit”, maar dit raak dan net te erg. Hy hou net aan en aan, dan doen ek dit maar net, dan los hy my weer uit [lag]. Hy inisieer altyd – ek nóóit nie. Ek slaap met hom al beteken dit niks vir my nie. Ek het nooit ‘n orgasme nie (Paula).*

Linda, apart from not feeling certain that she has the right to refuse sex, is feeling beholden to her husband for caring for her. Furthermore, her religious perspective (being Calvinistic) depicts the man as the head of the household with certain conjugal “rights”. In her study Lesch (2000) found that the women did not perceive it as a right that a man consider their

sexual discomfort or pleasure. She also found that they perceived sex as something that the man has the power to bestow or to withhold, as was the experience to which Paula referred. Herbst (2006) suggested that because women are in a subordinate position to men, they might find it difficult or problematic to negotiate with a man regarding sexual matters.

In summary, some of the participants felt they could not negotiate their right *not* to be sexual. This is in agreement with the findings of Wood *et al.* (2007), which showed that by the time women reached adolescence, many had internalised the notion that for them sex must be rooted in love, whereas men are permitted to have sex to fulfil their sexual desires. This double standard develops as part of social scripting, and can lead to women learn putting men's needs above their own.

Some of the women in this study, however, did not succumb to their partners' pressure, and declined sexual advances when they did not suit them.

### 5.3.2 Compliance with sexual encounters

The women in this study, who still had an active sex life with their partners, provided a range of reasons for doing so. Some participants, like Paula, gave in to sex as this might mean that their partner would not insist on sex for another while. Paula's version is putting this succinctly:

I have no desire, but I sleep with him, to get it over and done with [laughs] ... so that he can leave me alone. (Paula).

*Ek het nie 'n begeerte nie, maar ek slaap maar by hom, om dit oor en verby te kry [lag] ... sodat hy my kan uitlos (Paula).*

Berta's husband takes Viagra for erectile problems. However irritated, Berta also *felt sorry* for Freek and felt obliged to "*help him out*":

I don't want to say "no", because he had the little pill and I know the little pill is *expensive* [laughs] ... and I know he gets terrible headaches the next day because of it [laughs heartily] ... he has to swallow Mypradols (painkillers) in the evening and in the middle of the night and the next day ...! It is *terrible!* [laughs] and I just help him out, but totally uninvolved (Berta).

*Ek wil nie "nee" sê nie, omdat hy die pilletjie gedrink het en ek weet die pilletjie is duur [lag] ... en ek weet hy kry geweldige hoofpyn die volgende dag daarvan [skaterlag]...hy moet in die aand en in die middel van die nag en die volgende oggend Mypadols (pynpille) sluk ...! Dis érg!...[lag] en ek help maar uit, maar heeltemal onbetrokke (Berta).*

Dora and Linda concurred with the feelings of sympathy:

At times I feel so sorry for him, but I won't just do it the whole time just because I am sorry for him! (Dora)

*Soms voel ek so jammer vir hom, maar ek gaan dit nie die heeldyd doen net omdat ek vir hom jammer is nie! (Dora)*

When I say no, he does not like it, and ...it is like rejection, and then I just feel *so bad* (Linda).

*Wanneer ek nee sê hou hy nie daarvan nie...dis soos 'n verwerping, en dan voel ek só sleg (Linda).*

Another reason for taking part in sex seems *to reciprocate*. Theresa explained that her husband gives her money and generally is “good to her”. The relationship feels secure and satisfying, and she wants to have a family with her husband. For this she resigned herself that she will have to have a sexual relationship to keep her husband happy. Similarly, Linda explained:

He is very good to me ... and also he is very good to the children ... he *really* provides very well for us – and *that* is why I do it (Linda).  
*Hy is baie goed vir my ... en hy is ook baie goed vir die kinders ... hy sorg rêrig baie goed vir ons – en dís maar hoekom ek dit doen (Linda).*

Cathy added to this notion of compensation:

... and he loves me dearly, and I am very lucky. I *am*. I know lots of women who would give *anything* to have what I have. I have a *good* husband – he show me love and affection, and adores me so much ... and I must *show* him I am grateful (Cathy).

In order to be able to have sex without desire, Cathy consciously does the following:

I love Chris, but I do not desire him at all ... and there is too much stuff ... and what I try, is just to learn and train myself ... to do as when you hate porridge, to try and train yourself to like it ... to have sex and to like it. I ... I can't get myself to *do* that ... I am stubborn ... as much as I *want* to, I try ... but it is much better ... I am better at *pretending* now (Cathy).

Cathy also described giving in to sex as she felt it was an *obligation*:

I don't feel bad for not having sex – I just feel bad for *him*. I feel that I *owe* him that at least that ... because he loves me *so* much ... and because of everything he does for me, and gives me, and provides for me, and blah blah blah blah ... It is *not* a mutual wanting, so maybe it is a “gift” ... but gifts are normally that what you *want* to give ... but you could rather call it “payment” ... [thinks long] ... Maybe I am just prostituting under another name ... (Cathy).

Theresa also sees it as her “duty“. After returning to her husband when her extra-marital affair did not work out, she did not have sex with him for many months. He remained patient, and when they resumed their sexual relationship she still found it unpleasant (as before). It seems that Karel's patience paid off, as their relationship strengthened when she responded on advice from a friend who stressed the importance of family. In addition, Theresa is an active member of the church, and sees the man as head of the family, and having “conjugal rights”. She is working hard to make her home environment a pleasant one to keep her husband happy, and in coming to realise his worth, she takes steps to meet his needs:

And now I am so *good* to Karel because I now know...I have to make him feel nice, I have to sleep with him and all. I know I do it for *him*, and definitely *not* for myself; definitely *not* for myself! I do it for *him*; I want to make him happy, and make things nice for him. It is now about *them* (her husband and child) – before we “braaiied”, drank whiskey, socialised...but now we do not do it any longer. We don't socialise like “best friend-best friend” any longer. Now it feels to me, now that we have a child that I have to compensate in *other* ways to make it more pleasant for him at home. So I basically give *more* – I now sleep with him *more* than before. Before we

played “best friends” to make it nice for him.. I have this thing “it must be nice at home”. It *must* be nice at home. It *must!* Now I sleep with him about once a week...I try...otherwise about...I will decide in my *head* that I want to do it more times (a week), but then it does not work always out that way. And because he does not force himself unto me in my space, it is easier for me to do it once a week. I *want* to make it nice for him...so hy leaves it up to **me** (Theresa).

*Ek is nou so verskriklik nice met Karel want ek weet mos nou... ek moet hom laat goed voel, ek moet by hom slaap en alles...Ek weet ek doen dit vir sý part, en definitief nie vir my part nie; definitief nie vir my part nie! Ek doen dit vir hóm; ek wil hom gelukkig maak, en dit vir hom lekker maak. Dit gaan nou nogal om hulle (haar man en kind) – tevore het ons gebraai, whiskey gedrink, gekuier...maar nou doen ons dit nie meer nie. Ons kuier nie meer “maatjie-maatjie” nie. Nou voel dit vir my, vandat ons ‘n kind het, moet ek op ander maniere kompenseer om dit vir hom lekker te maak by die huis. So ek gee méér basies – ek slaap nou méér by hom as wat ek tevore by hom geslaap het. Eers het ons gemaatjie maatjie om dit vir hom lekker te maak. Ek het mos die ding “dit moet lekker wees by die huis”. Dit móét lekker wees by die huis. Dit móét!. Nou slaap ek so een maal per week..ek probeer ...anders so... ek sal in my kóp besluit ek wil dit nou meer kere doen (per week) dan werk dit nou weer nie so nie. En omdat hy hom nie opdring aan my in my space nie, is dit vir my makliker om dit een maal per week te doen. Ek wil hê dit moet vir hom lekker wees...so hy laat dit aan my oor (Theresa).*

Theresa (as do others like Cathy and Linda) described how they manage their sex life by *making a conscious decision* to behave sexually (like when the couple goes away for a romantic weekend), in accordance with Levine (1987, 2003) who noted that people whose drive manifestations are weak and infrequent might *decide* to behave sexually for idiosyncratic reasons.

Most participants were *sensitive to their husbands’ needs* and feelings, and often their own feelings would be placed secondary to those of their partners’ in providing in the husbands’ sexual needs. Linda and Cathy narrated that they consent to sex to provide in their *husbands’ emotional and physical needs*:

It is important to my husband – it is good for him. I know he feels good afterwards. He cannot keep his hands off me ... Also why I say “yes” so often ... I do not want him to be like my friends’ husbands who are just *so grateful* when it eventually happens ... I do not want to do this to my husband, or my marriage ... who go on their knees and say “thank you, thank you, thank you, *thank you* [animated] because we had sex”. I do not want to do it to my husband. It *is important*. It *is important* to men, for me, for him ... It *is important*, whatever...(Linda).

*Dit is belangrik vir my man – dit is goed vir hom. Ek weet hy voel goed daarna. Hy kan nie sy hande van my afhou nie...Dis ook waarom ek so baie “ja” sê, ek wil nie hy moet wees soos baie van my pelle se mans wat net só dankbaar is wanneer dit uiteindelik gebeur nie...ek wil nie dit aan my man doen nie, of aan my huwelik...wat op hulle knieë gaan en sê “dankie dankie dánkie [animeerd] want ons het seks gehad”. Ek wil dit nie aan my man doen nie. Dit is belangrik. Dit is belangrik vir mans, vir my, vir hom...Dit is belangrik, whatever...(Linda)*

I only initiate sex when I feel he is upset with me about something ... I can tell when Chris has not had sex with me for a while ... he gets a bit irritated, short with me ... and snappy with the kids and with me, and that. And then I think, ok well, it was four days ... or what ever ... OR when he is upset with me. Or when I feel bad about something ... I will agree - now I have to do it two to three times a week ... and it’s just like ... okey ... and it gets a bit ... You can’t carry on saying every night you don’t want to ... you’ve *got* to! Because otherwise I know he will get upset, although ... he is so much better since we’ve seen you. He used to get *really* upset. Now he tends to ... as long as it happens not too often ...(Cathy).

As is also described in literature (Weeks & Winters, 2002; Basson, 2005; Wood *et al.*, 2007), these aforementioned women feel obliged to meet their partners' sexual needs and engage in sex when that was not necessarily what they had wanted, or that satisfies or pleases them. Due to socialisation and social scripts they view sex as an obligatory task in partnership or marriage.

As already alluded to many of the respondents reported feelings of *guilt* as a reason for engaging in sex with their partners. Dora expressed this guilt when she refused sex:

We have no sex life ... but then I feel so guilty at times, you know, because shame, he provides for us, and he spends so much money ... you know what I mean? But I can't help it! (Dora).  
*Ons het geen sekslewe nie...maar dan voel ek soms so skuldig weet jy, want shame, hy sorg so, en hy gee so baie geld uit...jy weet wat ek meen? Maar ek kan nie help nie! (Dora).*

Karla stated that it is part and parcel of the relationship “*to compromise*”, when marital partners have discrepant sexual desires. Levine (1987) and Basson (2002a, 2005) noted with regards to the concept of “*compromise*” that couples agree to have sex for a host of individual reasons, and these individual reasons for doing so may be quite different and often not made known to the partner. As noted before, these reasons may be ranging from reasons such as self-soothing behaviour, to pleasing the partner, to other reasons such as being on holiday, or feeling loving. Sexual intercourse then would by necessity imply a *willingness* (rather than stemming from desire) from both parties to engage sexually, for their own reasons. Sexual behaviour is often used for purposes other than for the interest of the relationship – it may be for sexual, reproductive and non-sexual aims, and sexual motivation often is conflicted, deceitful and paradoxical (Levine, 2002).

Linda was in agreement with Karla in that she sees having sex as a compromise, and she is clear that she expects reaping the benefits (i.e. some motivation for self-gain) at a later stage:

It is building up points in the marriage [laughs], and picking the fruit of this later – *this* is what it is all about for me! (Linda).  
*Dis punte opbou vir die huwelik [lag], en vrugte-pluk later- dís waaroor dit alles gaan vir my! (Linda).*

Like Linda, Cathy and her husband have regular sex, between once and three times a week. She explained the compromise reached with her husband as:

We have a middleground at the moment. He allows me to say “no” but I am conscious of the fact that “I’ve said ‘no’ too often this week”, and now I’d better say “yes” ... (Cathy).

Apart from conceding to sex to please their partners, some respondents “allowed” sex for their own purposes, in spite of having no sexual desire. Berta explained that she permitted sex the last few times because of a need for affirming her sexuality (“... ‘n begeerte om bietjie seksueel te voel”), even though it was not that she desired her husband specifically, but he was the only one available (“hy was die enigste een beskikbaar”). This reminds of Levine (2003) who pointed out that sexual activity addresses the need for, amongst others, making a person feel good physically, feel loved/valued/important, or feel masculine/feminine.

Karla gives in to sexual demands because she loves her husband and she herself has a strong *need for emotional intimacy* (“to be close”) as the findings that women, especially in long-term relationships, agree to sex for increasing emotional closeness with the partner (Levine, 2002, 2003; Basson, 2005). Karla finds by having sex *affirmation of love* for her.

Apart from an affirming of love, Linda was *receiving emotional gratification* from the perception that her husband found her desirable, and she endured sex for that reason, in accordance with the finding by Wood *et al.* (2007) that women internalise the need to become sexual objects of men’s attention:

I feel *so* very privileged that this is how he feels about me – I know of many other women who shit themselves out of fear that their husbands are unfaithful...but I do not do it because of *that* reason – it is absolutely not in my books...I think I am *so* privileged – the man *genuinely* wants to have sex with me! I *really* am a turn-on for him. So this is the bigger picture of why I have sex with him – there the “emotional” comes in – this is then when your emotions drive you to say “yes”.. (Linda).

*Ek voel só baie verskriklik bevoorreg dat dit is hoe hy oor my voel – ek weet van baie ander vrouens wat hulself sal beskryt uit vrees dat hulle mans ontrou sal wees...maar ek doen dit nie vir dááí rede nie – dis absoluut nie in my boeke nie...Ek dink ek is só bevoorreg – die man wil genuinely met my seks hê! Ek is rêrig vir hom ‘n “turn-on”. So dis die groter prentjie van waarom ek met hom seks het – dís waar die emosionele inkom – dís wanneer jou emosies jou dryf om “ja” te sê. (Linda).*

Karla’s reasons for conceding to sex, included an *attempt revive lost desire*. She at times “tests herself” by allowing sex to see whether he could rekindle her desire. Karla also permitted sex to “break Hendrik’s theory”, which is that she pretended to like sex to “hook him into marriage”. Karla therefore has sex with him “to prove him wrong”.

Those participants who have a continued sexual relationship with their partners, all had reasons for “giving in” to sex. It was as though they had to justify this behaviour, and attempt to make sense of their assenting to sexual intercourse. This was in accordance with Levine (2002; 2003) who pointed out how sexual behaviour stems from a wide range of reasons,

ranging from serving the needs of the individual or to please the partner, or considering the interests of the relationship.

### 5.3.3 Experience of sexual relations with partner

As seen in the previous section, apart from various other reasons, some respondents feel obliged to have sex with their partners. Some find it boring, unpleasant or repulsive, and for others it is a frightening experience. Some of the respondents developed coping mechanisms to deal with these feelings.

I fantasised about other men whilst we had sex. Sometimes that was all that got me through the process [laughs] (Anna).

*Ek het fantaseer oor ander mans terwyl ons seks gehad het. Sometimes that was all that got me through the process [lag] (Anna).*

Karla also fantasised about other men, mostly her previous lover, whilst having sex with her husband. This she finds unpleasant (“*baie baie onaangenaam*”) and very disturbing, and ends up feeling very guilty, as this is the only way she can climax. However, use of fantasy seems to be normal, and in this regard Barbach (1975; 2000) noted that the use of fantasies and memories of past erotic experiences during sexual activities help women to become aroused, in line with the circular model of women’s sexual response (Basson, 2005).

Paula, Karla and Linda do not experience orgasm during sexual activity, and Paula and Karla expressed feelings of boredom. Linda revealed that her husband is a poor lover, and is unaware of the fact that she does not have an orgasm. Paula admitted that she just wants sex to be over and done with:

He does not stimulate me *at all*. Now I only do it to get it over and done with ... [laughs]. (Paula).

*Hy stimuleer my gládnie. Nou doen ek dit net om dit oor te kry... [lag] (Paula).*

Cathy mentioned:

It is fine to have sex with Chris ... it is okey. But I am constantly thinking “okey, finish now” ... or something. We have sex two to three times a week. Maybe *once*, if I am lucky! He allows me to say “no” but I am conscious of the fact that “I’ve said ‘no’ too often this week”, and now I’d better say “yes” and “get-it-over-and-done-with”! [fast, animated]. Sex with Chris is just a matter of “quickly!, just get-it-over-and-done- with!” ... and then its over [said with a sigh of relief] ... and I can tick [animate] it off ... [sigh] (Cathy).

Theresa equally does not enjoy having sex.

After I came back, I did not want to sleep with Karel. He ... we ... tried everything. He put no pressure on me. I moved out for eight months and after I returned I only slept with him about fifteen months later. It *really* was not pleasant for me ... it was *not* ... I tried *everything* It is still

not nice for me to sleep with him. It used to be quite *hard*, bad, but at least it is not sore any more. (Theresa)

*Na ek teruggekom het wou ek nie by Karel slaap nie. Hy ... ek ... het alles probeer. Hy het nie druk op my uitgeoefen nie. Ek het mos agt maande uitgetrek en na ek terug was het ek eers weer by hom geslaap so vyftien maande later. Dit was rérig nie vir my lekker nie...dit wás nie ... ek het álles probeer Dit was érg, sleg, maar dis darem nie meer seer nie (Theresa).*

Theresa described how she actively makes an effort to maintain a sexual relationship to meet her husband's needs:

I am now very nice with Karel, because I know now ... I have to make him feel good, I have to sleep with him and all.. it is more just fun and superficial ... and we laugh the whole time [laughs merrily]. But I have no *desire* to sleep with him (Theresa).

*Ek is nou verskriklik nice met Karel, want ek weet mos nou ... ek moet om laat goed voel, ek moet by hom slaap en alles... dit is meer maar net snaaks en oppervlakkig...en ons lag die heeltyd [lag uitbundig]. Maar ek het geen begéerte om by hom te slaap nie (Theresa).*

Theresa explained, in order to manage sexual activities in the light of the lack of her own sexual desire, how the sex is kept light (“*ons hou dit baie baie lig, baie lig*”) and she gave examples of how they have ‘fun-filled’ sex, like spontaneously asking Karel to join her in the bath, or going away for a romantic weekend and then having sex because “they had to”. This seems to be the only way that she can endure the intercourse. Theresa’s seeking of other stimuli to enable her to have sex, reminds of Basson (2000) who pointed out that in long-term relationships spontaneous desire does not seem to be experienced as readily, and has to be sought out “*by seeking stimuli necessary to ignite sexual desire. Sexual desire then is a responsive rather than a spontaneous event*” (Basson, 2000:53).

Linda’s experience of sex was, like Theresa’s, narrated in a lighthearted manner:

I have teased and say I am going to cut out the three parts (breasts and vagina) and place it in the bed next to him, and “you will not even notice that I am not there [laughs heartily] ...” You will not even realise there are no arm and legs! ... He then laughs, he thinks it is funny, and he says it *is not so, but it is*. (Linda).

*Ek het al so gespot en gesê ek gaan die drie plekke uitsny en in die bed langs hom sit, en “jy gaan nie eers weet ek is nie daar nie! [lag hartlik].. “jy gaan nie eers beseef daar is nie arms en bene nie!” ... hy lag dan, hy dink dis snaaks, en hy sê dit is nie so nie, maar dit ís. (Linda)*

The description of Linda referred to the difference in the manner she and her husband approach sexuality, in that men seem more likely to have a recreational orientation and likely to focus on sexual pleasure (Regan & Berscheid, 1996, 1999; Tallis, 2004). However lighthearted about the matter, still Linda experiences the encounter as unpleasant:

... when your emotions drive you to say “yes”. But it is **not** alright – NO! ... NO! ... NO!... I just don’t *want* to – **NO!** It’s **WORK!** [laughs]. It’s **terrible!** It is *not* nice, *no*, **NO! NO!** (Linda).

*... wanneer jou emosies jou dryf om “ja” te sê. Maar dis nie orrait nie – NEE...! NEE!...NEE!... Ek wil net nie – NEE! Dis WERK! [lag]. . dis ááklig! [laughs]. Dis nie lekker nie, néé, NEE! NEE! (Linda)*

Jana's husband increased his sexual skills over the years, but sex remained problematic with negative connotations, and she described how she tries to avoid sex by making excuses, such as that she has a headache. Jana's initial experience in the relationship, like Theresa's, was that of painful sex, and her low self-esteem hindered sexual fulfilment.

Also Berta spoke about dreading sex:

... because I feel "now I have to do it" [sighs]. I *don't* want to do it because I am forced to do it! ... The last couple of times ... I just satisfy him, completely unemotional, because I do *not* want him to touch me, I do *not* want him to touch me! (Berta).

...want ek voel " nou ek moet dit doen" [sug]. Ek wil nie dit doen omdat ek forseer word om dit te doen nie! ... Die laaste paar keer ... ek bevredig hom net, heeltemal onemosioneel, omdat ek wil nie hê hy moet aan my vat nie, ek wil nie hê hy moet aan my vat nie! (Berta).

Cathy's experience is more like a strong aversion, yet feels obliged to give in to the request for sex:

He puts pressure on me...not as bad as he used to, but he still does ... and it is this whole build-up that you can actually feel ... from the hour or two before you are meant to go to bed ... and I can see ... and it makes me feel ... grrr ... sort of torrid ... I *hate* it ... and then, in the two hours I sit there thinking for the past two hours, how I can get out of it [laughs]. I don't want it! I can't stand the heavy breathing ... him being sexual ... it is so off-putting ... he feels "sexual", and when he hugs me he gets aroused and he gets an erection. It sickens me ... it feels dirty ... animalistic. ... it's like a dog on heat ... it's pure lust ... it's repulsive... (Cathy).

The pressure causes a flight reaction in Cathy, who narrated how she loves going away for weekends or holidays without her husband. She said:

It is just so nice to get into bed at night, and not to feel the pressure or any thought of "should I or shouldn't I" ... and I feel bad ... but I just love it! It is just such freedom ... so ... (Cathy).

Although some studies claim that arousal stemming from anxiety, anger or other emotion-provoking events can increase sexual desire under certain circumstances (Regan & Berscheid, 1999), the experiences of the participants who experience aversion do not support this.

While some findings indicate that some women who lack spontaneous interest in sex are able to respond to their partners' approaches with arousal and orgasm, (Hawton, 1985; Basson, 2001; Goldmeier, 2001), *none* of the participants in this study indicated that they *enjoyed* sex. It would therefore appear that they did *not* experience arousal, and some also definitely not orgasm, as they faked orgasm.

The experiences of the participants (as also described by Linda) point to the perceived differences in sexuality for the genders. The respondents clearly were not interested in sex. In contrast, most of their husbands were reportedly very interested in sexual relations. Michael

*et al.* (in Levin, 2002) found that double the amount of women were uninterested in sex as opposed to men. Similarly, 20% of women said sex gave them no pleasure and only 1% of men indicated the same trend. These findings were supported by those of Beck *et al.* (1991), who found a staggering 97% of women reported engaging in sexual behaviour without desire.

Thus, the respondents do at times take part in sex and have developed various coping mechanisms to deal with sexual relations with their partners, ranging from refusal, to avoidance, to fantasising, to play acting, to just waiting it out. Some of the respondents fake orgasm to encourage their partners to “finish up” more quickly. The differences between the experiences between the women and their partners became clearer, and it appeared from the citations that some of the men have sex for fun rather than for the sake of the partner or the relationship. The notion that desire can follow arousal even if absent at first is not supported by the respondents’ experiences.

In summary, from the citations of the participants it is evident that the occurrence of sexual activity *clearly* does not necessarily imply the desire for sexual activity (Leiblum & Rosen, 1988).

## **5.4 THEME 4: THE IMPACT OF LOW DESIRE ON SELF AND/OR RELATIONSHIP**

Only Berta indicated that initially her husband had a lower sexual desire than she did. For the others, their sexual desires were lower than those of their partners. Some of the participants had still frequent sexual intercourse with their husband, whilst others had infrequent sex. Anna and Gwen had celibate marital relationships.

### **5.4.1 Experience of impact on the individual**

The majority of participants did not suffer distress due to their lack of desire for their husbands, and Gwen, Cathy, Theresa, Linda, Jana and Paula stated unequivocally that they did not feel that they were “abnormal” in any way. Linda stated that having no desire does not bother her in the least, but she wondered whether it would not have been easier to manage if she and her husband had similar levels of desire.

Paula's lack of desire did not trouble her either:

My desire is nought, and it does not bother me at all (Paula).

*My begeerte is niks, en dit pla my glad nie (Paula).*

Cathy desires men other than her husband, but has no desire for her husband, which was not a problem for her personally:

I do not feel bad for not wanting sex..I only feel bad for him... I feel..not abnormal..because I don't desire my husband, because I know how I feel about him, and the stuff I have inside of me..how I feel..about men in general. I don't think I am abnormal. I *do* have a sexual desire... I *do* find other men very sexually desirable.. (Cathy).

The sexual difficulties in the early stages of Jana's marriage (dyspareunia) she was led to believe that she was "the problem". When her doctor seemed unsympathetic by telling her that it must "all be in the head", she did feel "abnormal", and it took her many years to rebuild her sexual self-esteem.

Karla felt "uncomfortable" with the decline in her sex drive, and she makes concerted efforts to find reasons for this occurrence as it causes her considerable personal distress. The sexual experience is increasingly bland, and the fact that she is inorgasmic creates further problems for both her and the relationship, as her husband feels progressively more inadequate.

Theresa, Cathy, Berta and Linda realised that their lack of sexual desire was situational, and that they did experience desire in other circumstances.

My libido is not low - it just does not get treated correctly. I have told him hundreds of times ... and there is the desire for other men ... (Linda).

*My libido is nie laag nie. – dit word net glad nie reg hanteer nie. Ek het al honderde male vir hom gesê...en daar is die begeerte tot ander mans...(Linda).*

Some participants experienced feelings of loss and sadness because of their lack of desire. Berta's desire for her husband was "killed" by her perception that her husband rejected her. The intellectual knowledge that he has a low sexual desire did not lessen her feelings of rejection. She acknowledged feelings of hurt and that her absence of desire is like retaliation:

...I tried to work it out in my head...it bothered me that I do not desire him...I realised that if that is how he treats me, then I will also treat him like that. Deep within I wished that it was different because when we did have sex it was totally and utterly fantastic...we both climaxed...and it was actually sad for me...now I do not have the desire, but I have had it for very long, because it was so good, the times that we were together (Berta).

*...ek het dit deur my kop probeer werk...dit het my gepla dat ek hom nie begeer nie..ek het besef dat as dit is hoe hy teenoor my optree, dan tree ek ook so teenoor hom op. Diep binne my het ek gewens dit was anders want as ons seks*

*gehad het was dit totaal en al fantasties...ons het beide geklimaks...dit was vir my eintlik hartseer...nou het ek nie meer die begeerte nie, maar ek het dit vir baie lank gehad, omdat dit so goed was, die kere wat ons saam was (Berta).*

Anna also expressed feelings of loss:

It is sad that it is different now (Anna).

Although Cathy claimed to be unaffected by her loss of desire for her husband, she also expressed sadness with the situation. The reasons for this include relationship complications, the loss of romance, and failure to sustain the ideal relationship she had wished for:

I am *not* abnormal, and I wish I did feel another way, I wish I felt differently. But reality is that I don't, and I choose to stay with him [tearing] and this is it ... for the rest of my life ... and I feel this is hard. You get older every day, and this is not a nice thought (Cathy).

In summary, the women did not indicate that they experienced “marked distress”, nor feel their lack of desire was abnormal, but most expressed sadness at the loss of the emotional connection engendered by, and experience of, sexual intercourse.

#### **5.4.2 Experience of impact on the relationship**

Some participants mentioned that in their experience their relationships improved over the years, in spite of their lack of sexual desire, in contrast with studies that indicate that low sexual desire is associated with decreased levels of relationship satisfaction (Lopiccolo & Friedman, 1988; Trudel *et al.*, 1993; Trudel *et al.*, 1997; Brezsnayak & Whisman, 2004).

Some of the participants continued to have sexual relations with their husbands, even if they themselves had no sexual desire. According to Basson (2005) when women have a good relationship with their partner, feel emotionally close to their partner during sexual activity and report general emotional and physical well being, they have less distress about sex. At least some of these positives could be assigned to the participants in the generally positive relationships (such as those of Karla, Linda and Theresa), and they did accordingly report less distress about sex (section 5.4.1). But, these positive factors did not result in an increase in sexual responsiveness, as per the theory of Basson (2005).

Most participants like Paula, Dora, Cathy, Theresa, and Linda indicated that their partners seemed to accept their lack of desire. It is important that this be seen in the context of the fact that some of the participants still grant sex (some regularly) and that their husbands' sexual needs accordingly might be fulfilled the majority of times. The husbands therefore might not

really feel the impact, or even know, of their wives' lack of desire. Theresa mentioned that her husband did not put any pressure on her and waited patiently for her to be ready for sex. Because he is so loving and accepting, she grew willing to provide sex once a week. Therefore, her lack of desire does not impact on the relationship, and she makes a concerted effort to "make up" in many other ways, in a cheerful light-hearted way. In this manner Theresa provided her husband with enough sex to "keep him happy".

Others, like Anna, Gwen and Dora, indicated that their husbands did not put pressure on them for sex, so on face value do not impress to be unhappy about the state of affairs.

Even though their sex life can't be described as "good" especially from Paula's point of view, her partner finds enough satisfaction to continue their relationship.

He just does not leave me alone!. He went away for three months once, but then came back as he was just punishing himself! [laughs] (Paula).

*Hy los my nie uit nie! Hy het drie maande weggegaan eenkeer, toe kom hy weer terug, want hy straf homself! [lag] (Paula).*

Berta's husband accepted (and maybe preferred) her lack of desire, due to his own lack of libido. The couple had infrequent sex, but when he developed erectile problems, he started taking stimulants, albeit very occasionally. He is however, not at all worried about the infrequent sexual intercourse, or Berta's lack of desire for him as she still "helps him out".

As "turn-taking behaviour" in initiating sex is expected by some couples, the lack of desire impacts on this pattern. Participants (Linda and Cathy) indicated that their husbands wanted them to occasionally initiate sex, but none of them ever do. Linda described her husband as being totally mystified that she did not want sex as frequently as he does, and the differences between the sexes is pointed out by Leiblum and Rosen (1988) who proposed that while men have a more consistent and excessive sex drive, women have a less intense desire.

Jana's lack of sexual enthusiasm impacted on their relationship, as her husband became angry about being sexually "deprived", and put a lot of pressure on her when she refused sex. Her lack of desire (albeit due to very real circumstances) caused conflict, but the question can be asked which came first – relationship problems or her low desire. For Jana marital happiness took precedence to frequent sex, and she did not put a high premise on sex as her husband did. She indicated that her focus was on the emotional side of the relationship and that she

would have preferred to “cuddle” instead of always having penetrative sex. The couple clearly has different needs, leading to marital unhappiness as indicated by Davies *et al.* (1999) who found that for both husbands and wives who felt that there was a discrepancy between their own and their partners’ desire experienced lower happiness within the relationship.

The majority of the participants were adamant that even though their husbands did not receive the optimal amount of sexual interactions or were somewhat “short” of sex, they were very sure that their partners were not unfaithful. Even the women who were unfaithful to their husbands such as Theresa, Gwen and Anna were sure of this fact.

It was *I* that withdrew. He did not even ask about that...I think my sex drive was always higher than Ben’s...I think...and what he does now for a release I have no idea about... but I definitely do not think...I cannot even think...that he with other women...it will probably be for me the biggest surprise and shock... He is just not that kind of a guy; he is just too decent...(Anna)

*Ek het onttrek. Hy het nie eers daaroor gevra nie...Ek dink my seksdrive was maar nog altyd hoër as Ben s’n...I think...en wat hy nou doen om vir hom verlossing te gee, het ek géén idee oor nie, maar ek dink beslis nie dat hy...ek kan my nie vóórstel nie...dat hy met ander vrouens...dit sal seker vir my die grootste verassing en skók wees.... He is just not that kind of a guy; hy is net te ordentlik...(Anna)*

Karla’s loss of desire impacted negatively on the relationship and on her husband as a person, as he feels undesirable, unattractive and uncertain about her feelings for him. Because he is a “gentleman” he does not pressurise her for sex, but his sexual frustration and dissatisfaction manifests in other ways, for example getting irritated with her (Trudel *et al.*, 1997). Husbands who reported lower frequency of sexual activity were dissatisfied with their relationships, although this did not apply to their wives (Brezsnyak & Whisman, 2004). Karla suspects that he would have been less impatient and angry with her should he have more sex.

Although the couple have sex a few times a week, this seems not to be enough for Cathy’s husband and she explained:

...I can tell when Chris has not had sex with me for a while...he gets a bit irritated, short with me...and snappy with the kids and with me, and that... (Cathy).

Dunn *et al.* (2000) found that men are *more* dissatisfied with the infrequency of intercourse than their partners are. Due to Cathy’s refusal to have sex her husband became distressed to the point of arranging couple counselling. Cathy loathed going to the sessions, but found later that her husband became less dependent on her because of the therapy as he became more secure within himself. She also learned to compromise more, and their relationship improved to the extent that sex has become more tolerable for her (at times), albeit she still does not

enjoy sex. Some other husbands, who also experienced unhappiness about their partners' lack of desire, arranged for marriage therapy to vicariously or directly address this issue. These partners, like Anna and Jana, similarly did not find the therapy helpful to re-establish sexual desire.

In summary, some of the women's partners became distressed because of the lack of sexual activity, but most seemed to have accepted the fact. It has to be pointed out that most of these men still have active sex lives, and therefore do not forgo sex, even though some wanted their wives to play a more active role. All said, in this study the effect of the lack of desire from the side of the women, did not have a too serious effect on the relationship. Most of the couples were still to all extents and purposes happily married. In this study the high levels of marital satisfaction did not bring about high levels of desire, neither is the converse true.

## **5.5 THEME 5: PERSONAL REASONS FOR A DECLINE IN SEXUAL DESIRE**

Respondents, in their quest to understand and make meaning of their lack of desire, gave several explanations for their decline in sexual desire, focussing on personal reasons and relational aspects. Some of the respondents simply did not understand why there was the decline, and remained baffled by the occurrence. When Lief (1977) investigated the decline in sexual interest in women he also found that sometimes there is no adequate explanation for the decreased interest in sex.

### **5.5.1 Health**

The participants all impressed as healthy-looking. Even so, in an attempt to understand the decline in desire, many of them considered possible medical causes.

Karla related going to great lengths to understand her lack of desire, including seeing a sex therapist, undergoing continuous medical tests, and regular visits to homeopaths and naturopaths. She gave lengthy explanations of biological problems, varying from low hormone levels (androgens/testosterone) to other "deficiencies".

The need for emotional intimacy is *always* there. The need for the sex deed is *very* low nowadays, and for me it is directly related to my lack of energy. I went for tests, and now I understand it much better. I don't have the reserves, and this contributes to all sorts of side-

effects that I experience, one of which is the lack of libido ... that took a decline, *drastically* so. There *is* therefore a biological component (Karla).

*Die behoefte aan emosionele intimiteit is áltyd daar. The behoefte aan die seksdaad is baie laag deesdae, en vir my is dit direk gekoppel aan my lae energie. Ek het vir toetse gegaan, en ek verstaan dit nou baie beter. Ek het nie die reserwes nie, en dit dra by tot allerhande nuwe-effekte wat ek ervaar, waarvan een daarvan is die verminderde libido... wat afgeneem het, drásties so. Daar is dus die biologiese component (Karla).*

With respect to Karla's experience with androgen deficiency, androgens are thought to be the "libido hormones" in both genders (Kaplan, 1995; Northrup, 2004). Thus, testosterone deficiency in females may have an adverse effect on women's libido (Kaplan, 1995; Riley, 2000; Goldstein & Brandon, 2004).

Jana and Thereasa experienced pain during intercourse.

Deon was my first lover. I suffered from infections from the start, especially in the beginning just after we married. I went to several doctors, not finding the cause. One doctor said to me "there is nothing wrong - it is in your head". It was terrible ... it was really very sore and painful when we had sex ... And to be dismissed and not to get any treatment for that. This caused so many problems in our relationship. He thought I did not *want* sex, but it was just *too* painful. (Jana).

*Deon was my eerste lover. Ek het van die begin af met infeksies gesukkel, veral in die begin toe ons net getroud is. Ek het na baie dokters toe gegaan, maar nie die oorsaak gekry nie. Die een dokter het vir my gesê "daar is niks verkeerd nie – dis alles in jou kop". Dit was terrible...dit was regtig baie seer en pynlik wanneer ons seks gehad het ... En om netso afgesit te word, en nie eers enige behandeling te gekry het nie. Dit het baie probleme in die verhouding veroorsaak. Hy het gedink ek wil nie seks hê nie, maar dit was net té seer (Jana).*

Theresa explained:

It was just *so sore*. After two years I went to the doctor. He said it was biological ... either my bladder ... or my thyroid ... because I was also *very* tired. And then I was placed on anti-depressants for a few months ... and then I had heart palpitations. And so it went on. I went to see a doctor, then again a gynaecologist ... then more specialists ... even a psychologist! I *really* sought help! Karel remained very loving, but I ... just did not feel like sex any longer ... [sighs] (Theresa).

*Dit was net só seer. Twee jaar later het ek toe dokter toe gegaan. Hy het gesê dis fisies..of my blaas...of my theroïd...want ek was só uitgeput. En toe sit hy my op anti-despressante vir 'n paar maande...en toe kry ek hartkloppens. En so gaan dit aan. Ek het 'n dokter gaan sien, en toe weer 'n ginekoloog...toe nog meer spesialiste...selfs 'n sielkundige! Ek het rêrig hulp gesoek! Karel was heeltyd liefdevol, maar ek het net nie meer na seks gevoel nie ...[sug] (Theresa).*

The painful experiences that Jana and Theresa describe are known to traumatise some women, resulting in an avoidance of sexual interactions (Barbach 2000). Berman and Berman (2001) found that the causes of vaginismus and dyspareunia might be either medical or psychological, arising from for example, relationship conflict, which may account for the doctors' referral to psychologists.

Other physical reasons for affecting sexual experience and intimacy, and therefore possibly the decrease in sexual desire, as mentioned by the participants include the following:

After the birth of my children my vagina was stretched, and one's husband is not too kind about that (Gwen).

After the liposuction I lost some feeling and sensitivity ... also with the breast augmentation (Paula).

*Na die liposuction het ek van die gevoel en sensitiwiteit verloor ... ook met die borsvergroting (Paula)*

Many of the participants mentioned having had a depression at some stage in their lives. Paula, Karla, Cathy and Dora wondered whether their decline in desire might be side effects of their anti-depressant drugs. Others though had already presented with low desire *before* they took the medication (so that possibly the lack of desire was linked to a depression). Theresa was prescribed anti-depressants for the lack of desire, but it did not increase here sexual desire. Karla blamed her depression at least partially for her lack of libido:

A few years ago my sex drive was still very high, what I have thought was quite normal. That is the reason why I found it so uncomfortable when I started taking anti-depressants.... My whole life I have had *no* problems with my libido. About five years ago I had to start taking anti-depressants, and I *immediately* experienced that my libido suffered a blow (Karla).

*'n Paar jaar terug was my seksdrang nog baie hoog, wat ek gedink het normaal is. Dit is die rede waarom ek dit so ongemaklik gevind het toe ek begin anti-depressante gebruik ... Ek het my hele lewe géén probleme met my libido gehad nie. Omtrent vyf jaar gelede het ek begin anti-depressante neem en ek het onmiddelik gevoel dat my libido drasties afneem (Karla).*

Dora asked:

I have been taking an anti-depressant for about sixteen years now. Could this contribute to it (the lack of desire)? They say so, hey? I have taken so many kinds of them (Dora).

*Ek het nou al die afgelope omtrent sestien jaar 'n antidepressant gevat. Kan dit daartoe bydra? Hulle sê so nê? Ek het so baie soorte al geneem van hulle (Dora).*

Also Anna questioned the effect of her depression and anxiety on sexual desire:

And, of course, I had very severe post-natal depression with both my boys, so I have been on anti-depressants for the past eighteen years ... and I know the side effects include a low libido ... it could have been that. I am still on anti-depressants, but with a component for anxiety ... because anxiety is becoming more of a problem the past few years. (Anna).

The experience of the participants is supported by recent research, indicating that the use of anti-depressants (selective serotonin reuptake inhibitors, or SSRI's) reduce sexual desire in a high percentage of individuals (Weeks & Winters, 2002).

Anna also mentioned the effect of post-natal depression. Most of the participants have children, and as the incidence of post-natal depression is known to be under-reported (Regan & Berscheid, 1999), this condition may also have played a role, as post-natal depression has a debilitating effect a women's sexual desire (Goldstein & Brandon, 2004).

Thus, some participants felt that physical problems and ailments may have contributed to their lowered sexual desire, although none claimed these to be the sole cause. Physical health is an important factor in sexual desire (Levine, 2003; Westheimer & Lopater, 2005) and disease can limit sexual interest and pleasure. Medical conditions that may affect sexual desire include a multitude of medical conditions; pregnancy, STD's or other sex-related problems; side effects of medical treatments and drugs, endocrine conditions, urethral infections, hypothyroidism and many more (Kaplan, 1995; APA, 2000; Tiefer, 2000; Berman & Berman, 2001; Hicks, 2005). These medical conditions may cause discomfort, pain or lack of response during sexual activity despite a positive sexual environment.

Thus, the participants did allude to possible medical conditions to account for their lack of desire, but these reasons and explanations were not seen as paramount to their situation.

### 5.5.2 Menopause

The women in this study were all middle aged, and some of them referred to the possible effects of menopause on their libido. None of them unequivocally provided this as the reason for their decline in sexual desire, and for the most part they mentioned menopause *very* much by the way. For instance, Anna, Paula, Karla, Dora and Gwen vaguely wondered whether they might be menopausal:

...well, and I am peri-menopausal ... and I don't know ...if ... (Anna)

I *am* already fifty ... so I am menopausal ... I *think* ... Hot flushes and all! So it could also have some effect. (Gwen)

During menopause there is decreased production of estrogens, androgens, progesterone and prolactin. As poor oestrogen levels cause dryness or thinning of the vaginal wall (which could lead to painful sexual intercourse), hot flushes, nightsweats, moodiness, and irritability, the experience of these symptoms may *indirectly* affect sexual desire (Regan & Berscheid, 1999; Nothrup, 2001). Most studies, however, suggest that menopause does not necessarily result in decreased sexual desire (Basson, 2002b, 2005, Hicks, 2005).

It is suggested that as testosterone is responsible for sexual assertiveness, testosterone deficiency in females (due to factors like age or a hysterectomy) *may* lead to a marked decrease or complete loss of sexual drive (Kaplan, 1995; Riley, 2000 Goldstein & Brandon, 2004). At present, however, not enough is known about the role of testosterone in sexual

desire, and scientific study of testosterone replacement therapy for enhanced sex drive has rendered somewhat contradictory results (Basson, 2002a, 2005; Tiefer, 2001; Bancroft, 2002; Moynihan, 2003; Cook, 2005; Davies *et al.*, 2005). Other research studies show that in some women sexual desire increases during certain menstrual phases, however, no single pattern emerges in the findings of these studies (Regan & Berscheid, 1999; Levin, 2002).

High levels of dopamine and oxytocin may lead to a more seductive sex drive (Crenshaw, as cited in Goldstein & Brandon, 2004) as dopamine motivates the search for pleasure as it provides an emotional high. Berta may have demonstrated the possible role of oxytocin when she narrated in detail her sexual experiences and affectionate behaviour with her lover (section 5.2.3).

The participants showed little interest in acquiring knowledge on the possible role that hormones might play in their dwindling sex drive, and even though there is increasing research on the topic.

### 5.5.3 Ageing

Bertha and Karla touched on the factors of age:

As a teenager it is all that you want, and all you can think about. In your twenties it is also like that ... In your thirties... (Berta).

*As 'n teenager is dit al wat jy wil hê en al wat jy aan kan dink. In jou twintigs is dit ook so ... In jou dertigs ... (Berta).*

In my thirties it felt to me that I perhaps reached a peak ... partly because of the situation where I felt I found a person that I trust ... with whom I feel safe ... whom I loved ... then my sexual urges were very strong (Karla).

*In my dertigs het dit gevoel ek het miskien 'n piek bereik...deels omdat ek in die situasie was dat ek 'n persoon gevind het wie ek vertrou...met wie ek veilig voel...vir wie ek liefhet....toe was my seksuele begeerte baie sterk (Karla).*

As seen in the section dealing with theme of “sexual desire” as a concept, many participants (Linda, Berta, Gwen and Karla) expressed the perception that sexual urges are strong in younger people, but also that women should experience increased sexual desire with age. This is an oft-cited dictum, i.e., for women (in contrast to men) there is an increase in sexual desire after puberty peaking around the age of 40, after which it declines (Masters & Johnson; 1966; Kaplan, 1979; Levine, 2003). Knowing about this theory of heightened sex drive in the middle years, Linda expressed surprise that she did not experience the expected increase in desire:

I would have thought that it would have been better and more pleasant at my age, that I would have had *more* desire, because I am now so very contented, and really happy, and between Johan

and I things *really* are very good ... so I would have thought that the sexual desire would have been there. But it is not. (Linda).

*Ek sou gedink het dat dit sou beter word en lekkerder word op my ouderdom, en dat ek méér lus sou wees, want ek is mos nou so baie tevrede, en rerig gelukkig, en tussen my en Johan is dinge so baie goed...so ek sou gedink het dat die seksuele begeerte daar sou wees. Maar dit is nie (Linda).*

Jana noticed that her desire for sex increased after her thirties, when she felt more comfortable within herself, but that the effect of other issues around relationship, work stress, and other factors impacted negatively on her desire for sex with her husband in particular.

There literature is somewhat contradictory with regards to the effect of ageing on particular women (Regan & Berscheid, 1999). Kaplan (1979) mentioned that in a healthy individual sexual appetite is present throughout life in some form, but this is not supported by the experience of some participants who declared that they experienced absolutely no sexual desire or that their desire had waned in their thirties. Indeed, many studies illustrate a decline in sexual frequency in older years (Levine, 2002; 2003). Træn *et al.* (2007) agree that the level and intensity of sexual desire for both sexes decreases with age, but found that this decline is not pronounced until after the age of 50. Basson *et al.* (2005), however, suggested that age has a minimal effect on sexual desire as studies show both an increase and a decrease with age. These contradictory findings emphasise the complexities of factor affecting sexual desire and difficulties in attributing a decline in sexual desire to a single cause, such age. Whilst some respondents, like Jana, experienced an increase of desire, this was not the case for others, like Linda, who although expecting an increase in their sexual appetite did not experience such. It is likely then that the other factors raised by the respondents, relationship issues, emotions, and physical aspects also played a role.

Another reason alongside ageing is loss of attractiveness, as a negative body image may be responsible for a decline in sexual interest in the older woman (Hawton, 1985; Goldstein & Brandon, 2004; Carey *et al.*, 2005). Research demonstrates that women who felt dissatisfied with their bodies and felt unattractive, had reduced desire for sexual intercourse. This aspect overlaps with psychological factors, which is discussed next.

#### **5.5.4 Self-concept**

Berta mentioned that she always felt that she stood in her husband's shadow being "*only a housewife*". Her feelings that he did not finding her attractive were exacerbated when he confessed to having watched pornography for a long period of time. She felt that he chose to

rather “*help himself*” and avoided sex with her, which made her feel like second best (“*dit was goor, soos tweede beste*”). With her self-esteem so eroded she suspected that he might be unfaithful, and wondered whether he was attracted to the younger women at work.

I felt not pretty enough for years and years and years and years...I really grappled with it. The women at his work are all *absolutely* beautiful...does he look at these dollies and then find he cannot have sex with me....? (Berta).

*Ek het net nie mooi genoeg gevoel nie vir jare en jare en jare...ek het regtig daarmee gewroeg. Die vrouens by sy werk is almal absoluut pragtig...kyk hy vir daardie poppies en dan vind hy kan nie met my seks hê nie...? (Berta).*

Berta’s narrative underscores the finding by Koch *et al.* (2005) that middle-aged women lost their sense of control over their sexuality when they perceived themselves as less attractive as they aged.

Also Jana felt her self- and body image contributed to her problems with sexuality:

I was worried about how he sees me, and how other people see me. In my thirties I became more comfortable with myself (Jana).

*Ek was bekommerd oor hoe hy my sien, en hoe ander mense my sien. In my dertigs het ek meer gemaklik met myself geword (Jana).*

Cathy’s poor body image and low self-esteem too plays a part on her sexual desire:

I don’t think I am desirable ... I would not think that any man would find me desirable. Another thing that put me off (sex) is that I think I will get hurt ... also the lack of confidence is a major thing. Chris says I am attractive, but it doesn’t count ... hold weight, it is only words. It irritates me ... I feel silly when I tell him things ... in the sense of feeling silly for feeling that there are loads that I do not tell him (Cathy).

Four of the participants (Paula, Cathy, Jana, and Berta) offered the fact that they had plastic surgery (breast augmentation, liposuction and facials) as a possible factor affecting their sexual desire. The others did not mention this, but as it was not one of the interview questions, some of them may well have also had cosmetic surgery. Paula, Cathy, Jana, and Berta could all be described as attractive and athletically built. Nonetheless all had issues with their bodies. Træn *et al.*(2007) supported the notion that frequent negative thoughts about oneself may cause the person to be more vulnerable to developing sexual problems.

Paula feels she has a good body image but this view is contradicting by her multiple plastic surgery operations. She did however indicate that she was angry about her recent weight gain.

Berta noted that her husband did not find her attractive initially:

I was overweight at a stage, but he is also now! And I always thought that he did not want to be with me..but *hy* is overweight!. It always astonishes me that they (men) can talk about you being overweight, and then they are six times more overweight. When I had had my breast augmentation he was very attracted to me for about a month or so, but then it passed again. So for that moment...*and* I lost a lot of weight...he thought I looked good..sexy ... The sex was good then, and then he got used to it, and then we were back to square one. I of course felt for years... *years....years!.. YEARS!...*[animated] that I was not sexy enough for him. I *always* felt like that. I *always* took it upon me (Berta).

*Ek was oorgewig op 'n stadium, maar hy is ook nou! En ek het altyd gedink hy wil nie met my wees nie..maar hý is nou oorgewig! En dit verbaas my altyd dat hulle kan praat oor jou wat oorgewig is maar dan is hulle ses keer meer oorgewig. Toe ek my borsvergroting gehad het was hy baie oorhulps met my, vir so 'n maand, maar toe het dit oorgegaan. So vir daai oomblik...én ek het 'n klomp gewig verloor...het hy gedink ek lyk goed...sexy...Die seks was goed toe, en toe raak hy gewoond daaraan, en toe is ons weer terug by square one. Ek het natuurlik vir jare...jare!...jare!...JÁRE!...[animeerd] gevoel ek is nie sexy genoeg vir hom nie. Ek het áltyd so gevoel. Ek het dit áltyd op my geneem (Berta).*

Basson (2002b, 2005) noted that the woman's self-concept plays an important role in sexuality, as a positive self-view will result in a willingness to engage in sexual activities. Given the societal emphasis on physical attractiveness, especially in women, it seems likely that women would have a sensitivity to the role that their physical attributes play in their lives, especially in sexual matters (Hurlbert, Singh, Menendez, Fertel, Fernandez, & Salgado, 2005). A negative self-view or feelings of inferiority (Basson, 2001) may preclude or hinder development of desire and a continuing positive sexual experience.

Everything considered, the finding was that negative body image have a negative effect on the experiences of sexual desire for women in this study, as is indicated in the literature.

### 5.5.5 Role of emotions

The participants described an array of emotions that they suspected as impacting on their libidos. These included feelings of rejection, not being valued, disappointment, frustration and anger.

Some of the participants reported that they felt deeply unhappy at times. Dora related that she experiences distress in her marriage and as a mother, as she feels abused by her family. Her depression and despair is so acute at times that she feels the urge to selfmutilate:

I put in so much ... I do not deserve this. I say nothing ... I go out, or to my room. Nothing I do is right or good enough. They criticise me, and I don't see the reason for that ... I feel like cutting myself ... (Dora).

*Ek sit so baie in ... ek verdien nie dit nie. Ek bly tjoepstil... ek gaan uit, of kamer toe. Ek doen niks reg nie of goed genoeg nie. Hulle kritiseer my en ek sien nie die rede daarvoor nie ... ek voel lus om myself te sny ... (Dora).*

Dora's experiences accord with research that suggests that depression and anxiety can impair sexual desire (Hawton, 1985; Trudel *et al.*, 1997; Regan & Berscheid, 1999; Basson, 2005). This is also in accordance with the views in the DSM-1V (APA, 2000).

Linda mentioned that her own mood is affected when her husband is moody, and that she has no inclination for sex under those circumstances.

I cannot tell you what it does to me. I see *red!* (Linda).

*Ek kannie vir jou sê wat dit aan my doen nie. Ek sien rôoi!* (Linda)

Cathy concurred

I get put off (sex) when my husband irritates me (Cathy).

Karla expressed feelings of anger because her fiancé would not marry her:

He did not want to marry me, and this really *angered* me. I felt helpless ... there was *nothing* I could do ... I was frustrated ... I tried to subtly persuade him. In the process ... in the end ... my lack of self-confidence then further put him off me in social situations ... I felt very unsupported ... my energy was drained ... (Karla).

*Hy wou nie met my trou nie, en dit het my regtig baie kwáád gemaak. Ek het hulpeloos gevoel..daar was niks wat ek kon doen nie...ek was frustreerd...ek het hom subtiel probeer oorhaal. In die proses ... op die ou end ... my lae selfvertroue het hom net méér afgesit in sosiale situasies ... ek het baie onondersteund gevoel ... my energie was getap ... (Karla).*

Anna described how, over a long period of time, she became disillusioned, as the differences between she and her husband were not resolved. She found it impossible to relate to him sexually when they had had an argument (*“hy maak my die duiwel in”*), and she described how they drifted way from one another emotionally and sexually. Her own *“inability”* to be more *“casual”* about sex and *“to get over myself”* stood in the way of their continued sexual relations. Basson (2001), similarly, found that emotional intimacy is highly relevant to the experience of sexual desire.

Kaplan (1979:37) proposed that persons who have considerable hostility towards their partners experience sexually-related anxiety. The anxiety is evoked early in the sexual sequence when sex is anticipated, and the person defends against the evoked anxiety through involuntary suppression or deliberate distraction with asexual thoughts, or by focussing on the negative aspects of their partner or the situation. (This mechanism of focussing on negatives (*“turn off”*) is the opposite of conjuring up sexual fantasies in order to fulfil or liberate sexual desire).

Berta felt that her husband did not desire her, and the experience of continued rejections and disappointment in him as a lover resulted in her stating:

When nothing happened (sexually, between her and her husband) my (sexual) feelings towards him died also. When you are with one who is like my husband, then it goes out of your head. You realise, it is not going to happen, and you must just deal with it ... and later you just give up (Berta).

*Toe niks gebeur nie, het my seksuele gevoelens teenoor hom ook doodgegaan. As jy met een is wat soos my man is, dan gaan dit uit jou kop uit. Jy besef, dit gaan nie gebeur nie, en jy moet dit maar net vat ... en later gee jy maar net op. (Berta).*

Weeks (2002) concurred that over time chronically suppressed anger toward a partner can devastate a sexual relationship. Regan and Berscheid (1999) compared research results that concluded that there is connection between mood and desire, and found that when feeling “down“, both men and women reported lower levels of sexual desire.

Jana felt disillusioned with her sex life early on in her marriage. The couple was inexperienced sexually and she was disappointed with their struggle to adjust sexually. She expressed fear and negative emotion associated with sex, which impacted on her experience of sex. Her new husband was impatient and unskilled:

I was on honeymoon ... and quite fearful. He was the first person I had slept with. His approach could have been better ... he could have tried to reassure me instead of being all angry or disappointed ... he felt rejected. Sex was a disaster (Jana).

*Ek was op honeymoon ... en nogal bang. Hy was die eerste persoon by wie ek geslaap het. Sy benadering kon beter gewees het...hy kon probeer het om my gerus te stel in plaas van om so kwaad of terleurgesteld te wees...hy het verwerp gevoel. Sex was 'n disaster (Jana).*

Jana's anxiety drastically affected her sex life, caused anxiety and fear of rejection or vulnerability (Kaplan, 1979), and may have caused her to suppress desire because she did not *want* to feel sexual. In this situation her reaction would have been regarded as appropriate as her partner was abusive, sexual activity was disappointing (Kaplan, 1979) and emotionally and physically unsatisfying (Basson, 2002a). Jana's descriptions of anxiety and feelings of failure arising from her sexual inexperience could also be related to either performance anxiety or response anxiety, i.e., anxiety experienced for not being performing well enough sexually, or becoming aroused when expected to be so. (Apfelbaum, 1988; 1995)

Theresa also mentioned experiencing anxiety, but for a different reason than the ones expressed by Jana:

I was too scared of falling pregnant! Karel has to always pull out before he comes. I was *really* scared ... I was not in the Pill ... he was not allowed to come in me until just now the other day. I never “switched off” to give myself over ... I *always* held back for the risk ... *even* the times when I did go on the Pill. And he was just content ... [laughs] and he was only “lucky” *once* – when I *wanted* to fall pregnant, and then it happened so fast – only *once*, then I was pregnant! (Theresa).

*Ek was altyd so bang ek word swanger! Karel moes mos altyd uittrek voor hy gekom het. Ek was rérig bang...ek was nie op die pil nie...hy mag nie in my gekom het nie tot net die anderdag. Ek het my nooit afgeskakel dat ek myself kon oorgee nie. Ek het altyd teruggehou vir die risiko...sélfs die tye toe ek op die Pil was. En hy was maar net tevrede..[lag] en hy was net één maal lucky – toe ek wóú swanger word, en toe gebeur dit ook so vinnig – net één maal, toe is ek swanger! (Theresa).*

The experience of the participants was that negative emotions decreased their sexual desire. Much of the literature supports this notion, although there is also some support for the contrary notion that barriers to intimacy may in fact *increase* the attractiveness of the incentive and *amplify* desire (Everaerd & Laan, 1995; Morin 1995). This notion seems to be applicable to the experience of desire towards other men, not towards life partners, and speaks to the intricacies of emotions and erotism. The paradox lies in that anything that can cause arousal can also be a sexual turn-off.

Many of these afore-mentioned emotional causes for diminished desire mentioned by participants are listed by LoPiccolo and Friedman (1988), including religious orthodoxy (compare Karla's account), phobias or aversions (for example Jana, Theresa and Cathy), as result of a history of abuse (as described by Berta, Cathy, and Karla), fear of pregnancy (which Theresa mentioned) and depression, hormonal, medication side effects, or age, as described by some other participants.

In brief, the women mentioned an array of emotions that they demonstrated to have an affect on their desire, and the overall finding is that negative emotions have a deleterious affect on desire.

### **5.5.6 Childhood history**

Anna and Cathy clarified their understanding of the effect of controlling fathers and “unresolved issues“ as underlying causes for lack of desire:

I think I was the big problem in this relationship, because I have many unresolved father-issues. I have always said to Ben “I play out all my father-issues with you”, which was unfair. He deserves a medal for that. If I do not work through these issues, it would not matter if I am married to Ben, or Mr Poggenpoel – those issues will feature again (Anna).

I always felt that I had no control, with men, not Chris, but with men in particular. So I do use sex a bit like a control thing ... it is my own thing ... my own stuff: the issues about men (Cathy).

Some of the participants were insightful and psychologised to the extent of realising the influence of underlying unconscious issues or background factors (such as how they were raised, parenting and religion) on how they view and conceptualise sexual desire. In the

maturity process a multitude of messages, often negative, are being internalised by women regarding the appropriate place for sexuality in their lives (Ellison, 2000; Wood *et al.*, 2007).

Gwen's childhood may well have set the stage for her complex sexual relationships as an adult. According to Ellison (2000) the relationship with her father is a major contributor to a girl's image of her sexual self. Gwen was her parent's first child, and her father wanted a boy. Consequently she was raised "like a boy", but "knew" she was a girl, and on reaching maturity needed her sexuality and femininity affirmed. She married a man who leaned towards homosexuality, and again she experienced the pain of "not being a man", and "not good enough". Her extra-marital affairs were very sexual and unashamedly lustful, possibly addressing her underlying needs for sexual and gender affirmation:

I was consciously trying to make sure that I was a woman, so from about 23 to 40 I had other sexual relationships ... then Mike, who was a sexual bomb, who just loved my body: a *total* confirmation of my womanhood (Gwen).

Jana described growing up with highly critical parents. Her mother's negativity caused her to be hypersensitive towards her husband's moods and this in turn had a negative effect on her desire for him. When her husband criticised her, she felt unable to respond to him sexually. Equally, Linda's mother was described as a cold, "miserable, negative" fault-finding person, and when her husband displays the same characteristics, Linda finds it "off-putting". Thus, for example, when he wants sex after a hard day at work, but has been complaining about his day ("*moaning about rubbish*"), she then finds it difficult to have sex with him (as does Jana with her husband), as it reminds her of her bad-tempered mother. Both their mothers had a negative attitude towards sex or men in general which according to Kaplan (1995) has an impact on the child's development of sexuality.

Idiosyncratic sexual desires, preferences and fantasies are acquired as a consequence of our individual histories, learning and experiences (Kaplan, 1995). An individual's early sexually arousing experiences may become linked with desire in later life (Money, 1986; Morin, 1995; Kaplan, 1995) and will lead to a distinctive individual experience of desire and erotism. Another demonstration of the effect of modelling is that those who revealed extra-marital sexual interests, e.g. with "wild" and sexually promiscuous men, made the connection that these men reminded them of their infidel, but much adored, fathers. Theresa explained how she was sexually attracted to older men, because she grew up "looking for attention from

older people”. Her own husband bored her as he was so trusting and decent, (“*siek van ordentlikheid*”) and kind to her. After less than three years of marriage she began to lead a “double life”, and had her first affair (like her father did to her mother). Anna also mentioned her attraction to a man who treated her badly (reminding her of her father’s poor treatment of her mother) whilst her husband was also just “good” (“*die goedheid self – doodgoed, en goed dood*”).

Thus, in their own view, there is little doubt that negative messages and/or experiences during childhood and early adulthood have shaped the sex lives of the women in this study, as did the affect of sexual trauma.

Three of the participants (i.e., 30%), Berta, Cathy, and Karla, experiences sexual trauma in their childhood. Bertha was abused by her uncle, and Karla by her brother. An uncle and subsequently several older men, including a teacher, made inappropriate sexual advances on Cathy. The incidence of sexual molestation against children is high in South Africa and mostly underreported (Richter, Dawes & Higson-Smith, 2004), so there may even have been more participants who suffered this fate. Phobic aversion has been reported as a result of sexual trauma (Sgroi, 1982; Hawton, 1985), which reminds of especially Cathy’s expression of loathing of sexual intercourse (section 5.3.3) in the light of the possible effect of inappropriate sexual advances on her as a child. Ellison (2000:90) refers to the negative effect of sexual boundary violations of “dirty old men”, and the notion of “*all boys and men want only one thing; they’re not be trusted*”. The result of Cathy’s experiences is that she resents men in general for making her feel like a sexual “object”, and this resulted in her need for keeping control, also in the sexual relationship.

My whole life I have been the sexual object to some-body. I just for once don’t want to be...I just want the person to *be* with me, not to want to have sex with me...(Cathy).

Karla’s experience of incest by her older brother made her vulnerable to feelings of “sinfulness” and “naughtiness”, resulting in an association of sexual desire with “wrong” (as per Ellison, 2000). She acknowledges that her “baggage” has a negative impact on her views of herself as a sexual being. Berta’s husband is not allowed to approach her early in the morning with sexual advances, as this reminds her of being abused by her uncle. LoPiccolo and Friedman (1988) noted the negative effects of a history of abuse on sexual desire later in life. Indeed, it is well documented that childhood sexual abuse and trauma is linked to a decrease in sexual desire (Hawton, 1985; Bass & Davies, 1988; Sgroi, 1982; Trudel *et al.*,

1997; Goldstein & Brandon, 2000; Higson-Smith *et al.*, 2005) because this often leads to depression with the consequence of dwindling desire (APA, 2000). As has been indicated, many of the participants also spoke about suffering from depression in later years, but whether this was specifically linked to the trauma would be speculation.

Interestingly, Dora, in search of answers for her low desire, stated without any prompting that “*nothing had happened to me as a child*”, thereby reacting to the common societal belief that one must have suffered childhood trauma to account for low libido later in life.

### **5.5.7 Life-stage factors**

Levin (2002) explains how the concept of sexual desire is shaped in the different stages, as we move from being unattached to becoming engaged, getting married, becoming parents, having an affair, getting divorced, becoming widowed, getting married, and so on. Depending on the life phase and the social situation, sexual desire will be understood differently. The participants in this study were all middle aged. Research results indicate that some of the factors that play a role on an individual’s functioning in the stage of middle age are work stress, family issues and having children (Levin, 2002). The effect of *having children* will be discussed first.

Only one of the participants (Karla) has no children, and the other participants have between one and three children. The effects of life-stage changes and adjustments to circumstances after the birth of children were often alluded to in these women’s meaning making of their decline of sexual desire.

Dora’s child has a psychiatric disorder, which places an enormous emotional strain on Dora and impacts on her openness for sex:

He understands that with the children ... I just do not have the strength ... my head is too busy. There are just too many other things ... and he understands that (Dora).  
*Hy verstaan dat met die kinders ... ek het net nie die krag nie ... my kop kap aan. Daar is net te veel ander dinge...en hy verstaan dit (Dora).*

Gwen also mentioned the effect of children:

Once you have children, it had a huge effect on desire. I also suffered of post-natal depression. And one is tired. And Sean became jealous as the children slept in my bed, and they had colic – he struggled with that (Gwen).

Hawton (1985) and Wood *et al.* (2007) mentioned that loss of interest in sex in women often occurs after childbirth, due to factors such as exhaustion, stress with coping, and some physical discomfort after the birth itself.

Anna's attributed the decline in desire and sexual relation between her and her husband partly to post-natal depression and the effect of the birth of the children.

I just withdrew ... those were difficult years ... when the ending came ... I had three children under the age of six. It was tough ... and with the depression ... it was a difficult time. And neither of us was especially randy then. It just tapered off ... after the birth of the boys, fourteen months apart. I could not believe it when I fell pregnant again! How did it *happen!* We did not have sex for the whole year, and then I get pregnant! It just tapered off ... I became more exhausted and fed up ... There was definitely not a morning when I got up and thought "no more of that" (Anna).

*Ek het net onttrek...dit was moeilike jare...toe die einde gekom het...Ek het drie kinders gehad onder die ouerdomme van ses. Dit was rof...en met die depressie...dit was 'n moeilike tyd. En nie een van ons was toe besonders speels gewees nie. Dit het net afgetaper...na die geboorte van die seuns, veertien maande uitmekaar. Ek kon nie gló toe ek weer swanger word nie! Hoe het dit gebéúr! Ons het nie seks vir die hele jaar nie, en dan word ek swanger!.. Dit het net minder geword...ek was net meer gedaan en het meer die donner in geword. Daar was definitief nie 'n oggend was ek opgestaan het en gedink het "no more of that" (Anna).*

As described by Anna, the incidence of *post-natal depression* may have a devastating impact on a women's sexual desire (Regan & Berscheid, 1999; Goldstein & Brandon, 2004), but other factors also came into play such as *work stress*, which is part of life-cycle stressors with young families' building of careers. Many of the participants alluded to the effects of work stress (either their spouse's, or their own) on their relationship in general, and their sex drives in particular. Berta described her husband as "*dog-tired*" when he came home in the evening and not interested in sex, which left her feeling rejected and unsupported. Karla also explained:

He just has too much stress at work, and then he has no reserves for me to listen to my complaints or tend to my needs. He is tired, and so am I. He cannot understand I can also be tired, and this frustrates me. I wish he would help me more in the household task, but his work comes first. This frustrates me. (Karla).

*Hy het te veel stres by die werk, en dan het hy nie die reserve vir my oor om na my klagtes te luister of aandag aan my behoeftes te gee nie. Hy is moeg, en ek is ook. Hy kan nie verstaan dat ek ook moeg kan wees nie, en dit frustreer my. Ek wens hy wil my meer help met die huishoudelik take, maar sy werk kom eerste. Dit frustreer my (Karla).*

Jana mentioned how the effect of starting to work, embarking on an honours degree, and adjusting to marriage took its toll on her. She related:

We both would get home in the evenings very tired, and then I have to make food ... He did not help with this, or to any of the other household tasks. (Jana).

*Ons het altwee saans baie moeg huis toe gekom, en dan moes ek die kos maak...Hy het my nie gehelp met dit nie, of met enige ander dinge by die huis nie (Jana).*

Anna took cognisance of the effect of work, although she acknowledges that this was not the only reason for her low desire:

Life happens. I have worked all my life. The reason for my celibacy is far more complex than just busyness, but certainly taking care of my family was an exhausting thing, and having a business to look after, and a home to run is draining. And certainly at the end of the day, the last thing one wants to do ... and certainly *I* want to do ... is turn into a sex goddess ... (Anna).

Running a household clearly takes its toll, and women often feel harassed, with a multitude of tasks and worries that distract them from sex (Hawton, 1985; Wood *et al.*, 2007). Also Træn *et al.* (2007) viewed workload, stress and fatigue as being central factors in relation to reduced sexual desire. Karla experience certainly supports this:

Although I stopped taking the anti-depressants three years ago, other factors seriously impacted (my libido) such as work stress, and various other family relationship problems, which over a long period of time took it's toll...it eroded my energy ...and I felt unsupported by him (Karla).

*Al het ek opgehou om die anti-depressante te drink drie jaar gelede, het ander faktore ernstig daarop geïmpakteer soos werksdruk, en verskeie ander familie verhoudingsprobleme, wat oor 'n lang tydperk sy tol gevat het...dit het my energie afgetakel..en ek het het gevoel hy ondersteun my nie (Karla).*

Linda, however, could not attribute her lack of sex drive to children or workstress. She explained enviously that she knows that other women use their children as an excuse to refuse sex. As she does not have small children nor is working, she had no excuse for not wanting sex, but she still had no desire. She laughingly lamented:

I have *no* excuse – I do not work, I do not have small children, but I just *do not want to* – NO! (Linda).

*Ek het géén verskoning nie – ek werk mos nie, ek het nie klein kindertjies nie, maar ek wil níé – NEE! (Linda)*

Anna described how, in the course of the marriage, “*life sort of takes over*”, and compared this situation with divorcees who in her opinion seem to have more time for sexual interludes:

..and we as women are so busy with looking after everything and everybody who needs looking after, that there is really no time to indulge, you know. There might be the time, but there is no emotional energy left for that... whereas women of my age, and certainly women of the late 40's onwards, and especially if they get divorced, and that certain seems to me to be a growing trend...women of that age getting divorced. Their children are largely independent...and they have time on their hands, whether they be physical, sexual or whatever, or emotional...and it seems to me that these women...they remember that, “hey, there is more to life than doing homework, the bond, making supper and so on”... (Anna).

In the course of life also *divorce and death* occur, which may have an impact on sexual desire. Paula mentioned that after the death of her husband (at young age) she felt like “half a person” and had no sexual needs whilst grieving. She married again, and describes this marriage as one based on a “sexual contract”. She and her ex-husband had frequent sex, which even continued for a number of years after their divorce. In the years after divorce, she

had multiple sexual partners, and she described that she needed these encounters as they boosted her ego.

Anna's account of her divorcee friends who seek out sexual contacts, and Paula's own account of her experiences are in agreement with findings that death or divorce may dampen sexual desire until a new partner awakens it. Partner loss can induce more motivation for sex (Levine, 2002), and many people act out frustration and other feelings by "discharging" through sex in the midst of divorce. It is a well-known phenomenon that newly divorced people seek out sexual encounters (Rice & Rice, 1986; Van Staden, 1987).

In summary, factors within the individual contribute to her experience, or not, of sexual desire, and many of these were identified by the participants. These included early sexual experiences, sexual trauma, moods, self-esteem and the weight of daily responsibilities.

In the next section the role of the relationship was considered as a factor for the experience of no sexual desire.

## **5.6 THEME 6: RELATIONSHIP FACTORS IMPACTING ON SEXUAL DESIRE**

Of all the factors explored in the interviews, by far the most emphasis was placed on the relationship as a feature influencing sexual desire. In this study the importance of the relationship on their experience of sex and desire was clearly demonstrated by the participants. These factors fall into two distinct groups:

1. aspects of an individual or a partner that may ignite interest and the possibility of sexual desire towards that individual;
2. factors in the relationship affecting sexual desire.

### **5.6.1 Romantic love and attraction**

Karla, Jana and Paula, narrated that they initially experienced *deep romantic love* and passionate feelings towards their prospective husbands, but even so, these feelings could not be sustained in the latter part of the relationship.

Von Krafft-Ebing (1886, in Regan & Berscheid, 1999) described romantic love as consisting of friendship ignited by the spark of sexual desire, a view that was echoed by theorists (e.g. Freud, 1949; Fromm, 1956; Lewis, 1960, Caretomuto, 1989) throughout the past century. Fromm and Lewis (1956; 1960) agreed that romantic love was an intense fleeting state inspired by the fusion of sexual desire with an affectionate feeling and that sexual desire was posited the essential ingredient of romantic love, and crucial to the maintenance there-of. These writers observed that, when sexual desire disappears, a person is no longer in a state of romantic love, and sated desire may leave lovers disappointed and disillusioned.

Gwen described that she was very attracted to her “*exceptionally beautiful*” husband in the earlier stages of their relationship. They initially had a passionate sex life, and she was filled with desire for him. However, their relationship went through difficult times and desire dwindled. She said:

By the time we were older, we cared enough about each other ... the sexual energy slows down ... we really look at what is left ... and you see that it is gold. The other stuff burnt off, and I am left with a very caring relationship with some one I really love. I am glad the sexual energy is not there – what we are left with is love ... warmth ... The other stuff was dark, ugly stressful. That is what I love about our life. We don't have to deal with that shit really ... and spend all day wasting energy on it ... (Gwen).

Gwen described what is understood to be a “companionate” relationship, i.e., a stable affectionate love without a passionate element (Regan & Berscheid, 1999:135; Tallis, 2004). Even in a companionate relationship, positive feelings and events may spark sexual desire (Regan & Berscheid, 1999). Some participants described that they were more prone to sexual encounters when the circumstances were favourable. Theresa, for example described having gone to a beautiful hotel in Franschoek, where she and her husband had a lovely time together, with sex included as one of their “activities”.

Jana mentioned that in the romantic stages of the relationship, she found small things desirous, like when Hendrik “looked nice”, dressed well, was shaved, was showered and had “clean toes, clean hair, clean teeth” and “smelled nice and clean”. For her, *personal hygiene* was “super-important”. Her emphasis on smell may relate to the role of pheromones in sexual desire. There is some evidence, albeit inconclusive, that humans respond to aromatic aphrodisiacs (Berliner, as cited in Kaplan, 1995; Goldstein & Brandon, 2004; Tallis, 2004) and that these may have an effect on the person's mood and play a role in human bonding. Conversely, bad smells act as a repellent (Kaplan, 1995). Kaplan (1974) also described

“romantic conquest” behaviour, when people make themselves appealing (as is the case with Jana’s husband’s bathing rituals), and contrasted this with the person who destroys sexual appeal by poor hygiene, and taking no pride in appearance (LoPiccolo & Friedman, 1988).

Berta’s earlier description of her lover is a clear example of *physical attraction* and enhanced desire.

...when I hear his voice I am filled with desire ... it stimulates me!. It is also the way he dressed, and also his hair ... and certain body parts... his groin...it is very soft – like velvet. And his hands are beautiful, and soft, and when I feel his hands around my neck, it is fantastic. When I stand, and he stand behind me, and he puts his hands on me, then my knees go totally weak. And his hair is soft ... and his lips are soft ... (Berta).

*...as ek sy stem hoor is ek vol begeerte....dit wek my op!. Dis ook soos hy aantrek, en ook sy hare... en sekere dele...soos sy lieste..dis baie sag – soos fluweel. En sy hande is mooi, en sag, en as ek sy hande om my nek voel, is dit fantasies. As ek staan, en hy staan agter my, en hy sit sy hande op my, dan raak my knieëe totaal lam. En sy hare is sag... en sy lippe is sag... (Berta).*

Also:

...it also depends if I am very attracted to that person; then it is a very important aspect of my life (Berta).

*...dit hang ook af of ek baie aangetrokke is tot die persoon; dan is my begeerte baie sterk (Berta).*

The participants’ frequent mentioning of their partner’s physical attributes emphasise its important role in desire. It is evident from research findings that physical attractiveness (mostly focussed on the facial features) is an important factor in arousing sexual desire in both males and females (Regan & Berscheid, 1999). Linda mentioned that her partner, Johan, attracted many partners and sexual success before marriage largely because of his physical appeal. Interestingly, however, and in contrast with the mainstream view, she did not feel sexual desirous towards him then, nor does at present. She is, however, attracted to other men:

And I cannot say that I was ever extremely physically attracted to Johan, not even when I was younger...I cannot say that the “madly in love” was there, that feeling that the earth will rip open if you leave me...I feel like that *now*. *Nothing* will make Johan more attractive – I am *mad* about him! I just tell him that he must dress a bit more modern, not like the Dutch Reformed Paarl boys [laughs]. I find him physically attractive. I find him *flippen* sexy.. And he looks after himself...he can wear a Speedo. Other men *can’t* [laughs]...*they should not!* [laughs] but he *can!* No, he looks good; I do find him physically very attractive. I do not know why I find other men *sexually* attractive, and not Johan. Like the poor chap at the gym...! I do not know why *this* man’s looks work for me...(Linda).

*En ek kannie sê dat ek ontsettend fisies aangetrokke was tot Johan nie, nie eers toe ek jonger was nie ...Ek kannie sê dat die “mal verlief” daar was nie, daai gevoel dat die aarde gaan oopskeur as jy my nou los...ek voel nou so....Niks sal hom meer aantreklik maak nie – ek is mal oor hom! Ek sê hy moet net asseblief ‘n bietjie meer modern aantrek, nie die N.G.Paarl seuns kleredrag nie [lag]. Hy is vir my fisies aantreklik. Hy is vir my flippen sexy. En hy kyk na homself...hy kan ‘n Speedo dra. Ander mans kan nie [lag]...hulle móénie! [lag] maar hy kan! Nee, hy lyk goed; hy is fisies vir my baie aantreklik. Ek weet nie waarom ander mans vir my seksueel aantreklik is nie, en nie Johan nie. Soos die stomme jafel by die gym...! Ek weet nie waarom dié man se looks vir my werk nie...(Linda).*

Also Karla described mutual physical attraction, respect and adoration in her marriage, and their relationship is good. None of them hanker after other lovers, but even so, Karla experiences no sexual desire. Anna used to find her “*bohemian*” and unconventional husband very attractive. Her desire for him disappeared when he changed to “*ordinary and boring*” after they had children.

He was a good-looking guy, very charming, and it was for me an escape. He is artistic and musical ... those things are important to me. I was very attracted to him and he was always on my side. It is still like that in spite of all our issues. When the chips are down, I know he will be on my side. He will always be on my side, and I can always rely on him for well-considered opinion and advise. So he provided me with an escape: I wanted to leave home. Now he is more of an old fart ... [laughs] (Anna).

*He was a good-looking guy, very charming, en dit was vir my 'n escape. Hy is kunstig en musikaal..daai goed is vir my belangrik. Ek was baie aangetrokke tot hom, and he was always on my side. Dit is steeds so ten spyte van al ons issues. When the chips are down, weet ek hy sal aan my kant wees. He will always be on my side, and I can always rely on him., vir well-considered opinion and advise. So hy was vir my 'n toevlug; ek wou uit die huis wegkom. Nou is hy meer van 'n ou drol...[lag] (Anna).*

The need to “escape” sometimes means that women marry men they are not in love with and to whom they are not sexually attracted. Theresa, for instance, was never in love with her husband, although she did fall in and out of “love” with other men. Her love for her husband is platonic.

Karel did not have many girlfriends, and he is not very sexual, absolutely not. I was in love with Paul ... with him I had sex 24 hours of the day.... I never had this with Karel ... never, never ... (Theresa).

*Karel het mos nie baie meisies gehad nie, en hy is mos nie baie seksueel ingestel nie, glád nie. Ek was mos verlief op Paul...vir Paul het ek 24 uur van die dag seks gehad.... Ek het dit nooit met Karel gehad nie, nooit... nooit... (Theresa)*

Theresa narrated that she had had many other boyfriends when she met her prospective husband. Her other boyfriends were very possessive, and were unfaithful to her. Even though she was never physically attracted to Karel, it was other factors that drew her:

Karel was never jealous, and he accepted me just like I am ... It was a challenge to master him because he was engaged. He is too nice with me ... he allows me everything ... he does everything for me ...(Theresa).

*Karel was mos nooit jaloers nie, en hy het my aanvaar nes ek was..Dit was 'n challenge om hom te bemeester want hy was verloof gewees. Hy te nice met my... hy laat my mos enigiets doen...hy doen enigiets vir my (Theresa).*

Theresa married her husband for his easy-going manner, as “fixer-of-things” and for financial security. This is in accordance with Regan and Berscheid (1999) asserting that from an evolutionary perspective for survival and providing for offspring, the women’s need is for the partner to provide shelter, food and protection. Theresa explained that her present lover is “*ugly and fat*”, but he has a high social status and she finds that and his general unavailability exciting. She described the affair as a “*game*”, and she wondered whether her feelings of

“*being besotted*” were love. Romance, unavailability and social status come into play in her desire for this man.

Both Berta and Theresa described their lovers as overweight, but this did not affect their attraction, so not only physically or aesthetically attractive men are found to be desirable. Tallis (2004) and Carotenuto (1989) describe this phenomenon where a person who is in love “transforms” the imperfections of the loved one.

Also, not only physical attributes are sexually attractive. Both Cathy and Paula found intelligence very appealing in men. Paula mentioned both:

In the first year of the relationship my desire was very strong ... I thought he is so beautiful, he has such nice legs. Now it is intellect that stimulates my desire...(Paula).

*In die eerste jaar van die verhouding was my drang baie sterk.....ek het gedink hy is so mooi, hy het sulke mooi bene. Dit is nou intellek wat my lus opwek..(Paula).*

I find intelligent men very attractive...dark-haired men..a special look..not necessarily a good-looking man... nice hands. But not with Chris...there is nothing about him that makes me feel desirous... maybe specifically.. it is some-one *other* than Chris..[laughs]. I respect Chris, his intelligence, good ability to think things through, and reason things out (Cathy).

Again, even though Cathy described her own husband as intelligent, attractive, darkhaired, athletically built, and, which coincides with her aforementioned image of “desirous men”, but even so, she does not find him desirable (any longer):

Both Karla and Linda expressed a great deal of *respect* for their husbands, but this did not sustain a sexual desire towards them. Before marriage, Karla found her professionally successful prospective husband very desirable, and enjoyed seducing the “powerful” man. Both Karla and Linda, however, found that the work stress experienced by successful men took its toll, and led to feelings of neglect and/or irritation with the husband’s moods. Linda said:

He manages two companies. He is very popular at work. But he cannot take the last straw. I know he has a lot of worries and stress. I have enormous respect towards him ... But oi, if he can only ... “I can’t take more on.” [animated: pretends to be him]. Then I say I will do it. Then he feels so bad afterwards, always like a dog. It puts me off (Linda).

*Hy het twee maatskappye. Hy is baie gewild by die werk. Maar hy kan nie die laaste bietjie vat nie. Ek weet hy het baie worries en stress. Ek het ontsettend baie..bitter baie respek vir hom....Maar ai, as hy net kan...”Ek kan nie meer vat nie..” [animeerd: maak hom na]..Dan sê ek ek sal dit doen..Dan voel hy so sleg daarna, altyd soos ‘n hond. Dit sit my af (Linda).*

Research indicates that social status, wealth, and dominance are linked with men’s desirability (Levine, 2003). That social status enhances men’s desirability was confirmed by

some of the participants, who said they viewed social status as an attractive attribute in a man. Theresa's present attraction is to a very wealthy, unattractive man of high social standing. The ability to provide immediate resources is regarded as related to the man's social status (Regan & Berscheid; 1999), therefore social position and material possessions may contribute to a male's sexual desirability, as illustrated in Theresa's attractions as her expressed need is for financial security (due to her impoverished background).

I want money. His money fascinates me. I think he wants to sleep with me ... I like it that he wants me. We can talk for *hours* about business issues, and Karel cannot (Theresa).

*Ek wil geld hê. Sy geld fassineer my. Ek dink hy wil by my slaap...Ek hou daarvan dat hy my wil hê. Ons kan vir ure sit en gesels oor besigheid-sake, en Karel kan nie (Theresa).*

Equally, Berta's lovers are all wealthy, and have high social status (one for example is a surgeon). Berta, however, does not find her own husband attractive, even though he is also well known, highly regarded and affluent.

Anna mentioned that, although her husband is very intelligent and creative, he has not excelled in his career as he expected, and that this failing "*knocked the stuffing out of him*". She describes how he "*lost himself*" along the way, and that she feels that he might be depressed. She is no longer attracted to him.

Therefore, it was found that some participants do find men of *high status* desirable. This is in agreement with the evolutionary perspective that women seek a partner who can provide refuge, food and protection, thereby ensuring her own safety and comfort as well as that of her children (e.g., Regan & Berscheid; 1999). These attributes are stronger when linked with other positive traits.

In summary, the participants referred to the role of physical attraction in sparking their feelings of desire. Interestingly some of the participants found their husbands physically attractive, but did not desire them sexually. Others found unattractive men sexually attractive, provided they has status and wealth, although again this did not necessarily extent to their husbands. Finally, it appears that being in love (or "lust") heightens sexual desire, reducing (for a time) the influence of physical attributes and/or social status and wealth.

## 5.6.2 Interpersonal behaviour

Most of the participants made some reference to the effect of their partner's behaviour on their desire for him. They mentioned a wide spectrum of "off-putting" behaviour, including critical or humiliating remarks and lack of respect.

Anna explained how she could not have sex shortly after having had a "*blazing row*". She stated that when her husband was rude or dismissive of her, it put her off him sexually:

... don't treat the woman like dirt in the morning and expect her to turn into a sex goddess in the evening – it certainly does not work that way for me ... (Anna).

Paula finds her partner's behaviour unappealing when he abuses alcohol. Dora also mentioned alcohol abuse and the resultant unacceptable behaviour as a reason for her declining sexual desire for her husband. Her husband becomes verbally abusive and she was adamant that she would not be sexually available to him if he behaved in that manner.

Karla's prolonged disappointment when her boyfriend refused to marry her for many years, took its toll on her desire for him, as has his emotional unavailability and impatience with her because of work stress now that they are married.

Linda explained that her husband should not expect sex if he treats her with disrespect:

When he opens the garage door, and that bad-tempered man walks in here – I want to just run away ... I find it *terrible*, and it remains terrible to me – he is just like my mother, very harsh, horrid, negative, and *whines*... always *moaning*, you know. Gee ... **it makes me** ...! He is at times *so* rude, ugly, and yells at the kids ... Gee ... "How do you want me to have sex with you if you were like this to me the whole day"? Because that irritated streak he can carry through right thought to Monday. When I just think, oh dear, I have told you a thousand times ... **He. Can. Not. See. It.!** That the emotional drama he put me through hurt me and makes me unhappy, and the poor kids. But then I have to be **nice!** Agh, that argument is as *old* as the mountains ... **OLD** ... (Linda).

*As hy die garagedeur oopmaak, en daai bedonnerde man stap hier in – ek wil die hasepad kies...Dit is vir my verskríklik, en dit bly vir my verskríklik – hy is soos my ma, verskríklik kwaai, mislik, negatief, en kerm...altyd klá,weet jy. Jis dit maak my...! Hy is soms só onbeskof, lelik, verskreeu die kinders...Jis, "hoe wil jy hê ek moet met jou seks hê as jy so met my was die hele dag?" Want daai ge-irriteerde streek sal hy mee kan deurdruk Maandag toe. Waar ek maar net dink, ag vader, ek hét mos nou al vir jou 100 maal gesê...Hy.Kan.Dit. Glad. Nie. So. Sien. Nie!. Dat daai emosionele drama waardeur hy my gesit het, het my seergemaak en ongelukkig gemaak, en die stomme arme kinders, maar nou moet ek nice wees! Ag daardie argument is al hólrug gery...HOL...(Linda).*

The experiences of the participants echo the findings of Kaplan (1995) who identified unattractive behaviour that negatively impact on the partner's sexual desire, such as hostility, betrayal, obnoxiousness, and insensitivity. Cathy, however, finds her husband's loving and romantic behaviour off-putting, even though other people tell her that she has the "*perfect*

*husband*’. Although Cathy described her husband as having many good attributes, she finds her husband intense and smothering, and his adoration of her off-putting.

If he did not love me so much ... or had an affair. I have often wondered about that ... maybe ... and the pressure about being everything to him. The wining and dining irritates me. He just wants to swallow me. Chris says I am attractive, but it does not count, hold weight..it is only words...it irritates me. The more insecure he feels, the more he needs sex, and it becomes a bit...desperate...then you feel you *don't* want to give it even *more*...because it almost becomes like a ... it is very unappealing ... it's like a needy ... sort of over-needy sort of a thing...it becomes almost like a leech ... you know ... feeding off you ... dependent (Cathy).

Behaviour such as criticism, especially around sexual issues, has a profoundly negative impact on experience of desire. Jana described how impatient her new husband was with her experiences of painful sex when they first got married by blaming and criticising her.

Instead of reassuring me, he got angry, or disappointed. He felt rejected...since I became pregnant he threatened to divorce me...sex was a disaster... It would have been better if he'd rather helped me...by being intimate also on another level...he even blamed me while we were busy (with sex)...it broke me down emotionally. It put me off when he bothered me when I was sick or tired...or did not feel like it...(Jana).

*In plaas om my gerus te stel, het hy kwaad geword, of was terleurgesteld. Hy het rejected gevoel...sedert ek pregnant was het hy gedreig dat hy my sou skei...seks was 'n disaster. Dit sou beter gewees het as hy my eerder gehelp het...om liefdevol en intiem te wees ook op 'n ander vlak...hy het selfs die blaam op my gesit terwyl ons besig was...dit was emosioneel afbrekend. Dit het my afgesit as hy lol met my wanneer ek siek of moeg was..of nie wil nie..(Jana).*

Berta explains that her desire for her husband deteriorated in response to problems in their relationship, mostly the result of his insensitive behaviour towards her. Berta found her husband's sexual unavailability hurtful, and caused her to also withdraw sexually from him. Berta experienced her husband as rejecting, and not desiring her sexually, as he watched television all the time, never cuddled with her and he would not kiss her. Research into factors such as interpersonal responsiveness and warmth, indicated by touching, interpersonal distance and lingering eye contact, suggest that these cues may be read as sexual interest (Regan & Berscheid, 1999), and the lack thereof would clearly be read to the contrary, as in the case of Berta.

Berta also complained that her husband's work “came first”, while she was last on his list of priorities. He is reportedly unromantic, does not compliment her, and criticised her when she gained some weight. She also said that he used to watch pornography, and that she therefore felt that he objectified women, including her. She described his behaviour as causing her to feel undesirable, which in turn destroyed her desire for him in the long run. When he presently “warns” her about having taken a pill (Viagra) it completely puts her off him

sexually. Wood *et al.* (2007) found that some women are disappointed in their partner's sexual technique and lack of skill to arouse their sexual desire, such as the case of Berta.

Freek's behaviour reminds of Stuart *et al.* (1987) and Basson (2001) who mentioned importance of sexual stimuli mostly those being outside the bedroom, such as consideration, respect, warmth and physical affection, for igniting sexual desire. Researchers note that women may seek emotional intimacy in a non-sexual ways such as hugging, but are disappointed and frustrated if the partner takes it to the sexual level (Wood *et al.*, 2007).

In short, the behaviour of their partners towards women has a profound impact on their feelings of sexual desire towards them.

### **5.6.3 Relationship duration/ novelty**

Most of the participants indicated that, in the earlier parts of their relationships, they did feel sexual desire for their husbands, but for many these feelings faded over time. Berta, Linda, Anna, Theresa and Cathy all described their present marital relationships as "*platonic*". In the main, the participants had difficulty explaining their loss of sexual feelings towards their husbands, particularly those for who love towards and attraction towards their husbands had increased over the years.

Paula described an active sex before the decline in her desire. Even though later their relationship became celibate, Gwen explained:

"When we got married it (the sex) was ... everything I dreamed of" (Gwen).

Anna and Dora reported a similar change:

It was frequent – overly frequent –.... it is different now (Anna).

When I was young and newly wed, I definitely had more desire than now (Dora).

*Toe ek jonk en pasgetroud was, het ek beslis meer begeerte gehad as nou.*

As did Cathy:

... there are changes in the experience from the new, fresh, new relationship desire in the beginning.... I think you lose it (Cathy).

Anna, Linda, Theresa and Jana expressed active aversion to sex, while Cathy expressed *strong* repulsion (section 5.3.3). Levine (2002) observed that once a life partner is found, there seems to be a decline in sexual activities for at least some women, as described in the current study.

However strong the desire was in the beginning stages of the relationship, as their relationships progressed there was a decline for *all* the participants. Furthermore, they related that the same was true for their friends. Notwithstanding the fact there is a societal expectation of ongoing sexual relationships in a marriage, this decline in long-term relationships is well documented (Money, 1986; Kaplan, 1995; Levine, 2002; Basson *et al.*, 2005). This phenomenon begs the question whether longer term relationships are indeed able to sustain a sexual relationship (Money, 1986; Kaplan, 1995; Schnarch, 1991, 1997, 2000; Perel, 2007). Moreover, as was indicated in previous sections, some of the participants reported that they were attracted to *other* men when they lost sexual interest in their partners.

Certainly it seems that “familiarity” in longer relationships may reduce sexual desire (Levine, 2002). Long-term relationships allow the couple to explore various exciting and pleasurable sexual activities, but after some time they have done everything that they feel comfortable with (Levine 2003). Boredom and repetition set in, triggering the search for new experiences. Westheimer and Lopater (2005:228) call this process “habituation“ which leads to “*diminished behavioural responses during repeated presentations of the stimuli that elicit them*”.

In short, the findings that there is a reduction in sexual desire in longer-term relationships were substantiated. Even though Basson (2000a, 2000b, 2005) indicate that responsive desire may be evoked under certain circumstances in long-term relationships, this did not prove to be true for the women in this study.

#### 5.6.4 Relationship satisfaction

Gwen, Berta, Linda, Anna, Theresa and Cathy depicted their relationships as companionable.

Linda, who has regular sex with her husband, said:

We are very good friends. We are genuine friends. We enjoy the same things, read the same things, enjoy the same music ... we can have a “jol” like absolute teenagers. We really do get along well. I am not ever sorry that I married him (Linda).

*Ons is verskriklike lekker pelle. Ons is genuine pelle. Ons geniet dieselfde goed, lees dieselfde goed, geniet dieselfde musiek...ons kan 'n jol hê soos absolute tieners. Ons kom rêrig goed oor die weg. Ek is nie 'n dag spyt dat ek hom getrou het nie (Linda).*

She also added:

I never have a desire...no, very seldom...I am **not** interested. I just do not **WANT** to – **NO!**(Linda).

*Ek het **nooit** begeerte nie... nee wat, bitter min... ek is **min** gepla. Ek **WIL** net nie – **NEE!** (Linda).*

Cathy concurred:

I have *no* desire for Chris. I don't *ever* desire him [laughs]. I feel I love him...sometimes... not as often as I should, but sometimes I do...It is more the love like towards a brother, like a good friend... I respect Chris....I love Chris, but I don't desire him at all...(Cathy)

Karla described her respect and adoration for her husband, and how they grew emotionally closer, and in understanding for one another. Gwen recounted the improved emotional intimacy and deepened emotions towards her husband. Both these women have reciprocally respectful relationships, in accordance with Brezsnayak and Whitman (2004) who mentioned that egalitarian couples report the highest levels of marital satisfaction. As sexual desire may be seen as a form of expression of one's satisfaction with the relationship, one is more likely to desire increased intimacy and sexual activity. The finding that sexual desire is highest in those who report high levels of marital satisfaction was *not* borne out by the results of this study. Even though some participants have high levels of marital satisfaction, and some even *increased* levels of satisfaction, this is in contrast with research findings that high sexual desire is associated with *high* levels of relationship satisfaction (Trudel *et al.*, 1993; Trudel *et al.* 1997; Donnelly, 1993; Brezsnayak & Whisman, 2004).

Brezsnayak and Whisman (2004) also reported that men and women have different criteria for what for them constitutes "marriage satisfaction" - men who felt that they had a satisfying sexual relationship were more satisfied with the marriage. The difference between sexes is clearly demonstrated here, as the women in this study described themselves as happily married, even though they did *not* desire sexual intercourse. Indeed, it seems that for some, their marriages would be better if their husbands also had no desire for sexual intercourse with them.

Even some of the participants who described themselves as happily married were "put off" by periodic conflict and other marital difficulties. Four of the participants were more openly dissatisfied with their marriages. They reported longstanding problems such as poor communication, lack of support, feeling criticised and neglected, and a plethora of other factors, which caused dissatisfaction with the relationships.

Anna and Berta harbour deep resentment towards their husbands for disappointments early in their marriages. Dora narrated how her husband's criticism of her, coupled with other stressors, took away her desire for him. Jana also mentioned lack of support, and emotional

unavailability as some of the many reasons for a decline in her sexual availability. Even though they worked through their marital problems, Gwen and her husband did not resume their sexual relationship. Cathy found many aspects of her husband's loving behaviour intolerable. The experiences of these participants are echoed by researchers indicating that marital distress, dissatisfaction and conflict in the nonsexual areas of a couple's relationships are reflected in partners' level of sexual desire (Brezsnyak & Whisman, 2004; Træn *et al.*, 2007).

As indicated before, marital distress is seen simultaneously as a *causal* determinant and as an *outcome* of low sexual desire. Low marital satisfaction can reduce motivation for sexual intimacy, and may even promote sexual withholding. Lack of desire over time can lead to dissatisfaction and to frustration, and this reciprocal cycle may lead some couples into a pattern of escalating sexual dysfunction (LoPiccolo & Friedman, 1988; Brezsnyak & Whisman, 2004).

Other causes for dissatisfaction and unhappiness include for example Theresa's fear of pregnancy, Jana's subjection to criticism whilst having sexual intercourse, and Linda and Paula deriving no sexual pleasure or orgasm so that the sexual interactions experienced are unsatisfying and not experienced as erotic.

With so many factors influencing sexual desire, it becomes impossible to ascertain which came first – marital dissatisfaction or low desire. Both marital satisfaction and sexual desire may be the product of some *third* variable, whereby life events of such severity lead to relationship stresses (Brezsnyak & Whisman, 2004).

### **5.6.5 Discrepant sexual desire**

Participants indicated that their sexual needs differed significantly from those of their husbands. Apart from Berta, who's husband initially had lower sex drive than her, the other participants all felt their husbands had a greater need for sex than they themselves did, and at times their partners' desire for intercourse was experienced by the women as unwanted or highly inappropriate. Both Dora and Paula narrated how their partners pressurise them even if they indicate that they do not want sex, and whilst Dora's husband may then withdraw, Paul's "carries on and on" ("*hou net aan en aan*") until she gives in. Linda, Jana and Cathy said:

If I had said “no, not now”, then he will just carry on **until** I give in. No heck [laughs], he does not get put off [laughs]. He cannot *understand* what my problem is – he wants it every day (Linda).

*As ek gesê het “nee, nie nou nie”, dan sal hy net aanhou tot ek ingee. Nee wat,[lag] hy laat hom nie afsit nie [lag]. Hy kan nie verstaan wat my problem is nie – hy wil dit elke dag hê (Linda).*

... His expectation was different- he thought that one should have sex every evening, and this did not work, as I did not want it (Jana).

... Sy verwagtinge was anders – hy het gedink mens moet elke aand seks hê, en dit het nie gewerk nie, want ek wou nie (Jana).

...and it is this whole build-up that you can actually feel...I *hate* it...and then, in the two hours I sit there thinking for the past two hours, how I can get out of it [laughs] (Cathy).

Wood *et al.* (2007) indicated that sexual drive discrepancies in relationships necessitate negotiation around each others’ drives and psychological intimacy needs. Yet many people (like Karla and Anna) believe that direct references to their own sexual drive is offensive and inappropriate, and the resultant inadequate sexual negotiations might end in the couple’s sexual withdrawal from one another, as is the experience of some participants (Davies *et al.*, 1999; Clement, 2002; Levine, 2002).

Linda related an example of an incident of where she and her prospective husband clearly had apposing desire states, and where he showed great selfishness in exerting his desire. She was hospitalised for an extended period of time for a serious stomach operation. When she was discharged from hospital, still suffering from enormous pain, he rushed her home, carrying her up the stairs to the bed. She remembers being “in utter shock” as he pressurised her into sex, regardless of her lack of desire in those circumstances.

Verhulst and Heiman (1988:242-245) noted that the frequency of sexual contact between partners depends on the variation of desire in each individual, as well as in the ways that partners interact to synchronise these rhythms that seem to be lacking in the experience of the participants. Their perspective on low desire emphasise the *problem of synchronisation* or coordination of the sexual rhythms in a relationship.

Davies *et al.* (1999) examined discrepancies between partners’ desire and found that for both husbands and wives, individuals who felt that there was a discrepancy between their own and their partners’ desire showed lower satisfaction with the relationship. However, for women at least, this is not supported by the results of this study (see Section 5.6.4), as, in summary, many participants have loving relationships with their husbands in spite of the discrepancy in their sexual desires.

### 5.6.6 Power struggles

Most of the relationships described in this study were in a fairly conservative, patriarchal style, where the husband, as the provider, seems to be the more powerful partner and “head of the household”. The women, however, retained/regained power through, for example, taking lovers, declining sexual overtures, or living separate but equal lives. More than one respondent referred to power as a factor in their sexual relationships.

Cathy feels coerced to give in to sex:

.... He puts pressure on me...not as bad as he used to, but he still does...and it is this whole build-up that you can actually feel.... I *hate* it... (Cathy).

Cathy is aware of using sex as a tool to regain power:

...it is also the feeling that Chris has controlled my whole life...I use sex unconsciously as a control mechanism, in a way, even when we are having sex...it is very controlled. We only do what *I* want us to do, what *I* want...that is my control.... ...it is a bit of a strange thing. The more I see he needs it, the more I do not want to give it to him....(Cathy).

Also Anna described that she would then withhold sex when her husband was “undermining” of her and abusing his power by overriding her ideas.

The avoidance of intercourse remind of clinical observations and theory that indicate that power issues in a couple’s non-sexual relationship may become manifested in low sexual desire as an attempt to equalise the power dynamics and regain control in an unbalanced relationship, which process may be unconscious and not necessarily manipulative (Brezsnyak & Whisman, 2004). This finding may be applicable to Berta’s situation where she attempts to regain control within a situation where she is financially, and otherwise, dependent on her husband. In attempts to regain some of her life, they have severe arguments, and her husband’s present impotence might be an unconscious reaction to the shifts in power. This is in accordance with Brezsnyak and Whisman’s study (2004) that unequal power may lead to lower levels of sexual desire for *both* husbands and wives.

Therefore, it was indicated that power imbalances may have an effect on sexual desire, as it might be consciously or unconsciously suppressed to gain a hold over the partner.

### **5.6.7 Conflict, connectedness and intimacy**

The participants indicated that emotional conflict in the relationship had a negative impact on the emotional intimacy necessary for the experience of sexual desire (Trudel *et al.*, 1997). Anger or other negative emotions stemming from interpersonal conflict suppress sexual desire (e.g. Kaplan, 1979, 1995; Hawton, 1985; Stuart *et al.*, 1987; Leiblum & Rosen, 1988; Basson, 2002a, 2005; Wood *et al.*, 2007). The impact of factors hindering intimacy, and therefore potential sexual desire, will be discussed next.

Some participants complained that their husbands want to be sexual with them at times when they do not feel emotionally close to them. Anna and Linda noted that at the end of a busy day their partners insist on sex, even after arguments, which is in accordance with Basson's findings of reduced arousability if the sexual situation is too hurried, too late in the day or lacking emotional connectedness (Basson, 2000, 2004, 2005).

Many of the participants made reference to the negative impact of conflict, depression, exhaustion, disappointment, stress, and so on, on their desire for sex with their partners. Moreover, their husbands reportedly appear to be less affected by these factors, and continue to pursue their wives sexually, which would support the notion that men and women approach sex differently. While men are more likely to have a recreational orientation (i.e. for pleasure, or stress-relief), women tend to associate sexual desire with the pursuit of intimacy and relationship goals (Regan & Berscheid, 1996, 1999; DeLamater, in Regan & Berscheid, 1999; Tallis, 2004).

Dora said that her husband was often "dismissive" of her, and that this aspect put her off having sex with him. Also Anna made it very clear that her husband could not expect of her to turn into a "sexual goddess" at the end of the day when he had been dismissive or rude of her. Tiefer (2001) and Hicks (2005) mentioned the decline in sexual desire in situations of partner's abuse, the couple's unequal power, or arising from the partner's negative patterns of communication.

Anna described where her resentments originated from during their marital history, dating back to her becoming the breadwinner while her husband returned to University. He failed his examinations and she lost her respect for him. They remained in a functional, but

superficial relationship without sex. Træn *et al.* (2007) found that habitualised negative thinking about a partner, is also correlated with a loss of sexual desire towards that partner.

Both Theresa and Jana found sex physically painful, which meant that they avoided intimacy and intercourse (see Section 5.3.3). Jana described how she tries to avoid sex:

..Sex...it is just not *nice*. A person at times becomes anxious when they shave...getting ready for sex...then I start to get frightened, and I say I am sick, or I have a headache, or I pretend to sleep [laughs]. Or if he says that we will not go out tonight because we are going to have sex – it *frightens* me! (Jana).

*Seks...dit is net nie vir my lékker nie. 'n Mens raak soms benoud as hulle skeer...regmaak vir seks...dan begin ek benoud word, en sê ek is siek, of het hoofpyn, of ek maak of ek slaap [lag]. Of as hy sê dat ons nie vannaand uitgaan nie, want ons gaan seks hê – dit maak my sommer báng!* (Jana).

The anticipation of being approached for sex heightens Jana's her anxiety, when she sees her husband planning the event. Her husband did not believe her when she complained about pain during sex, and got angry as he thought she withheld sex from him unreasonably. He threatened her with a divorce, and made degrading remarks about their lack of sex life publicly, which she experienced as deeply humiliating. Accordingly, Træn *et al.* (2007) noted that conflicts over sex were a powerful indicator of reduced sexual desire. The occurrence of reduced desire was the case for Jana, but not for her husband and he continued to expect intercourse from her, in spite of the conflict. Also Berta explained how “panicked” she gets when she her husband prepares for a sexual encounter.

He tells me about two hours before I got bed, “I had a little pill” (stimulant) and then this fear starts to grow within me... (Berta).

*Hy sê so twee ure voor ek gaan slaap “ek het 'n pilletjie gedrink” (stimulant) en dan begin hierdie vrees in my (Berta).*

Inhibition, avoidance, or distress about sex arises also from feelings of betrayal, dislike, or fear of the partner (Tiefer, 2001; Hicks, 2005).

Shared experience, positive affect and mutual acceptance in relationship are stressed as important for the experience of desire (e.g. Basson, 2002; Leiblum & Rosen, 1988), especially so for women. A lower level of intimacy and connectedness is associated with low sexual desire (Rosen & Leiblum, 1995; Brezsnyak & Whisman, 2004), and low desire often indicates underlying relationship conflicts. For most women in ongoing relationships, sexual satisfaction is closely linked to feeling attuned to and connected to their partners (Ellison, 2000).

### 5.6.8 Love-making techniques

Linda revealed the huge discrepancy in her and her husband's sexual enjoyment as follows:

It is just not *nice* – there is no orgasm for me. ... See, I don't think he knows that I don't have an orgasm.... I pretend to have one [laughs]...you know, it will be **very** interesting to me if he does know, or does not know... I do not think he does. He thinks the flippen earth moves! [laughs] (Linda).

*Dis net nie vir my lékker nie – daar is nie vir my 'n orgasme nie. ....kyk, ek dink nie hy weet dat ek nie 'n orgasme kry nie...Ek maak dat ek het [lag]...weet jy, dit sal vir my verskriklik interessant wees of hy weet, of nie weet nie...ek dink nie hy weet nie. Hy dink die flippen aarde skuif! [lag] (Linda).*

Linda's attempts to address her husband's poor sexual techniques were unsuccessful and she had given up:

Johan has no “coocin clue” about foreplay. It is just non-existent. And I am sick, sick, sick and tired talking about it...and explain...en ask...and to say how it should be. I have closed that book: **it ain't gonna happen!** (Linda).

*Johan het geen “koeken clue” van foreplay nie. Dis net non-existent. En ek is siek, siek, siek en sat daaroor gepraat...en verduidelik...en gevra ..en gesê hoe dit moet wees. Ek het nou die boek toegemaak: **it ain't gonna happen!** (Linda).*

It seems that Linda resigned herself to the fact that she has to be available for sex for her husband and that he will “do sex to her”, without any pleasure for herself. This is in accordance with Wood *et al.* (2007) citing a study by Fine that demonstrated that women's experience of sexual desire tended to be without mentioning of sex for fun, pleasure, stress relief or relaxation, and they perceived sex as done *to* them. Women are socialised to be passive in sex, while men learn to desire and obtain sex (Barbach, 2000; Fine in Wood *et al.*, 2007).

Linda, however, said that she loves her husband and has remained in the relationship despite his inadequacies in the bedroom. She has turned the poor experience of sex into something light-hearted and fun between them:

He can't keep his hands off me in bed – I tease him now, and I say to him “you only touch me on three places – my tits and my cookie – the rest of my body does not exist (Linda)

*Hy kan nie sy hande van my afhou in die bed nie – ek spot nou met hom, en ek sê vir hom “jy vat net aan drie plekke – my tiete en my kwak” – die res van my lyf bestaan nie. (Linda)*

Theresa also chose to turn disappointing sexual experiences into something positive, by explaining how they have fun when having sex:

We used to kiss and hug each other...but now there is no foreplay and sexual... we just have sex and then it is **finished!** We have sex, and laugh, and this and that...but there is no soft loving kutch-kutchi... (Theresa).

*Ons het mekaar altyd gedruk en gesoen...maar nou is daar geen foreplay en seksuele...nie...ons het net seks en dan is dit **klaar!** Ons het seks, en lag, en die en daai...maar daar is geen sagte liefdevolle kutchi-kutchi nie... (Theresa).*

Paula, Karla and Linda explained that they never experience an orgasm during sexual intercourse, and Paula and Karla expressed boredom with sex. Literature often make reference to the role of the partner in the development of low desire, more in particular, the lack of sexual skills and the resultant development of decreased desire by the other partner due to unpleasant sexual experiences or disappointment (e.g. Basson, 2005; King, 1997; Goldstein & Brandon, 2004; Berman & Berman, 2004).

Paula found the sex life with her present partner at first interesting, and she was very attracted to her partner. She enjoyed taking the lead in initiating, but this aspect caused her partner to feel offended. She then stopped, and now leaves it up to him to initiate. Paula admitted that she wants the encounter to be “over and done with”, adding:

...it is boring – it is ridiculous [laughs]. (*Paula*).  
...*dis vervelig - dis belaglik!* [lag] (*Paula*).

Paula’s partner insistence on taking the lead most probably comes from script perspectives that prescribe male-female differences in sex roles and behaviour, where the conventional heterosexual scripts emphasise female passivity and acquiescence to male initiation and direction (Rosen & Leiblum, 1988). Male scripts traditionally have highlighted that men, being always desirous of sex, take charge of orchestrating sex.

When the partner is a poor lover, anxiety may arise when the woman does not feel desire or become aroused when expected by her partner to do so (Apfelbaum, 1988). Paula and Linda said that they faked orgasm, in response to the pressure to be responsive, to please and support the partner’s ego, to shift the attention away from the process and free them of pressure to have an orgasm (Ellison, 2000).

Others, like Anna and Karla, mentioned fantasising about other men in order to reach orgasm, due to their partners’ ineffective stimulation. Karla’s husband has virtually no prior sexual experience, is unskilled and feels inadequate because he ejaculates prematurely. Verhulst and Heiman (1988) noted that low desire can originate due to inappropriate stimulation, or when one partner requires a longer period of stimulation.

Karla expressed a wish that her husband would develop his skills, but he does not read the books she unobtrusively leaves for him. Barbach (2000) noted that women often erroneously assume that men *should* be the authority on sex and should “give” the woman sexual

satisfaction, in accordance of Karla's expectations. She expressed feeling disillusioned about their sex life, and wondered if his poor technique has any bearing on her low sex drive. Karla wants her husband to learn to take the lead in seducing her, and these seduction rituals are found to be necessary to facilitate the coordination of individual sexual rhythms (Verhulst & Heiman, 1988) and address desire discrepancies.

Karla finds it too difficult to communicate openly about sex, and her vague hints are not acted upon. Ignorance or inhibition about communicating preferences, or initiating, pacing or shaping sexual activity contributes to sexual difficulties (Verhulst & Heiman, 1988). If Karla's husband was more attuned, or able to openly communicate about how he can improve his approach this may have facilitated Karla's desire (Stuart *et al.*, 1987; Verhulst & Heiman, 1988; Wood *et al.*, 2007).

Berta's felt used by her husband. Even at the outset of their relationship he did not kissed her or make love to her face-to-face: he turned his face away, or she had to look away. She said that it felt to her that "*he could as well have had sex with an animal*".

I just always felt very much rejected – it is really shocking. Because I still want to caress, and kiss, and if he had turned me over *thereafter*, it would have been fine still...but he immediately turned me on my side. It was ...really repulsive... it was as if he really did not want to have sex with *me* – he does not want to see my face...I could just as well have been a blow-up doll (Berta).

*Ek het net altyd baie verwerp gevoel – dis regtig skokkend. Want ek wil nog hê ons moes liefkoos, en soen, en as hy dán vir my sou draai, sou dit nog fine wees...maar hy draai my dadelik op my sy. Dit was vir my ...regtig walglik...dit was of hy regtig nie met my wou seks hê nie – hy wil nie my gesig sien nie...ek kon netsowel 'n opblaaspop gewees het (Berta).*

Berta experienced sex with her husband as impersonal, and with no emotional connection, and there seems to be inadequate romance from her husband's side. This underscores the findings that women emphasise the emotional aspects of sexuality more strongly than men while men seem to emphasise pleasure (Tallis, 2004; Træn *et al.*, 2007). Berta's experiences seemed to be devoid of the loving emotion that is usually expressed through facial expression, sounds and speech (after Verhulst & Heiman, 1988). These authors also stress the importance of seduction manoeuvres and certain behaviours to evoke feelings of desire (which also were not present in the sexual interactions between Berta and her husband). The sexual act therefore was experienced as unpleasant and sorely lacking of personal contact.

Jana's husband criticised and demeaned her while they were being intimate. He was forceful, skipped foreplay, and did not try to alleviate her fears of painful intercourse:

I was a bit scared...his approach could have been different. He could have tried to approach me by attempting to alleviate my fears...(Jana).

*Ek was bangerig...sy benadering kon anders gewees het. Hy kon my probeer benader het om my gerus te stel...(Jana).*

Jana's husband expected certain sexual acts from her that she was not comfortable with. Verhulst and Heiman (1988), and Træn *et al.* (2007) mention how partners' preferences for sexual activity contribute to sexual difficulties. Loss of sexual interest can follow as a result of conflict over issues such partner's sexual problems (such as Jana's physical problems including pain during sex), the premature ejaculation of Karla's husband, and the impotence of Berta's husband.

Anecdotal evidence and clinical impressions support the notion that inadequate or poor information about sexuality is another contributing factor to the eventual development of low sexual desire, as was found in this study. Lack of security or comfort with personal sexuality (Westheimer & Lopater, 2005), and attitudes people have towards their own bodies and towards their own sexual urges play a role. Religious beliefs may create uneasiness and anxiety during lovemaking (Morin, 1986). Sexual problems may also be the result of dysfunction in the partner, or poor techniques (Hawton, 1985; Ellison, 2000).

In summary, relationship factors, such as whether the woman is still attracted and in love with her partner, the nature and quality of the relationship, discrepant sexual desire and poor lovemaking techniques have an impact on the women's desire for sexual relations. Of note is the conundrum of intimacy in the relationship, as both being too close emotionally and too distant affects the woman's openness to sexual activities.

In the following section the important influence of culture and life situation will be examined. Humans do not only have idiosyncratic experiences, but also have experiences as shared by others. We have seen that some of the themes revealed the subjective unshared aspects of experience, being internal and unique to the participants, and others touched on those experiences that are contracted within the roles which the individual takes on (friend, spouse, mother, worker) in their culture (compare Shaw, 2001).

## 5.7 THEME 7: SEXUAL DESIRE WITH-IN THE SOCIAL CONTEXT

The ability to participate in sexual relationships is learned behaviour, like any other social behaviour (as is supported by Tiefer, 1995). Sexual interaction has the effect of bonding, due to the pleasurable and self-disclosing nature. The result is that all societies have created sexual customs that place boundary mechanisms around sexuality. Societies shape various aspects of sexuality, defining what is normal or abnormal, or unnatural, or taboo (Reiss, in Regan & Berscheid, 1999).

### 5.7.1 Social scripts

The participants repeatedly voiced their expectations that sexual relations would be conducted in a particular manner. Simon and Gagnon (in Regan & Berscheid, 1999:73) proposed that “*a variety of sexual scripts.... define those persons and objects with whom it is acceptable to engage in sexual activity, when and where sexual activity appropriately may be conducted, and the motive and reasons an individual should possess to engage in sexual activity*”.

Some participants indicated that they viewed sex as something that belongs to the younger generation. Gwen spoke of her sexual desire in past terms on numerous occasions, and explained that in her later years her relationship became non-sexual with her husband, in a way explaining it as if this is the “normal” progression because of age:

I had a very high libido...but I lost it...the sexual energy slow down...the other stuff burnt off (Gwen).

Anna in turn relayed with astonishment and some horror how her newly divorced friends engage in frequent sex. Cathy and Paula also expressed surprise that some of their friends still willingly engaged in sexual relations. None of these participants explained why they felt this way, but the impression was gained that they were at least to some extent, subscribing to the myth that sexual desire is the prerogative of youth, resulting in the belief that desire is inappropriate when experienced by older individuals (Hawton, 1985).

Apart from the myths that only the young and attractive may enjoy sex, other misconceptions include that sex should cease when procreation is no longer possible and that sexual activities should cease after middle age (Hawton, 1985). Regan and Berscheid (1999) indicated that pervasive stereotypes persist depicting older persons as having little interest in sex or being

asexual, as sexually unattractive and unable to perform sexually. Koch *et al.* (2005) found that middle-aged women lost interest in sexuality when they perceived themselves as less attractive as they aged. In this regard we have seen in previous sections that some of the women indicated that changes in their bodies affected the women's desire to be sexual.

Karla made mention of the notion of prerequisites for "acceptable" sex – as was mentioned before, Karla's husband would not commit to marriage but continued to have sex with her. As they are both religious, and she perceived him to be "decent", from a good home and respectable, she expected him to act differently:

... I expected that he would treat me differently...a more conservative attitude...not to just continue with the relationship for years (Karla).  
... *ek het verwag dat hy my anders sou hanteer... 'n meer konserwatiewe houding inneem...nie net aangaan met die verhouding vir jare nie* (Karla).

When Karla initiated their sexual explorations initially, she felt it was morally acceptable to be sexual as they were "in love". This is in line with scripts dictating and providing a framework for sexual behaviours, such as that falling in love provides justification for first intercourse (Simon & Gagnon, 1986, in Rosen & Leiblum, 1988). This is in accordance with Karla's experiences, but for her their continued sexual relationship did not correspond with her understanding of the socially acceptable norms.

Scripting focuses also on dimensions of inviting participation for sexual behaviour (Simon & Gagnon, 1986, in Rosen & Leiblum, 1988). There appears to be a mystical "correct" amount of times per week to have sex at a certain age (depicted in the media and popular literature) which Dora, Paula and Gwen referred to. Jana mentioned that her husband tried to find out "how many times" he could "expect" sex per week. She also indicated that she thought about three times per week is "normal" for some-one her age, whilst Dora thought once a week was the norm. Karla related that "according to the norm of people in their 40's have sex between one and four times a month", basing this statistic on "general knowledge". This knowledge is often based on articles in popular magazines prescribing sexual behaviour such as "*Dance your way to sexy self-confidence*", "*Let's talk about sex*", "*Love, sex and sport cars*", "*First time with a new guy? Get shag night right*", "*Red hot sex tricks to drive her wild*" and "*Speak her sex language. Magic wife decoder*" ("O"-magazine, 2008; Vogue, 2008; Cosmopolitan, 2008; Men's Health, 2008; Men's Health, 2008).

Briefly, scripts create expectations, which may contribute to disappointment in sexual experiences, which in turn may contribute to the lessening in sexual desire. These myths include the notion that all should know intuitively which particular ways in which sex should be performed, how frequently this should happen, how one should feel and respond. However, these vague scripts create confusion and misunderstandings, and it was indicated how this lead to misinterpretation between partners.

### 5.7.2 Comparisons with cultural group

Both Cathy and Paula said that often in social settings, both the men and the women tease and joke about sex or the lack of it. It is here amongst friends that “a common baseline” is often established. It becomes therefore quite common knowledge who has sex often, and who does not. Linda said that *all* her girlfriends do not want sex with their husbands, and they often joke about ways to get out of it.

Us girls are *all* the same...it is just the flippen men **do not** leave you alone...you **do not** feel like it now, you *do not* have the strength for it now, but they just keep on and *on* and **on**...my girlfriends are *all* on the same wavelength. There is just *no* desire for it whatsoever. The girls say “this is the *last* thing on my priority list”, and the men just cannot *understand* it!! (Linda).

*Ons girls is álmal dieselfde...dis net die flippen mans los jou nie uit nie...jy is nie nou lus nie, jy hét nie nou nie krag nie, maar hulle hou aan en áán en aan...my vriendinne is álmal op dieselde golflengte. Daar is net géén behoefte daaraan nie. Die girls sê “dis die lááste ding op my prioriteits-lys”, en die mans kan dit net nie verstaán nie!! (Linda).*

What Linda is describing is the apparent common phenomenon that women are expected to put their own needs as secondary to those of their husbands. Feminist researchers describe this as handing over of control to become sexual *objects*, i.e. denouncing “sexual agency” (Mansfield, 2006; Wood *et al.*, 2007). “Sexual agency” describes women’s ability to to act on their own wishes, needs and interests in terms of sexual decision-making and sexual behaviour (Wood *et al.*, 2007). Women internalise socio-cultural assumptions, which privilege men’s sexual needs, and relinquish control over their own bodies and sense of self to men (Mansfield, 2006). Therefore, like with Linda and Cathy, they are not being in charge of their own sexual choices but being “used” by men.

Whereas Linda’s friends concurred that they do not desire their husbands, Cathy expressed, “it amazes me that friends of mine still desire their husbands...I just can’t see how!”

Dora’s comparisons also surprised her and she exclaimed:

Mine is definitely lower than theirs – they have *no* problem. We have to talk about it. I do not know how they do it...Can you believe it!?! (Dora)

*Myne is definitief laer as hulle s’n – hulle het géén probleem nie. Ons moet daaroor gesels. Ek weet nie hoe hulle dit regkry nie....Kan jy dit gló!?! (Dora)*

Although social discussions about sex seemed to be a common occurrence amongst the participants, and not all of the participants found it equally light-hearted. Jana experienced it as excruciating when her husband brought up the topic of their sexual problems in company. He often gained the sympathy of others who would then collude with him in putting pressure on her regarding her “withholding” of sex. She was too embarrassed to explain the nature of the problem (namely the pain during intercourse, multiple infections) and he used their friends’ support to criticise her later.

At other times the comparison with other couples strengthens the woman’s arguments for avoiding sex. Due to her husband’s insistence, Linda and her husband have more frequent sex than their friends as she gathered from discussions, but he feels it is not yet enough. Many of her friends refuse sex for long periods of time and their husbands, due to sexual frustration, become quite pathetic and plead for sex. Linda does not want to humiliate her husband in this way, being aware that she has to accommodate his very high sex drive. She feels, however, that he should give her some credit for her efforts to provide in his needs:

He does not complain. He *did* a few times when I did not want to. Then I tell him...then I say “you don’t know how lucky you are! You don’t have a flippen coocin” clue – it does not have to be 24 hours a day and 7 days a week”, but he cannot *understand* why not! (Linda).

*Hy kla nie. Hy hét al ‘n paar maal gekla oor ek nie wil nie. Dan sê ek vir hom...dan sê ek “jy verstaan nie hoe gelukkig jy is nie! Jy het nie ‘n flippen koekin’ clue nie – dit hoef nie 24 uur per dag 7 dae per week te wees nie”, maar hy kan nie verstáán waarom nie! (Linda).*

In short, most of the participants attempted to test their “normalcy” on information provided in popular literature or on conversations with other people, in other words, on sexual scripts. The women and their partners compared themselves with others in order to establish whether they fell within the norm of sexual behaviour. The information gained as a whole was in accordance with their own experiences, in other words, other women mostly also do not want to have sex with their husbands.

### **5.7.3 Parental influence**

Karla’s conservative upbringing, and deep religious convictions in accordance with the doctrine of the conservative Dutch Reformed Church (where sex before marriage is frowned upon) caused feelings of guilt:

I felt guilty all the time for sleeping with him – like a bad girl. I felt all the time like a naughty woman (Karla)

*Ek het skuldig gevoel omdat ek by hom slaap – soos ‘n slegte meisie. Ek het heelyd gevoel soos ‘n stoute vrou (Karla).*

Interestingly, under these circumstances Karla had a high sex drive, in accordance with Money (1986) and Morin's (1995) notion that, paradoxically, the experience of negative feelings such as guilt and naughtiness could be powerful erotic stimuli. Karla's lack of desire followed only after the marriage, which she then attributed to other factors, such as hormones, anger, and her husband's lack of sexual skills.

Hawton (1985) noted that sex is a forbidden subject in many families, and children of those families may begin to associate sex with something shameful and wrong. The message is often portrayed that a "good" woman is not sexual, or is someone who successfully suppresses her sexuality. Such a woman is depicted as a suitable marriage partner as opposed to the "bad" woman who actively enjoys and seeks out sexual experience, who is perceived as "not the marrying kind". Karla internalised these concepts, and when her husband took seven years before he asked her to marry him, it caused in Karla feelings of frustration and despair, and entrenched her perception of herself as "a naughty woman", who was "not the marrying kind".

... I found it so uncomfortable when I started taking anti-depressants because of work stress, and also because of frustration because my husband did not want to marry me at the time ... which impacted very negatively on how I saw myself ... (Karla).

... ek dit so ongemaklik gevind het toe ek begin anti-depressante gebruik oor werkstres, en ook oor die frustrasie omdat my man nie daardie tyd met my wou trou nie ... dit het 'n slegte effek gehad oor hoe ek myself gesien het (Karla).

Paula was averse to masturbation as she was brought up to believe that it is "*wrong and sinful*", and Morin (1995:4) refers to the notion of "sex-as-sin" as rooted in the "pathology" model of which Freud has been a proponent. Kaplan (1974:174) referred to society's equation of sin and sex, so that in the child's upbringing the longing for sexual pleasure is denied, ignored or treated as a shameful thing, which is "*in general relentlessly assaulted with painful associations and consequence, especially during the most critical childhood years*". The child is taught to deny sexuality, and that it is "*dangerous, nasty, hostile, dirty, disgusting and immoral*" to give expression to sexual urges (1974:175). These repeated negative reactions to early sexual pleasure result in inappropriate control of sexual urges, and lead to conflict, guilt and alienation from sexuality, as was the case for some of the participants.

The citations corroborate the findings of Wood *et al.* (2007) that the overwhelmingly negative messages women receive about their sexuality influence their conceptualisation of

sexual desire. Sex becomes associated with negativity in repressive/conservative households. Sexual “double standards” are entrenched where-in men are freer to act as sexual agents whilst women who were in tune with their sexual needs and desires, incur social stigma and are viewed as “sluts” (Westheimer & Lopater, 2005; Wood *et al.*, 2007). The result is that many women distance themselves from the experience of sexual desire.

#### 5.7.4 Sex role stereotypes and gender differences

Of those participants who still have a sexual relationship with their partners, the majority indicated that their husbands wanted them to occasionally initiate sex. They *all* indicated that they do not ever initiate, and some said that if their husbands did not expect sex so frequently, they might have been able to get to the point of actually considering initiating. Linda put it very aptly:

If he says “but you don’t do anything from your side”, then I say “but I do not have the *time* to do anything from my side – you don’t give me a gap”! [laughs]...I do not have the privilege to be left alone long enough to see...[laughs] (Linda).

*As hy sê “maar jy doen niks van jou kant af nie”, dan sê ek “maar ek het nie tyd om iets van my kant te doen nie – jy gee my nie ‘n ‘gap’ nie”! [lag]....Ek het nie die voorreg om lank genoeg uitgelos te word om te sien...[lag] (Linda).*

As was noted in previous sections, Karla used to seduce her reticent friend, but since their marriage, she is disappointed that he does not take more charge in line with her expectations of a man. With Paula sexually taking the lead her partner felt offended as he expected her to be passive. The conventional heterosexual scripts emphasise female passivity and acquiescence to male initiation and direction (Rosen & Leiblum, 1988). Male scripts traditionally have highlighted the role of men being “*always available and desirous of sexual encounters, taking charge of orchestrating sex*” (Rosen & Leiblum, 1988:170). Ignorance about initiating, pacing or shaping sexual activity contributes to sexual difficulties (Verhulst & Heiman, 1988).

Quite the opposite with the findings about men’s sexuality, the participants indicated that they themselves, in contrast with their partners, would be able to go without sex either “*for a long time*” or even “*forever*”. Levine (2002, 2003) supported the perception that female sexual desire is weaker, more easily suppressed by circumstance, and fluctuates in response to the menstrual cycle, pregnancy, menopause, and fatigue.

The majority of participants indicated that their husbands had a higher sex drive, as is supported by many researchers such as Kraft-Ebing (1886, in Regan & Berscheid, 1999:56),

Kinsey (1953), Kaplan (1979), Bancroft (1989) and Leiblum (2002). Levine (2002, 2003) concurred that men's drive is more reliably present and intense. In accordance with this norm, Berta expected her husband to have a high sex drive; therefore she perceived his low drive as a rejection and in turn got even by withholding avoiding sexual encounters from him. Tiefer (2001) and Hicks (2005) described also the sexual avoidance that may follow the perceived inability to meet cultural norms regarding "correct" sexuality.

Linda, Jana, Cathy, Berta and Karla remarked that their husbands did not approach them in the "correct way" in setting the scene for sex, or in the way the husband orchestrated the sex act. Karla described frustration with her husband's poor sexual skills and premature ejaculation, and this points to the mistaken assumption that men should be an expert on sex in giving the woman sexual satisfaction (Barbach, 2000), giving rise to unrealistic expectations, as men do not 'naturally' know how to perform this act (Tiefer, 1995). It follows then that if the couple don't openly communicate how they can evoke each other's sexual desire with seduction rituals, the problems will worsen (Verhulst & Heiman, 1988; Wood *et al.*, 2007).

Paula, Cathy, Karla and Linda described their partners' insistence on sex despite their own hesitance, which support studies that found that men and women have different orientations towards sexuality. From their descriptions their husbands tend to engage in sex for pleasure. The participants took a far more serious view and stressed the importance of improved emotional intimacy as part of the aim of sexual intercourse (as per Regan & Berscheid, 1996, 1999; Tallis, 2004; Træn *et al.*, 2007). Linda noted that her husband seems to be focused on her genitalia, and not on her as a person:

...the rest of my body does not exist....It is the only parts that he cares about! (Linda).  
... die res van my lyf bestaan nie.... Dis die enigste plekke wat vir hom saakmaak! (Linda)

Most participants indicted that they were not open to sex whilst not in the right emotional space for it. Anna said:

... for women there always is an emotional component also. Men are quite capable to feel the desire, have a "quickie", and get on with it...and don't feel a sense of betrayal as such. (Anna).  
...vir vrouens is daar altyd 'n emosionele komponent ook. Mans is heeltemal in staat "to feel the desire, have a quickie, and get on with it...and don't feel a sense of betrayal as such" (Anna).

Women concentrate on the emotional closeness (that comes with the “cuddling”) more so than on the sex act itself:

I cannot go without the physical contact – I find it pleasurable and very important, **VERY** important. The penetration is not important to me (Linda).

*Ek kan nie sonder die fisiese kontak gaan nie – dit is vir my lekker en baie belangrik, **BAIE** belangrik. Die penetrasie is nie vir my belangrik nie (Linda).*

This citation point to another difference mentioned by Linda, and also Karla and Jana, that women desire and yearn for physical intimacy *without* taking it to the sexual level like their partners inevitably do. Gwen said in this regard:

...the desire can overwhelm men much more easily than women... (Gwen)

and added that men seem to “lose their senses”, while “women desire more carefully”.

Other differences mentioned was that Paula and Berta both related that men seemed to be more visually stimulated, for example looking at breasts, magazines, or how a women dresses. Gwen thought that men’s “bodily responses” happen quicker for men than women, and those men react more easily to visual stimulation. The participants’ experiences are supported by researchers such as Kinsey (1953), who found that women are far less responsive to all forms of psychosexual stimulation, including fantasy, imagery, and visual erotica. Men are more susceptible to pornography, prostitution and paraphilias, and found varied sex practices more appealing than women (Leiblum, 2002). Leiblum and Rosen (1988) concluded that women are less likely to focus on erotic imaginary between sexual encounters, and seem to be less sexually aware or desirous than men. Nonetheless, recent anecdotal evidence suggests that at least *some* women do in fact respond strongly to fantasy (Friday, 1973; Ogden, 1999), as did some of the participants.

In brief, there seems to be differences in the way the genders approach sexuality. Moreover, scripts play an important part in the shaping of the individual’s views of the appropriateness of sex roles, and create expectations that at times are unrealistic. Men are generally seen as the sexual predator, and the women having to assume the more passive role. Sex for men can be fun-filled but not for women. It is clear that the experience of the participants is that men and women are different in their approaches and experiences of sexual quests.

In the next section the role of circumstances in the participants’ experience of sexual desire will be illustrated.

### 5.7.5 Contextual factors

Paula mentioned that other environmental factors enhance her experience of desire:

... lots... like when it is a beautiful day... or a cold day, and he wants to stay in bed. And also when I think he looks nice...humour, nice personality...and when I drink alcohol! When I drink and am social... I sometimes drink too much! But then I am open to a lot of things! For me the flirting is more sexual... the flirtation, the thoughts, to tempt the men... the strategies... *that* causes me to desire! (Paula).

*...baie...soos wanneer dit 'n mooi dag is..of 'n koue dag, en hy wil in die bed bly. En ook as hy vir my mooi is...humor, nice persoonlikheid...en wanneer ek alkohol drink!. Wanneer ek drink en sosiaal is... en somtyds drink ek te veel!. Maar dan is ek oop vir baie dinge! Vir my is die flirting meer seksueel...die flirt, die gedagtes, om mans uit te lok...die planne...dít maak my lus! (Paula).*

What Paula described is in accordance with Basson's advice that in longer-term relationships it is necessary for the woman to try to find other stimuli to evoke sexual desire (Basson, 2002) as spontaneous desire is lacking. These stimuli include aspects of conquering, mystery, novelty and the unexpected, (Morin, 1995; Perel, 2007) to evoke eroticism and desire.

Apropos to this notion, Theresa also described her inclination to "provide" sex (even without desire) when things are beautiful, like when in beautiful surroundings "with white linen, cold white wine, and candles burning". Regan and Dreyer (in Regan & Berscheid, 1999) indicate that physical settings or circumstances (such as soft music, candlelit dinners, or erotic scenery) may incite sexual desire, or the willingness to behave in accordance to the desires.

Equally Jana mentioned candles and music to create a romantic atmosphere causing her to be more open to sex. Tallis (2004) suggested that candlelit dinners might hide imperfections such as facial asymmetries, which would heighten the chance for a sexual attraction. Karla in turn enjoys going away for weekends where she finds that in the relaxed surroundings that she is more inclined to engage in sex (although not necessarily due to desire). She described the renovations to their house, and their home being in disarray, as off-putting, and unromantic, and contributing to her experience of lack of desire. Research by Wood *et al.* (2007) found that women noted that a romantic setting could turn them on sexually, whereas an unpleasant setting (e.g. a smelly room as opposed to a beautiful setting) could turn them off, as was described by the participants.

Paula mentioned that her eldest daughter's visit from overseas provides her with a good excuse to avoid sex, as there is "another adult in the house." Her statement of her daughter's

visit, reminds of Delvin (2005) who found in his research that couples that live under the same roof as parents, sleeping on squeaky beds, adjacent to the women's in-laws, only separated by a thin wall, contributed to loss of sexual desire. As Levine (2002) indicated, women have more sporadic and less intense desires, which is more easily repressed or ignored if other conditions are not met, while men's desire is more readily accessed through a large variety of external and internal prompts.

In summary, it is clear that the negative messages relayed during upbringing, the unrealistic expectations raised by social scripts, and socialization affect women's desire. Comparisons with their cultural group highlight the prevalence of low desire in women towards their partners.

In conclusion, this chapter analysed the data as transcribed from the interviews with the ten participants. The whole process of the research was determined by the account given by the participants and their voice was central to the development of theory (Shaw, 2001). Both the subjective experiences and contextual factors were highlighted as the seven main themes emerged from the data.

## **5.8 REVIEW OF THE SEVEN THEMES**

### **5.8.1 Perceptions of desire**

All of the participants found sexual desire to be a complex and multifaceted construct.

Even though sexual desire is strongly linked to biology, it is not only a physiological drive, and cannot be seen separately from the psychological aspects. It was established that it seems that desire and arousal overlap in the experience of respondents, as is indicated in literature. Desire has quantitative and qualitative dimensions – high and low, and different ways of experiencing desire. Desire and sex is not the same thing – the one can manifest without the other. Desire can be spontaneous (a more biologically based drive) or responsive (as a reaction to stimulation), and has many components, such as biological, physiological, emotional and cognitive.

### **5.8.2 Experience of sexual desire**

The respondents unanimously reported that, although they do not experience sexual desire towards their partners at present, they desired them and/or other men in the past. Most of them presently have strong feelings of desire towards lovers or other men. This aspect touches on the complexities of eroticism and what individuals find attractive and desirable. Factors such as flirtation, playfulness, mystery, novelty, conquering, the lover not being readily available, and highly charged emotions such as guilt, were mentioned that come into play for evoking sexual desire. This strong sexual desire was thus ignited by something about the particular lover/affair. This pointed to the highly complex nature of desire combined with the human factor involved.

### **5.8.3 Sex life without sexual desire**

Some participants felt powerless to negotiate their own right not to be sexual. In this regard they appeared to conform to a sexual double standard of women providing for men's needs, whilst overriding their own.

Some participants explained their experience of engaging in sexual relations when they had no desire to do so. Mostly these experiences were described as unpleasant and unwanted. They developed mechanisms to cope with the events ranging from avoidance, to escaping into fantasising, to being frivolous or "grinding their teeth", faking orgasm and wishing it over. The notion that desire can follow after the person engages in sexual activity is not substantiated by the findings of this study. In short, none of the participants enjoy sex with their husbands, and the stimuli/attractions needed for the evocation of desire are either absent, or the individual chooses not to tap into them.

The participants pointed out reasons for still participating in sexual relations even though they do not experience the need or inclination to do so. It is apparent that the occurrence of sexual activity does not imply the desire for sexual activity, and that the respondents agree to sex for a multitude of other reasons such as feelings such as guilt, sympathy, feelings of obligation and needing to provide for the needs of their partners. This was in accordance with Levine (2002; 2003), and the experiences of the participants indicate that the occurrence of sexual activity does not necessarily imply the desire for sexual activity (Leiblum & Rosen, 1988).

Some participants refuse sex, but others mentioned that they still agree to sex for a variety of reasons. These include so that the partner would not insist on sex for a while, others because of feelings of pity or guilt, to compensate, a sense of obligation, in order to meet the partners' needs, to compromise and meeting some other needs other than sexual needs such as affirming love, for intimacy or in an attempt to revive lost desire. These findings correlate with these research observations that people engage in undesired sexual activities for a multitude of reasons such as to please their partner or to avoid rejecting their partner's advances, to prove that they care, to express feelings of closeness, to avoid hurting their partner's feelings (e.g. Beck *et al.*, 1991; Regan, as cited in Regan & Berscheid, 1999; Tiefer, 2001; Wood *et al.*, 2006).

#### **5.8.4 The impact of low desire on self and/or relationship**

The majority of the participants were adamant that the experience of having no sexual desire caused them *no* distress and that they in no way felt abnormal for it. Others did say that this caused them discomfort on a personal level, and they mentioned feelings of sadness because of the loss of something that were experienced before as good at some time in their lives, or which was seen to be the ideal. Overall, their levels of distress were minimal about the lack of sexual desire, and where distress was experienced, it had more to do with the loss of the emotional connection that should or could accompany sex.

Most of the women indicated that their husbands accepted their disinterest in sex. This must be seen in view of the continued sexual experiences, and that the men do not necessarily know the extent of their wives' aversion, and unwillingness, also because enjoyment is faked. Therefore, most of the men in this study still have regular sex due to their wives' compliance.

Some of those participants who refuse sex experienced relationship problems because of it, as it evoked feelings of disappointment, anger, or rejection and hurt by their life-partners. Even so, most of the relationships were still intact, and very fulfilling in other ways, and the lack of desire did not seem to have had a hugely negative impact. Even in the case where marriages were celibate for many years, the husbands chose to remain within the marriage.

Many the participants and their partners compared their sex lives with friends, or were aware of social scripts in this regard. These comparisons at times made them feel “just like everybody else”. In comparison with friends who were perceived to be sexually active, feelings of envy, failure, or even surprise were raised. Still most of the participants did not feel abnormal, or that anything was wrong with them as they could mostly normalise and explain their lack of desire for their partners.

#### **5.8.5 Personal reasons for decline in sexual desire**

In attempting to understand and explain their lack of sexual desire, the participants considered both physical and psychological factors. Indeed, none of the participants was able to identify one factor that could alone explain their lack of sexual desire. Literature supports the wide spectrum of reasons for the decline in sexual drive and that sexual desire is a complex phenomenon.

With respect to physical factors, participants mentioned the possible role of hormones but none considered this as a major cause for her diminished sex drives. Medical conditions were also contemplated, in particular the adverse side effects of anti-depressants. Health problems and lack of attraction as a factor of ageing were also considered as possible reasons for the decline in sexual drive, and some respondents’ experiences correlated with the literature in this regard. Other health problems that were considered included thyroid problems and complications after birth, but again these were not regarded as major factors in their lack of desire.

The participants afforded more weight to psychological factors as contributors to low sexual desire than they did to physical factors. The debilitating effects of negative messages by parents and/or sexual abuse were indicated as factors contributing to sexuality. Emotional state and self-esteem were also seen as major factors affecting their openness to sexual experiences. Life stage and circumstances, such as the daily responsibilities of women, work stress, and the effect of childbirth were also cited as affecting availability and responsiveness sexually.

### 5.8.6 Relationship factors impacting on sexual desire

The importance of interpersonal aspects of sexual desire disorders have been recognised since the earliest works on the topic (Kaplan, 1979). Stuart *et al.* (1987:93) noted that as sexual desire is most often directed towards another person it is very much part of relationship. In this regard, DSM 1V TR (2000:540) states that individuals who have sexual desire disorders “*may have difficulties developing stable sexual relationships and may have marital dissatisfaction and disruption*”.

From the array of factors mentioned which negatively impacted on the participants’ already dwindling desires, whilst their husbands purportedly continued to experience strong sexual desire, it became very clear that women’s desire is more easily repressed or ignored if other conditions are not met. Women also indicate less intense desires, while men’s desire is more readily accessed through a large variety of external and internal prompts, as was found by several researchers such as Baumeister, Catanese & Vohs (2001) and Levine (2002).

In this study, some of the participants were not passionately in love with or sexually attracted to the men they married, but found their husbands more attractive/appealing with time. Participants who expressed great adoration, love or respect towards their husbands did not necessarily desire them sexually. Other participants were sexually attracted to their husbands initially but this attraction faded over time. When in love, most participants experienced desire. For some there was a correlation between physical attraction and desire, and for others not, and some indicated being attracted and desirous of unattractive men. Others who have good solid relationships presently, the nature of the relationships have changed to lose its romantic character, and the resulting platonic or companionate relationship did not lend itself so easily to evoke desire. The issues remain complex and paradoxical, as a good, intimate relationship is often accompanied with decreased sexual desire (Snarch, 2000; Perel, 2007). The aforementioned writers point out that separateness, not emotional fusion is needed as too much closeness impedes desire. Morin (1995) and Perel (2007) note that to maintain desire and attraction, elements of elusiveness, teasing, longing and naughtiness are needed, which is often lost in the longer relationship.

It was found that even though many participants describe a “good” marriage, this did not result in sexual desire. Interpersonal behaviours such as conflict, disrespect, alcohol abuse and rudeness were described as eroding participants’ sexual desire for their partners. The

women are all in long-term relationships and it was pointed out that there is a lessening of desire in long-term relationships. In relationships that are unsatisfactory, the sexual desire lessened, but the contrary is also applicable – even in satisfying relationships the participants lost their sexual desire towards their husbands. They all described having discrepant desire in their relationships – most husbands still demanded sex, whilst the participants had no desire for sexual intercourse. Control-issues were highlighted, and some participants consciously or unconsciously use their low sex drive to regain control in relationships where they feel disempowered. Conflict impacted negatively on partners' connectedness and resultantly the women's openness to experiencing sexual desire. Lastly the effect of disappointing sex due to the partners' poor sexual techniques yielded insights.

### **5.8.7 Sexual desire within the socio-cultural context**

In this last section the role of scripts and meaning within context of contemporary culture were described. "Script" refers to the cognitive framework that guides the planning, coordination, and expression of social conduct generally, including sexual behaviour (Rosen & Leiblum, 1988). Scripts provide the cognitive organisation of sexual interactions, defining the situation as sexual, naming the actors, and directing the behaviour. Scripts also determine the circumstances under which sexual activity is to occur (the "when and where"), the range of sexual behaviours (the "what") and the motives in sexual interactions (the "whys"), functioning like a "blueprint" or a "recipe". This "code" directs sexual actions and anticipation of the partner's response (Regan & Berscheid, 1999).

The participants indicated that their childhood upbringing had an impact on the way they viewed sexuality and experienced sexual desire. Messages from home and from society as a whole were found to be particularly negative about female sexuality, and the message is given that it is not appropriate to desire or enjoy sex, resulting in denial of the right to expect desire or pleasure. Negative messages were also associated with religious views that sex is "sinful" and shameful, which contributed to the hesitance to discuss sexual matters. Moreover, scripts endorse sexual double standards for men and women, in prescribing that men may engage in sex for enjoyment, whilst women who do so are viewed in a negative light.

All the participants were in their middle-years, and to some extent affected by the views that older people are expected to be not participating in sexual relations, as desire is seen as the privilege of the young and beautiful. Changes in their bodies lead to feelings of being less attractive, and indirectly impacted on their desire.

The participants were also exposed and subjected to scripts about the “right” way to have sex and the “right” feelings to have. This resulted in many of the participants having expectations of their partners to intuitively know how to please them sexually as if this knowledge came naturally to men, leading to frustration and disappointment. Other expectations included a particular frequency of sex, about the “right” feelings to have around sexual issues, including to experience desire, enjoyment and an orgasm, and it was indicated how this notion accounts for the participants’ tendency to fake orgasms. The role of popular media in creating expectations was highlighted.

The analysis highlighted the differences in the sex roles and of the genders’ approaches to sex. Generally speaking, men are seen to have a higher sex drive, and have sex for pleasure and recreation. Women in contrast, have sex for love and for relationship goals. Women are supposed to be passive recipients of sex, and to always be available whilst men are seen as the initiator of sex. We have seen how these scripts and gender role expectations lead to misunderstandings between the partners.

Lastly, the role of the immediate environment was explored, and it was pointed out how certain conditions enhance desire, whilst others lead to the suppressing of desire.

The final chapter in this dissertation will present an overview of the study, summarise the findings, and present the conclusions and recommendations of the study. Based on the experiences of women who present with low sexual desire in their relationships with their partners, recommendations will be made to the practitioner with regards to gaining an understanding into the phenomena and intervention strategies. Directions for further research will be given.

## CHAPTER 6

### CONCLUSIONS AND RECOMMENDATIONS

#### 6.1 INTRODUCTION

The research question for this study is “*How do women themselves experience low sexual desire?*” The purpose of this study was to gain a better understanding of the subjective experiences of women that present with low or no sexual desire, in their cultural and social context. Low sexual desire is a prevalent issue, which regularly presents itself at practitioners’ offices, but which has as yet not been extensively researched in South Africa. In this study, therefore, I aimed to understand how the participants themselves experience the phenomenon, and to gain insight into the role of society in stipulating how women “should” behave in order to be viewed as “normal”. I then used the understanding gained in the local context, in combination with insights on the issue from the international literature, to provide guidelines for practitioners for its management should it arise in therapy.

The specific objectives of the study were:

- to provide an overview of sexual response models and of sexual dysfunctions;
- to provide an overview of the factors affecting sexual desire;
- to explore women’s experiences of sexual desire in marriage or partnership;
- to establish whether women experience marked distress or interpersonal difficulties arising from their experience of low desire;
- to examine the meaning of low sexual desire within contemporary culture;
- to place the implications of the findings in context for the practitioner.

In this chapter, I present a brief overview of the study, indicating the effectiveness of the methodology in meeting the objectives. I summarise the literature on normal and abnormal sexual responses to provide a therapeutic context for those findings, and then summarise the main findings of the interpretative phenomenological analysis, and the conclusions drawn there from. Thereafter, I discuss the implications of the research findings and conclusions for health and counselling practitioners, and make some recommendations for their treatment. I conclude with recommendations for further research, as advised by Willig (2001).

### **6.1.1 Overview of the study**

A qualitative research approach was chosen for the study because of the goodness of fit between qualitative methodology and the goal of this study. I identified ten participants and interviewed them using semi-structured interviews. The interviews were audio taped and transcribed for interpretative phenomenological analysis. I focused on the uniqueness of the participants' experiences, how their experiences were made meaningful, and how these meanings manifested themselves within the context of the person both as an individual and in their many roles, such as spouse, mother or friend. The analytic technique aimed at providing an in-depth understanding of both the idiosyncratic and culturally constructed aspects of the person's life-world (as per Shaw, 2001). In this analysis I attempted to make sense of the accounts I collected, by engaging in an interpretative relationship to the transcript (as per Smith, 2003).

The next section deals with meeting the first objective of the study, namely providing of an overview of sexual response models and sexual dysfunctions.

## **6.2 SYNOPSIS OF THE RELEVANT LITERATURE**

The framework of sexual response models and an overview of sexual dysfunctions were provided in the literature reviews in Chapters 2 and 3, and are summarised here. Much of the controversy surrounding women's sexual desire and its treatment is encapsulated in the debate over its conceptualisation and definition.

In the early models of human sexuality as developed by Masters and Johnson (1966), and Kaplan (1979), the male experience of sexuality was used as the standard (Tiefer, 2000) and sexual desire was conceptualised as spontaneous sexual thoughts and biological urges (Schwartz & Masters, 1988; Kaplan, 1995). The further assumption was that the amount of genital contact was an indicator of sexual desire. These models suggested that sexual experiences followed a linear pathway with each phase being a precursor to the next being the "correct" way to have a "normal" sexual experience.

The early models were widely criticised for using male sexuality as a standard for normal human sexuality (Tiefer, 2000), and furthermore for giving biology and physical changes undue emphasis, thereby neglecting the influence of psychosocial factors (Wood *et al.*, 2006).

These criticisms have been supported by recent research, which indicates that women do *not* necessarily experience spontaneous desire or a linear progression of sexual phases, and are more motivated for sex by other factors such as a desire for emotional intimacy. Furthermore, sexual desire may only manifest *after* a woman is involved in sexual activity (Basson, 2002). Recent research findings point to the greater importance of factors *other* than sexual desire, such as interpersonal relationships and socio-cultural environments, and on women's willingness to engage in sexual activities (Breznyak & Whisman, 2004). Correspondingly, recent studies (e.g., Wood *et al.*, 2006) indicate that women's unique experiences of desire are best explored by tapping into women's lived experience, illustrating important differences to that of males' experience.

From a clinical perspective, the conceptualisation of human sexuality is important as it forms the basis of the DSM-classification, which is the basis for diagnosis of sexual dysfunctions. The diagnoses in the DSM pertaining to sexual desire and sexual desire disorder have tended to track the developments in the conceptualisation of human sexuality. As such, the DSM has been subjected to many of the same criticisms, including that its diagnostic criteria were male centred, ignored subjectivity and meaning (Tiefer, 2001:90), promoted the false notion of sexual equivalence between men and women, and neglected age, cultural and relationship differences between women.

In the latest edition of the DSM-1V-TR (2000), in cognisance of some of the criticisms levelled at earlier versions, the definition for Hypoactive Sexual Desire Disorder was altered to include the criterion of "personal distress". It was hoped that this criterion would prevent the classification of someone as "dysfunctional" when they themselves did not feel concerned about their level of desire.

In response to the short-comings of the DSM-1V-TR (2000), the New View classification system of sexual problems was proposed in 2001 (Hicks, 2006). This defined sexual problems as "*discontent or dissatisfaction with any emotional, physical, or relational aspect of sexual experience*", and no aspect of sexual functioning, such as desire, was singled out (Tiefer, 2001:91). The New View classification system also recommended that the term "dysfunction" be replaced with the term "problem" (Hicks, 2006) in an effort to acknowledge the multifaceted nature of sexual relationships and to move away from the biomedical model. Four comprehensive and interrelated areas were defined as the major contributors to women's

sexual problems, *viz.* socio-cultural, inter-personal, psychological and medical. Each of these has been supported by research findings and/or clinical practice (Chapter 3), including the results of this study, which highlight the plethora of factors impacting on the sexual desire experienced of women.

Subsequent to the New View classification system there were further revisions proposed by the International Committee of the American Foundation of Urological Disease, which incorporate more contemporary categories of women's sexual dysfunction (Basson *et al.*, 2005), but these are a work in progress. Their key features include criteria to account for a lack of responsive desire, which highlight the notion that sexual desire is a *receptivity/willingness to choose* to experience sexual stimulation because of awareness of the rewards that sexual intercourse may bring. The point being that women may not be receptive to disappointing love-making experiences, but that this should not lead them to be classified as "dysfunctional". Indeed, lack of desire may often be a normal and appropriate response to a particular situation (Basson, 2005).

Since many of the diagnostic criteria hinge on whether or not a woman is, herself, uncomfortable or distressed by her lack of sexual desire, consideration of the pressures of society in defining a woman's views on what constitutes "normal" and "dysfunctional" sexuality are extremely important (after Wood *et al.*, 2006). This is true, if for no other reason, because women who view themselves as dysfunctional are far more likely to be distressed than those who consider themselves (and their sexual responses) to be normal.

Since the successes of Viagra for men, the focus of the pharmaceutical industry has turned to finding an equally lucrative drug to treat female "dysfunctions", which has led more than one researcher to question whether there was indeed a problem for which a remedy could be found, or if was more a case of a product in search of a disorder (e.g., Tiefer, 1995:269).

Certainly, in having reviewed the literature and in analysing the results from this study it became clear that sexual desire is an exceedingly complex form of sexual motivation and aspect of human life (after Leiblum & Rosen, 1988:vii; Schnarch, 1997:134). The following section is a summary of the findings and conclusions of this study.

## 6.3 PRÉCIS OF THE FINDINGS AND CONCLUSIONS

The results of the empirical study presented in Chapter 5 explore the participants experience of sexual desire in marriage or partnership, the meaning of low desire for them personally and for their relationships, and their experience thereof within their particular social environment (contemporary culture), furthering the objectives of the study.

Seven themes emerged from the analysis, namely:

- Perceptions of sexual desire
- Experience of sexual desire
- Experience of sex life without sexual desire
- Impact of lack of desire on self and/or the relationship
- Personal reasons for decline in sexual desire
- Relationship factors impacting on sexual desire
- Sexual desire within the socio-cultural context.

Conclusions and recommendations will be based on the findings of the empirical study.

### 6.3.1 Perceptions of sexual desire

It was found that the concept of “sexual desire” was difficult to define and the women’s interpretations thereof were often unclear. Attempts to describe the presence or absence of sexual desire were complicated, which remained a theme throughout the study. Furthermore, the individual understanding of “low” or “high” desire were arbitrary and depended on a wide array of factors, including (but by no means limited to) the state of the partnership, the age of the woman and life circumstances. In explaining their perceptions of sexual desire, most participants agreed that it was the product of both physical and psychological factors (after Levine, 1987; Bertram, 2000), although it was evident that for women the *emotional components were of greater importance*.

The findings indicate that for women sexual desire cannot be distinguished from sexual arousal as these phases overlap (Levine, 2002; Basson, 2005). Desire implies the wish to attain a sexual object, whilst arousal has to do with the awareness of physical and genital responses: they can coincide, but sexual desire does not depend on genital reactions, whilst arousal does. Whereas for men genital engorgement is easily detected, women may be

unaware of physical/genital arousal, (subjective sexual arousal) and therefore accordingly might report a lack of feelings of “desire” (Basson, 2002b).

In accordance with literature (Kaplan, 1995; Levine, 2003), the women indicated that that sexual desire manifests with different intensities and qualities depending on the situation. Also, sexual desire might be experienced as a general state, or be specifically directed at a particular person.

The occurrence, or not, of sexual activity does not imply a desire for sexual activity. Findings indicate the importance and need for physical and emotional closeness (*without* penetrative sex). The results indicate that many of the participants engaged in sexual activities for a multitude of reasons *other* than having sexual desire (in accordance with research, e.g., Leiblum & Rosen, 1988b; Tiefer, 2001).

A significant finding was the evidence of the awareness of the *difference* between *spontaneous/innate desire* and desire ignited *after* the sex act had commenced (*responsive desire*). Without exception, the participants reported that they lacked spontaneous desire for their partners (as did for example Schnarch, 1991, 1997; Perel, 2007), and when reporting responsive desire (after Basson, 2004), it was not in response to their present partners. Finally, women’s experience of desire is distinctly different from that of men’s, inasmuch as women’s desire is most often ignited after sexual stimulation, if at all.

Based on the findings the following *conclusions* were reached:

It was evident that sexual desire is an extraordinary complex construct, which is difficult to conceptualise. Desire has both physical and emotional components, of which the latter is more important to women. Furthermore, the experience of sexual desire and sexual arousal is indistinguishable. It can be concluded that the incidence of sexual activity does not correlate with sexual desire, as many women partake in sex without sexual desire as they do not experience desire, (either spontaneous or responsive), towards their partners. Lastly, it can be concluded that the need for emotional and physical closeness is of greater importance to women than penetrative sex, and that this need inadvertently at times may lead to sex.

### 6.3.2 Experience of sexual desire

The participants all had histories of strong sexual urges as teenagers and young adults (as per Kaplan, 1979; Levine, 1987). It was found that in the early stages of their relationships they had a strong sexual desire for their partner and enjoyed frequent sex (compare Schwartz & Masters, 1988; Levin, 2002). All, however, reported a decline in their sexual desire towards their partners over time, despite the fact that most sustained positive and loving relationships with their partners. This decline in sexual desire in long-term relationships is gradually being recognised as a “normal” occurrence (Baumeister *et al.*, 2001; Levine, 2002; Schnarch, 1991, 1979; Money, 1986; Morin, 1995; Kaplan, 1995; Basson *et al.*, 2005; Perel, 2007). Even though the participants mostly sustained positive and loving relationships with their partners, it was evident that this did not culminate in sustained sexual desire, contrary to other research findings (e.g., Breznsnyak & Whisman, 2004) suggesting that sexual desire only wanes if the relationship is poor.

Somewhat surprisingly, it was found that more than half of the participants had had, or were having, extra-marital affairs in which they experienced passionate and lustful sexual urges, in stark contrast with their total lack of desire towards their husbands. Hence, their lack of desire was specifically towards their partners, as they found *other* men desirable. It was evident that their lustful feelings had little place for “moral sensibilities” (Levine, 2003:283), as they disregarded their otherwise reputable middle-class values in their pursuit of these affairs.

Moreover, the women revealed that when they have had, or still did engage in, sexual relations with their partners, they fantasised about *other* men. Most also reported a vivid fantasy life to which they masturbated (see Friday, 1973, for verification of women’s erotic fantasies). So, in short, *whilst the women do not have any desire towards their own partners, they do experience desire towards other men.*

Based on the findings the following *conclusions* were reached:

While a woman’s sexual desire towards her partner may be strong and spontaneous in the early stages of the relationship, sexual desire decreases with time to the point of no desire. This, however, does not mean that the woman does not experience sexual desire at all, as the lack of desire is specific to her partner, and she often continues to experience strong sexual desire for men *other* than her partner.

### 6.3.3 Experience of sex life without sexual desire

It was established that a majority of women turned down the sexual advances of their partners, but often their partners still pressurise them into sex. It was evident that many of the participants engaged in sexual relations with their partners even without desire to do so. This accords with findings that 97% of women engage in sex without desire (Levin, 2002). It was found that some women do not perceive it as their right to refuse sex, and regarded their partners' needs more important than their own (as according to the findings of Herbst, 2006; Wood *et al.*, 2006).

The participants described their unwanted sexual experiences in *varying degrees of offensiveness*. Some coped by fantasising, some by keeping sex light and less intense, and others simply hoped it would be over with quickly. Some of the women experienced the sexual encounters as merely boring, or unpleasant and anxiety provoking, while others found the sexual experience offensive and repulsive. It was evident that, at most, the women tolerated the experiences, without deriving any pleasure. The results suggest that a higher percentage of women in this study did not derive pleasure from sex than indicated by other studies (for instance by Levin, 2002, who concluded that 20% of women gained no pleasure from sex). This may well be because the women in this study were referring specifically to sex with their long-term partners, as they did report pleasurable sex with lovers.

The participants provided a wide *variety of reasons for engaging in sex* that they deemed to be undesirable and unpleasant, including love, power, commitment, to please the partner and guilt about sexual infrequency (supported by Beck *et al.*, 1991; Levine, 2002, 3003; Weeks & Winters, 2002; Tiefer, 2001). Participants submitted to sex so that their partner's would leave them alone for a while; because they felt pity, obliged, or felt a need to compensate their partner for their financial support. One woman felt that she was "prostituting under another name". Some saw sex as the husband's right not to be deprived of sexual release, although there are no recorded adverse physical affects to sexual abstinence (Everaerd & Laan, 1995). A few of the women mentioned occasionally engaging in sex for self-gain, (i.e., fulfilling their needs for intimacy or to affirm their sexuality). However, by far the most frequent motivation to have sex was based on their perception of their partners' needs (Leiblum & Rosen, 1988; Beck *et al.*, 1991), rather than their own.

It was therefore evident that, for those who still partook in sexual activities with their partners, there was an *active conscious decision* by the women to be sexual, or to be open to sex, for a multitude of reasons, rather than experiencing sexual desire leading to sex. Basson (2005) pointed out that when women do not experience spontaneous desire, they might become “willing” to experience sex, for the secondary gains of an emotionally satisfying outcome. But, in this study, the women did *not* experience the increased intimacy and sexual gratification they were supposed to derive from sex. Furthermore, the notion that women, when willing or open to sexual advances, and would react to sexual approaches by arousal and responsive sexual desire (Hawton, 1985; Goldmeier, 2001; Basson, 2005) did not hold true for these women. This last aspect speaks directly to diagnosis and classification of the problem, which emerged as one of lack of responsive desire (Goldmeier, 2001).

Importantly, as indicated in the previous section, many of the women desired, and fantasised about, sex (albeit not with their partners), which would rule out the DSM-IV-TR diagnosis of Hypoactive Sexual Desire Disorder. In terms of a DSM- diagnosis, the results of this study point more towards features of Sexual Aversion Disorder, which include recurrent avoidance of all/almost all sexual contact with a sexual partner. Of importance is the supporting finding that these women derived no pleasure from the sexual encounters with their partner, which suggests the more accurate ICAFUD diagnosis of Sexual desire/interest disorder that includes *lack of responsive desire*.

Based on the findings the following *conclusions* were reached:

Whereas women within a long-term relationship experience sex as distasteful, only a minority believe that it is their right to refuse sex. Most women feel disempowered to negotiate their right *not* to be sexual, or are swayed by their partners’ needs rather than their own, and thus tend to engage in sexual behaviour without the desire to do so. Furthermore, the conclusion was reached that women often make a *conscious decision* to be willing to engage in sex, based on a plethora of reasons unrelated to their own innate sexual desire. Sex is then tolerated with degrees of emotional resistance, and is experienced as derived from physical pleasure or emotional enjoyment, and at times with extreme aversion /repulsion. Various coping mechanisms are employed when engaging in sexual activities under duress, and their sexual experiences therefore point to a *diagnosis of ‘lack of responsive desire’*.

### 6.3.4 The perceived impact on the individual or the relationship

The clinical diagnoses of Sexual Desire Disorders include manifesting “marked distress” on a personal level, or experiencing “interpersonal difficulty” because of its occurrence (APA, 2000:539). The majority of women were, however, not markedly stressed about their lack of sexual desire, nor did they feel “abnormal”, particularly since most of them had experienced sexual desire in the past and many desired men other than their partners. Most viewed their lack of desire for their partner as an appropriate response to a particular situation (for example, the partner being a poor lover or overly critical). Evaraerd and Both (2001) stated that it must be comforting for people to know that finding sex unimportant is not necessarily unhealthy.

It was found that some women, who had initially experienced distress over their lack of desire, did so because they perceived themselves as being “the problem” and thus to blame for experiencing dyspareunia or vaginismus. However, once they gained an understanding of their partners’ contribution towards their lack of desire, these feelings of distress abated. At most, it was found that there is a level of discomfort of having discrepant desires resulting in undesired sexual experiences, and a perception that it simply would have been easier if both the partners felt the same about sexual intercourse. The experience of feelings of loss and sadness for missing out on the sexual experience cannot be described as “marked” distress (APA, 2000). However, participants indicated physical and emotional closeness as of vital importance to them, and in this regard, Basson noted accordingly that “marked distress”, *if experienced, has more to do with “suffering that may be related to the deprivation of emotional intimacy”* (Basson, 2002b:26).

The impact of the women’s lack of sexual desire on their relationships and/or partners was more slightly marked than that at a personal level. Among the women partaking in this study, those who had sought the help of marriage counsellors all reported that their partners had been the initiators of this process. This is unsurprising as men are reportedly more dissatisfied with low frequency of sex (Trudel *et al.*, 1997; Dunn *et al.*, 2000). According to these women, some of their men reacted overtly, and others covertly, with displays of anger, hurt or rejection. However, as most partnerships were solid and satisfying in other ways, and the women mostly “allowed” sex to meet their partners’ needs, the “interpersonal difficulty” for most of the respondents was marginal.

All in all, it was found that that even in celibate marriages there were limited negative effects on the marriage. This is contradictory to other research studies indicating that low sexual desire is associated with decreased levels of relationship satisfaction, both for the partner with low sexual desire and for their partners (Fourie, 1984; Davies *et al.*, 1999; Trudel *et al.*, 1993).

It should also be pointed out that even if an individual does not suffer marked distress because of their lack of sexual desire, this does not take away from her discomfort (which could be described as marked distress) when having to engage in unwanted sexual activities.

From the findings the following *conclusions* were reached:

The impact of low sexual desire on the individual and the relationship was minimal, and the DSM-1V-TR diagnosis (which includes the criteria of “marked distress” or “interpersonal difficulty”) is therefore not applicable. The limited impact on the relationship should, however, be seen in the light of the continued sexual interaction between most partners, as well as other supportive behaviours that keep the relationship satisfying and intact.

It is worth noting that, even if a woman does not suffer marked distress because of *lack* of sexual desire, it indirectly leads to her experience of real discomfort and actual distress when having to engage in unwanted sexual activities.

### **6.3.5 Personal reasons given for a decline in desire**

An attempt to understand lived experience, and how people make sense of their worlds giving their personal perceptions (as per Smith, 1994; Willig, 2001), is central to IPA. In this study that experience is the decline of sexual desire towards life partners, and how participants made sense of the occurrence

It was found that the need to explain (or justify) the decline of sexual desire towards life partners was a response to the societal expectation and assumption that a “normal” marriage will have a sexual component otherwise the marriage is viewed as deviant and abnormal (Masters & Johnson, 1966; Donnelly, 1993). The personal reasons given by the participants for their declining sexual desire did not point to any single factor, but rather a combination of possible factors.

Some of the participants felt that *medical conditions* had contributed to their decline in desire (Hicks, 2005), particularly those that resulted in pain during intercourse. Painful intercourse is experienced as highly unpleasant and results in sex avoidance, thereby indirectly affecting desire (Barbach, 2000). Other medical factors such as lack of sensitivity in genital areas after operations, and the effect of childbirth trauma, were also raised as possible determinants of diminished sexual interest. This supported the finding of Berman and Berman (2001) that vaginal tearing and/or episiotomies (the cut made in the vagina) during childbirth lead to diminished sensation and/or pain during sexual intercourse.

The participants were all middle-aged and some wondered whether hormonal changes, such as those related to *menopause*, might have played a role. Other research related to the effects of hormones on sexual desire in women has yielded somewhat contradictory results (e.g., Northrup, 2004; Davies *et al.*, 2005). Certainly, in this study, there is probably as much evidence supporting the midlife change in hormones enhancing the participants' desire, since many of them were engaged in lustful, raucous affairs (Goldstein & Brandon, 2004), than there is the midlife change in hormones leading to a decline in desire.

Some theorists, such as Kaplan (1979), have proposed that women experience an increase in sexual desire in middle age but the responses in this study indicates that age, in and of itself, has a minimal effect on desire (Basson *et al.*, 2005). The fact that the women experienced desires towards men other than their partners does not necessarily constitute an increase in desire with age, since all of these women had experienced high sexual desire in the past. This said, the participants did indicate that factors that tend to be linked with *aging*, such as loss of attractiveness, account for loss of interest in sex, when they perceived that their partners were critical about their physical attributes. It was found that weight gain, feelings of inferiority and negative feelings and thoughts accounted for their lack of interest in sex (Carey *et al.*, 2005; Træn *et al.*, 2007). These factors affected, *inter alia*, their body images and their emotional safety to be comfortably sexual. This finding concurs with those of several studies, which have shown that a woman's *self-esteem* has a profound effect on her sexuality and that, particularly for women, feeling sexually attractive is an integral part of the way a woman perceives herself (King, 1998; Goldstein & Brandon, 2004; Carey *et al.*, 2005; Koch *et al.*, 2005).

*Depression* (post-natal and clinical) was an important contributor to lowered sexual desire. Most of the participants had been, or were, on anti-depressants, which are known for their devastating effect on libido (Goldstein & Brandon, 2004). Berman and Berman (2001) reported that depression affects twice as many women than men.

In general, the participants felt that *psychological* aspects had a more far-reaching effect on their desire than did physical factors. Indeed, empirical studies have indicated that for women, as opposed to men, emotional aspects before and during sexual intimacy are of paramount importance for the experience of sexual desire (Tallis, 2004). It was found that *negative emotions* such as fear, anger and anxiety, suppress women's desire and were also cited as reasons for avoidance of sex. This is supported by other research (e.g., Stuart *et al.*, 1987; Kaplan, 1979; Trudel *et al.*, 1997; Regan & Berscheid, 1999; Leiblum & Rosen, 1988; Morin, 1995). It was evident that the experience of negative emotions did *not* enhance desire (as per Morin, 1995), and in fact led to continued avoidance of sex. More pertinently, it was found that women were not available for sexual encounters unless being "in an emotional space" and emotionally close to their partners. Yet, there is an inverse correlation between intimacy and emotional closeness, as it in itself leads to a breakdown of desire (Morin, 1985, Schnarch, Perel, 2007).

The findings concurred *that life cycle* factors (Barbach, 2000; Levin, 2002), such as adjustment to marriage; having children with the resulting postpartum blues; performing additional household tasks; having husbands stressed by building careers; or losing partners to death, influence women's sexual desire. These life-cycle stressors were an important contributor to lowered desire, and the participants succinctly explained their exhaustion and lack of sex drive, partly due to a shift of their focus away from their partners and the resultant emotional distance between them.

The participants also cited *negative perceptions* of sex arising from upbringing and childhood sexual trauma as reasons for their decline in desire, in line with other research studies (e.g. Hawton, 1985; Richter *et al.*, 2004; LoPiccolo & Friedman, 1988). Their childhood environments clearly had an important effect in creating the women's attitudes towards sexuality, and were re-enacted in their intimate relationships, whether in response to the internalisation of negative messages, or complexes about parents. Some participants were the victims of boundary violations during their childhood, which may have compromised their

development of healthy sexuality, resulting in sex being associated with negativity (Sgroi, 1982; Richter *et al.*, 2004).

From the findings the following *conclusions* were reached:

An array of psychological factors have a profound effect on sexual desire, and physical (including medical) factors also play a part but to a lesser degree. A further conclusion is that the stage of life (with all the relevant stressors and burdens) has a profound impact on the women's availability for sex and her lack of experience of sexual desire. Women's desire is elusive, delicate, and easily influenced and suppressed by an array of factors.

Importantly, the experience of negative emotions and the resultant emotional distance between partners is highly relevant to diminished desire, as women highly value the role of emotional intimacy in sexuality. The delicate balance of emotional intimacy between partners is extraordinarily complex but appears to be essential to maintain the woman's ability to experience sexual desire.

### **6.3.6 Relationship factors impacting on sexual desire**

The findings of this study most certainly supported the notion that "*experience of sexual desire is intricately connected to the quality of the relationship between individuals and other interpersonal phenomena*" (Regan & Berscheid, 1999:108). In fact, the participants spent the majority of the time during the interviews discussing relationship issues that impacted on their sexual desire in accordance with the bulk of research evidence on sexuality that emphasises that relationship issues play a crucial role in the igniting and maintaining of sexual desire (see also Kaplan, 1997; Stuart *et al.*, 1987; Basson, 2001; Donnelly, 2003; Brezsnayak & Whisman, 2004; Træn *et al.*, 2007).

Establishing *which* aspect(s) of a relationship affected sexual desire was, however, considerably more difficult. All of the participants in this study felt that sexual desire was a crucial component of *romantic love* (Lewis, 1960; Morin, 1995) but somehow this was not maintained in their long-term relationships (Schnarch, 1997; Levine, 2003; Money, 1986; Kaplan, 1995; Perel, 2007), despite their expectation it should be. It was evident that with *relationship duration*, there was a gradual reduction in sexual desire supporting other research findings (e.g. Money, 1986). Most of the women felt happy and satisfied within their

marriages but, in contrast with some research findings (Donnelly, 1993), their *marital contentment* did not translate into a sexual desire for their partners. In fact, the close companionship described by many of the participants had the opposite effect on their need for sexual intimacy. Somewhat paradoxically, *emotional intimacy* does not necessarily lead to good sex. Emotional fusion deadens desire, and separateness/differentiation, rather than intimacy, may be a prerequisite for sexual connection (Morin, 1995; Schnarch, 1997; Perel, 2007). This is in apparent contradiction of the previous finding and conclusion (in Section 6.3.5), which was that women were not available for sexual encounters unless they felt an emotional closeness and connectedness to their partners. In fact, research has repeatedly stressed the relevance and cardinal importance, of emotional intimacy in the experience of sexual desire (e.g. Leiblum & Rosen, 1988b; Basson, 2005). This dichotomy is possibly one of the most interesting outcomes of the study, and will be discussed in more detail in Section 6.3.8. One reason for this may be the aspect of *familiarity* (Levine, 2002; Perel, 2007), as some participants described their partners as their “best friend” or “like a brother”, i.e., relationships in which eroticism has no part (Morin, 1995).

*Physical attraction* plays an important part in evoking desire, and it was evident that most of the participants were strongly attracted to their partners when they first met, in accordance with the well-known notion of “love at first sight” (Tallis, 2004:119-147). Some still found their partners physically attractive, and although they professed to love them very much, they did not experience sexual desire towards them, thereby illustrating that physical attraction alone is insufficient to maintain desire. Some of the women even found *unattractive* men sexually desirable and took them for lovers. It may be that, for women, “attractiveness” comprises more than just physical aspects, and includes considerations such as wealth, status and intellect (Berscheid & Regan, 1999), once again pointing to the complexities of sexual desire.

Findings indicate the relevance of the women’s partners’ *behaviours* and habits, which affected their desire to have sex with them. Poor sexual skills were a frustrating factor, which resulted in active avoidance of sexual encounters (King, 1998, Goldstein & Brandon 2004). For the most part, the women described their partners as sexually persistent, selfish, and out of tune with their emotional and physical needs. Many of the women faked orgasm for a variety of reasons, including to hasten an unpleasant encounter. Other negative behaviours and attitudes were also cited as reasons for sexual withdrawal (Hawton, 1995; Hite, 1987;

Basson, 2001; Stuart *et al.*, 1987, Wood *et al.*, 2007). These included insensitivity, dependency, lack of consideration, moodiness, alcohol abuse and emotional unavailability. It was found that emotional conflict with a partner was cited as the most common cause of diminished desire (after Regan & Berscheid, 1999), and that women use low sex drive either unconsciously or deliberately to regain control if they feel disempowered.

Other discordant issues raised were lack of *attunement* and lack of *communication*, particularly those pertaining to synchronisation and coordination of the sexual rhythms in the relationship (as per Verhulst & Heiman, 1988; Davies *et al.*, 1999; Clement, 2002).

Loving behaviour outside the bedroom, on the other hand, slightly improved the possibility of women utilising these stimuli to promote a willingness to be open to a sexual encounter, and to evoke their sexual desire (Basson, 2004). It must be said, however, that even the women who reported that their partners were loving and supportive did not have desire to have sex with them. However, it was found that these aspects served to increase their compliance to engage in sexual activities for a multitude of *other* reasons, such as to compensate, to please the partner or to feel emotionally closer to him (as pointed out in Section 6.3.3.).

In summary, the findings underscore that, while interpersonal factors most certainly affect the experience of desire, almost all of the factors cited by the participants had a potentially negative impact on their desire. It was evident that, in contrast with their male partners whose desires are readily accessed through a large variety of prompts, *women's desire is easily repressed if her conditions are not met* (supporting Levine's findings in 2002).

From the findings the following *conclusions* were reached:

Interpersonal relationship factors are major determinants in the experience of loss of sexual interest in women. However, sexual desire wanes in long-term relationships, regardless of whether these unions are happy or unhappy. In short, women are sensitive to a wide range and multiplicity of relationship factors which influence her feelings of desire, and their motivational force for sexual interaction can best be described as "very fragile" (after Basson, 2002b:18). Moreover, the aspect of the correlation between emotional intimacy and sexual desire proves to be complex and paradoxical, and appears to have an inverse correlation.

### 6.3.7 The experience within the socio-cultural context

Donnelly (1993:2) noted that in our society married people are “expected” to have sex, as the marital relationship is the only avenue for sexual fulfilment that is legally sanctioned. Furthermore, the prevailing belief in society is that “a good relationship begets good sex”. (Perel, 2007). These societal expectations provided the backdrop for the findings of this study, as all but one participant was married (and she was in a long-term-relationship, where the same expectations prevail).

IPA has the valuable benefit of its capacity to investigate experience within the contextual factors and the environment having an influence on an individual’s life within the cultural context (Shaw, 2001). Accordingly, this study yielded insights in the role of context such as long-term relationship, life stage, role-divisions as partner, mother or woman, and the environmental factors such as conflict or stressful situations in diminished desire. Other contextual aspects are the effects of upbringing, religion, and the particular typical middle class norms and expectations, as depicted in the popular media. Importantly, the society and culture the individual finds herself in defines what is normal or taboo (as per Regan & Berscheid, 1999; Perel, 2007), and the customs that prevail around sexuality.

It was evident that growing up in *restricting households* where sex for women was depicted as “sin”, shameful and disgusting, had affected perceptions of sexuality (Kaplan, 1979; Morin, 1995). Socially ascribed *gender roles* pertaining to sexual encounters, such as women should be passive in sex (Barbach, 2000) and men taking charge by initiating (Verhulst & Heiman, 1988), were also internalised by many of the participants. They also ascribed to scripts about the “*right*” way and “*normal frequency*” to have sex (Hite, 1987; Rosen & Leiblum, 1988a), which created unrealistic expectations that their partners intuitively should know how to please them sexually (Tiefer, 1995). It was also evident that there were *gender differences* with regards to sexual stimulation, reasons for engaging in sex, and libido, which concurred with other findings (Bancroft, 1989, Levine, 2002; Leiblum, 2002). Many of the women wanted physical intimacy and affection without necessarily taking it to the sexual penetrative level, again supporting other research findings (Regan & Berscheid; King, 1998; Perel, 2007).

Other contextual factors that impacted on the women's sexual desire were *environmental aspects*, such as beautiful or off-putting surroundings. Again this is in accordance with other research findings (Delvin, 2005; Wood, 2007).

It was found that discussions about sex were prevalent in the participants' social circles (Perel, 2007), and sex was often the topic of discussion and debate at parties. It was evident from these social discussions that other women held similar views about their partners having no understanding of women not needing/wanting sex. The majority of women reported that their women friends had an equally low desire for sex with their partners, and felt that the occurrence of diminished desire in long-term relationships was widespread (Basson, 2002; Davies *et al.*, 1999; Leiblum & Rosen, 2000; Goldmeier, 2001; Hicks, 2006.). This concurs with local research findings (Craig, 2002) that *lack of sexual desire is very common*, in line with international trends, and that the majority of women do not want sex even though they love their husbands (McIntosh, 2005). In this study, however, the proviso was that the low desire was experienced specifically "with their long-term partners" since at least half of the women were involved in extra-marital affairs with men whom they claimed they desired greatly.

Following on from this, while the women professed to adhere to scripts and stereotypes that hold that, with age and loss of youthful looks, one should not continue to be sexual (Hawton, 1985), at least half of them were engaged in sexual relationships, albeit not with their long-term partners.

In summary, this study highlights the findings of other researchers (e.g. Rosen & Leiblum, 1988b; Regan & Berscheid, 1999; Basson, 2005; Wood *et al.*, 2006) with regards to the impact of scripts by providing a "code", which directs sexual actions and anticipation of responses. The findings emphasise that the sub-culture and context that the women finds herself in, has a profound effect on her sexuality. It amongst others, determines her perceptions of sex, the gender roles, and creates expectations of sexual interaction.

From the findings the following *conclusions* were reached:

*Societal scripts* prescribe "correct" ways to have sex and the "right" feelings to have in response. These prescriptions have a major contribution to the development of negative perceptions towards sexuality, the creation of unrealistic expectations of

sexual relationships and experiences, and idealistic expectations of sex role performances by partners. Gender roles are assigned and internalised which contribute to misunderstanding, and feelings of alienation. It can be concluded that the social communications about the topic of sex is an attempt to understand and normalise phenomena, thereby counteracting confusing scripts, in particular, the expectation that a “good” relationship should include having continued sexual desire for sex.

To sum up, low sexual desire in women is *extremely common* and many women *do not* desire continued sexual intercourse in long-term relationships, in spite of expectations that continued sexual intercourse is part and parcel of marriages or partnerships. However, the findings also show that this does not necessarily mean that the women concerned have generalised low sexual desire. In fact, the low desire focussed specifically and only on their long-term partners. The role of emotional intimacy in sexual desire is of cardinal importance and leads to the erroneous belief that safe, intimate relationships nurtures sexual desire, while the opposite, perplexingly, is true. This conundrum proves to be a highly significant finding and conclusion.

### **6.3.8 Implications of the findings and conclusions**

Explaining the phenomenon of low sexual desire is difficult, as the lived experiences as communicated by the participants are scattered with inconsistencies and contradictions. Sexual desire is also often confused with subjective sexual arousal and the two may be indistinguishable from one another. What is clear is that women’s feelings of sexual desire are, for the most part, well defined and heightened in the early phases of a relationship. Thereafter, they are sensitive to an extremely wide range of factors, most of which result in a steady decline sexual desire in long-term relationships, regardless of whether these unions are happy or unhappy.

That marital contentment did *not* promote a sexual desire for the participants towards their partners is contrary to much of the available literature; not only that which purports that marital contentment enhances sexual desire (Donnelly, 1993; Træn *et al.*, 2007) but also that which suggests that women need to feel emotional connected to a man in order to experience desire (e.g., Leiblum & Rosen, 1988b). In fact, the results of this study support the contention of Morin (1995), Perel (2007) and others, which is that emotional fusion deadens desire, and that individuation and separateness, rather than intimacy, is a prerequisite for sexual

connection. Certainly, from the responses in this study, a powerful positive influence on women's feeling of sexual desire is the wish to establish emotional intimacy with a man, but it seems that once this has been achieved, such as with long-term partners, this particular positive influence is no longer there. Since the majority of other influences, such as merging, familiarity, domesticity, stress, age and conflict, dampen sexual desire, the absence of a positive influence, even if others remain, is likely to be significant.

For the practitioner, the findings suggest that there are two key issues that require consideration before intervention on low sexual desire can be properly planned.

The specific **identification of lack of spontaneous and /or responsive desire** is the first key issue for the practitioner planning intervention. Importantly, for many of the women in the study, their lack of desire was targeted at their partners, and they both desired, and acted on their desire for, other men. Hence, their lack of desire can be described as *situational*, rather than a general condition, especially for those in satisfying relationships, and they could/would not respond to stimuli to evoke their desire, even when in a sexual situation. This then may point to a factor *in the relationship itself* affecting desire as well as *aspects/stimuli that evoke desire*, and the answer seems to lie in the intricacies of emotional closeness and eroticism. Being too familiar or close emotionally decreases sexual intimacy, and the participants indicated boredom and lack of 'mystery' in their relationships with their partners which contributed to their lack of sexual desire (see Section 6.4.5.5.).

The remainder of the women in the study presented with a *general* lack of responsive desire, i.e., they simply did not want sex. Thus, it is important that the type of lack of desire is also correctly identified.

The women in this study experienced a lack of sexual desire for their partners but, in general, were not overly distressed about this state of affairs. For the most part, their relationships were intact and happy, which can be partly attributed to the participants' willingness to have sexual relations with the partners, despite their own lack of sexual desire. This **willingness to engage in sex for reasons other than having sexual desire**, (and the attendant discomfort attached thereto), is a second key issue for the practitioner to keep in mind when planning intervention (see Section 6.4.1.3.).

The findings and conclusions have an important impact on how the practitioner should address the issue of discrepant desire when faced with it in the therapy situation. This will be covered in the next section, which addresses the last objective of the study, i.e., to place the implications of the findings in context for the practitioner.

#### **6.4 RECOMMENDATIONS FOR INTERVENTION**

Devising an intervention plan is not an easy task, due to the hugely complicated nature of sexual desire, and the particular conditions promoting its experience. In fact, sexual desire disorders are perceived as both the most common and the “*most challenging of all sexual problems*” confronting practitioners (Pridal & LoPiccolo, 2000). In the next sections I have made recommendations, based on the insights and findings gained in the study, for consideration in planning treatment.

With regards to the treatment of sexual desire disorder, Westheimer and Lopater (2005:594) asserted: “*The formidable challenge facing the sex counsellor or therapist is to try and help the client find pleasure in his or her sexual feelings, where in the past those feelings have been absent, diminished, or ambivalent*”.

The first *recommendation* is that the practitioner assesses whether or not to intervene, and, if so, how, when clients present with low or no desire. Therefore the first consideration is the correct classification or diagnosis, and the second priority is to determine whether the problem requires treatment.

The findings of this study corroborate others that clearly demonstrated that low sexual desire is a common problem, and that women in long-term relationships have little or no spontaneous desire (e.g. 75% of women seen by Goldmeier, 2001). Authors such as Schnarch (1991, 1997), Basson (2005) and Perel (2007) regard this occurrence as inevitable, so whether it should be seen as a “problem”, or as a *normal variant* (Goldmeier, 2001), is open to debate.

Similarly, whether lack of responsive desire needs to be treated, especially in the context of good health and within a good relationship, remains a question. The majority of the women interviewed for this study did not express a need for change. Furthermore, those who had been in marital therapy found it of little or no value. The one exception was a participant who indicated that some of the issues that had caused her to distance from her partner (e.g., his

neediness/fusion) shifted, which enabled her to be more available to him for sex. This positive shift clearly demonstrates the necessity for ascertaining the correct focus for intervention. Importantly though, in this case, the therapy did not heighten her experience of sexual desire, rather it engendered a more tolerant attitude and thus a *willingness* on her part to be sexual.

In the next section I recap the various diagnostic classification systems in the light of the conclusions of the study, and the underlying complexities of sexual desire, and suggest possible ways to manage low desire if faced with in practice. The practitioner should gain a clear understanding of the complexities of sexual desire, to face the challenge of intervention.

### **6.4.1 Applicable diagnostic classification systems**

*“How you treat sexual desire problems - and the results you obtain- depends on how you think about desire per se”* (Schnarch, 2000:18).

#### **6.4.1.1 DSM-1V-TR**

As stated before, DSM-1V-TR (2000) classifies sexual desire disorders as Hypoactive Sexual Desire Disorder and Sexual Aversion Disorder. The essential feature of Hypoactive Desire Disorder is *“a deficiency or absence of sexual fantasies and desire for sexual activity”*. Sexual Aversion Disorder is the *“persistent or recurrent extreme aversion to, and avoidance of, all (or almost all) sexual contact with a sexual partner”*. In both the disturbance must *“cause marked distress or interpersonal difficulty”*. Further criteria are the distinction between the lifelong or acquired type, and the generalised or situational type, and in the identification of causal aspects, which can be either psychological or combined factors (APA, 2000:539-541).

Adherence to the DSM-1V-TR (2000) diagnostic guidelines raises several dilemmas, and the following limitations of the diagnostic system become prevalent. Firstly, the diagnosis presupposes the occurrence of spontaneous sexual thoughts and desire. In this study it was found that most women do not experience spontaneous desire towards their partners, for a multitude of reasons. The absence of spontaneous desire alone should not represent a “dysfunction”, or even be maladaptive, as it is a common and widely accepted occurrence (Bancroft *et al.*, 2002). Furthermore, the findings of this and other studies (Goldmeier, 2001)

suggest that it is often a normal adaptive mechanism to personal, relationship, and environmental or other circumstances.

Secondly, it was established in this study that although the women may meet the “absence of sexual fantasies *for*” criterion, many have sexual fantasies “*in*” sexual activities (tapping into fantasy of some of the aspects that evoke desire, as found by Friday, 1973). This too has been shown to be a normal means of focusing on sexual stimuli and necessary for the enhancement of desire (Basson, 2000; Barbach, 2000).

Thirdly, the DSM classification system requires a distinction between desire and sexual arousal, but the findings indicate that women’s experiences of desire overlap with those of sexual arousal, and that it is often not possible to distinguish between the two “phases” (Hicks, 2005).

Lastly, the women in this study presented with some of the features of the “acquired” and “situational” type of the DSM-1V-R classification of Hypoactive Desire Disorder and/or Sexual Aversion Disorder, but none reported the “marked distress or interpersonal difficulty” required for diagnosis. Moreover, Basson (2005) made the point that it is questionable whether a problem that causes “distress” warrants a diagnosis of “dysfunction”, especially when the lack of desire for, or avoidance of, sexual activity, are appropriate responses to the particular situation (Basson, 2005).

I, therefore, propose that the DSM-1V-TR diagnostic system in its present form does not fully encompass women’s particular situations or experiences, and **recommend** that the practitioner look to other diagnostic systems to classify the problem.

#### **6.4.1.2 The “New View”**

The “New View” definition of sexual problems is “*discontent or dissatisfaction with any emotional, physical, or relational aspect of sexual experience*” (Wood, 2006:241). The pathologising term “disorder” is deliberately avoided, and this system acknowledges the vast group of aetiologies evidenced by this and other studies. The New View of women’s sexual problems, based on women’s real-life experiences and seen from the women’s point of view, is applicable and useful in understanding women’s experiences as it acknowledges that women’s desire is more about sensuality and intimacy than the amount of genital contact, and

that women are easily distracted from sex by a host of factors (Tiefer, 2001). The participants in this study indicated varying degrees of dissatisfaction with one or more aspects of their sexual experience, and hence the New View definition is applicable to their problems.

It is *recommended* that the practitioner gain knowledge of the New View because it represents a significant contribution to the understanding of women's sexual desire.

#### **6.4.1.3 Revised and expanded definitions**

The International Committee of the American Foundation of Urological Disease (ICAFUD) revisions to the "New View" classification system resulted in more contemporary categories of women's sexual dysfunction (Basson *et al.*, 2005), of which more than one is of relevance to this study.

Basson's contributions (2001, 2002a, 2002b, 2004, 2005) to the understanding of women's sexuality are relevant to the newer ICAFUD definitions. Her recognition of the two desire phases (spontaneous and responsive), in particular, shaped the foundation of the classifications. "Sexual desire/interest disorder" was defined as follows: "*Absent or diminished feelings of sexual interest or desire, absent sexual thoughts or fantasies, and a lack of responsive desire. Motivations (reasons/incentives) for attempting to become sexually aroused are scarce or absent*" (Basson *et al.*, 2005:293). Here the essential element is a "*lack of responsive desire*", acknowledging the normalcy of the lack of spontaneous desire.

The conclusion of this study indicates that the women presented with both lack of spontaneous and responsive desire. This distinction between spontaneous and responsive desire has important implications for management of low sexual desire in women. Although to be expected that in longer term relationships there is lessening in spontaneous desire, the possibility remains for the ignition of responsive desire, if the woman is willing and motivated by reasons other than desire. Very importantly therefore, *the lack of responsive desire indicates the lack of these motivating factors (including those evoking erotism), and these then should direct the focus of the therapy.*

Accordingly, the ICAFUD classification also includes criteria relating to motivations or reasons for attempting to become aroused, which take cognisance of the fact that women choose to be sexual for a multitude of reasons that are unrelated to sexual desire.

For these reasons, ICAFUD classification seems to be the most pertinent diagnostic system for the management of desire problems, and I *recommend* that the practitioner use the ICAFUD definitions in the management of low sexual desire in women.

#### **6.4.2 Aims of therapy**

The aim of sex therapy is to restore for the client(s) a ...“*natural or healthy state of sexual functioning*” (Wiederman, 1998:4). Thus, it is essential that the clinician have clarity about what constitutes “healthy, positive sexual functioning” (Hicks, 2006), as this provides the goals in therapy.

Importantly, the practitioner should take cognisance that contemporary research strongly suggests that a *lack of spontaneous sexual desire* in long-term relationships is normal. Furthermore, as noted by Evaraerd and Both (2000), it is difficult to think of remedies for hypoactive sexual disorder because most people, professionals included, erroneously think that desire should be spontaneous, and that the aim of therapy is to restore it’s spontaneous occurrence. Many patients therefore have unrealistic expectations that therapists will be able to restore the spontaneity of their desire. Conversely, others resist therapeutic attempts to address their lack of desire on the grounds that intervention would mean that their desire, even if restored, would not be “spontaneous”. The practitioner should thus not aim for an essentially unattainable outcome, particularly if the “problem” being presented is an aspect of normal behaviour.

*Responsive desire* is possibly more of a grey area. In this study all of the participants experienced low (or no) responsive desire towards their partners, which may indicate that this too is a prevalent occurrence. Moreover, only a few indicated that they wanted to address their lack of desire. Pridal and LoPiccolo (2000) accordingly found low desire patients are often unenthusiastic to come for therapy, fearing that they will be identified as the problem, or pressured into behaviours (such as ‘sensate focus’) they have little inclination for. The key for successful therapy lies in identifying the “motivations (reasons/incentives)” for attempting to become sexually aroused by their partners.

Addressing these issues might be experienced as overwhelming, especially since many of them already made unsuccessful attempts to remedy the situation in the past (by for example

seeking medical help, marital counselling, or taking it up with the partner). Indirect pointers or direct discussion did not make changes (“...*ek is siek, siek, siek en sat daaroor gepraat...*”), and women give up and “accept their fate”. That being the situation, the main reason given by those who did want to address their lack of desire was that it would be easier for them to cope with their partners’ sexual demands if they desired to have sex with their partners, i.e., their motivation was to enhance their coping mechanisms rather than enhance their responsive desire.

To address fear of labelling, it is *recommended* that women be afforded knowledge and education about the normalcy and differences in spontaneous and responsive desire to allow them to make a realistic and informed decision about whether they require intervention and, if so, what the aims of that intervention should be. Depending on the individual’s perspective, the goal of intervention may be to assist with communication, understanding and coping mechanisms rather than to restore sexual desire for a long-term partner.

It is furthermore *recommended* that the practitioner recognises the main causes of lack of desire from the individual woman’s perspective, and address these in therapy.

### **6.4.3 Applicable models of sexual response for management of low desire**

The earlier models such as the HSRC (Masters and Johnson, 1966) and Tri-phasic model (Kaplan, 1974; 1979) assume a linear progression through the separate phases (awareness of desire, arousal, orgasmic release and resolution). These models presuppose innate, spontaneous desire as the starting point of sexual experience, which is mostly not the experience of women and therefore these models are not relevant for intervention.

The subsequent circular Sex Response Cycle model Basson (2000, 2001, 2004, 2005) accurately indicates that women’s sexual motivation is infinitely more complex than the mere presence or absence of innate desire. In this model the phases overlap, and arousal and desire can occur in any order (Both & Evaraerd, 2002). The experiences of the women in this study bear a strong resemblance to the theories and findings on which Basson based her model. Thus, this model has emerged as most applicable and relevant to the management of low responsive desire.

Gehring (2003) also promoted the applicability of the Sex Response Cycle model, primarily because of its distinction that although some women report spontaneous desire (especially when young, and in the beginning of a relationship), most women do *not* experience this in long-term relationships.

To recap the Sex Response Cycle model:

At the beginning of a sexual experience a woman may be sexually neutral/have no spontaneous sexual desire, but may be receptive to a sexual experience for other reasons (which may comprise an extensive list, including enhanced emotional closeness). If motivated to participate, this leads to willingness to deliberately find and seek sexual stimuli (including focussing on the partner's loving behaviour and sexual techniques in and out of the bedroom, and using fantasy). If she stays focussed (in an erotic context) sexual excitement, subjective arousal and pleasure intensify, and *responsive* sexual desire is now experienced. Emotionally and physically positive outcomes will increase subsequent sexual motivation (Basson, 2004; 2005) and receptivity for a future repeat of sexual encounters. Each phase is therefore sexual and nonsexual, affecting and affected by the previous one (Gehring, 2003)

Basson (2002b:23) points out that there are many sites of potential breakage of the response cycle as the motivation behind the cycle is "fragile", accounting for the high prevalence of impaired desire. Damage to one site (e.g. pain whilst having sex) will have a cascading effect on the rest of the cycle (e.g. difficulty to focus on pleasure, resultantly no arousal, no responsive desire, and no emotional intimacy, leading to no motivation for another sexual encounter).

Importantly, sexual arousal in women is more strongly modulated by *thoughts and emotions* triggered by the state of sexual excitement. It is of vital importance for women being able to become *subjectively aroused* for the continuation of the process and a rewarding outcome. A great many psychological and biological factors may negatively influence this arousability and subsequent responsive desire (Basson, 2005).

In summary, the sexual response cycle is biopsychosexual and mind-body dependent on the overall context of the atmosphere of the relationship or family life (Gehring, 2003), and particularly sensitive to a great many factors that could potentially cause a break in the cycle.

## 6.4.4 Management of low responsive desire

### 6.4.4.1 Causes of low desire

Contemporary expanded definitions of women's sexual dysfunctions acknowledge the highly contextualised nature of women's sexuality. With regards to assessment of the lack of incentives to become aroused, Goldmeier (2001:385) reminds the clinician that: "*listening carefully to our patients will ultimately tell us many of the answers*". Hicks (2006) also stresses the necessity to begin with a women's own description of her sexual problem, and to attempt to place it in her lived context, rather than to diagnose her as having a "problem".

Basson *et al.* (2005) and Hicks (2006) recommended that the clinician take cognisance of:

- personal psychological aspects, such as psychosocial development, including past abuse, anxiety, and low self-esteem (predisposing factors);
- interpersonal, and contextual factors, such as the emotional relationship with the partner, environmental and social aspects (precipitating and perpetuating factors in the current life context), and;
- biological aspects, such as illness, depression, and sexual pain (medical factors).

Listening to a woman's reasons for her low desire will indicate whether the focus of her therapy process should be on aspects of sexual desire or on other issues such as psychological issues, life-style, life-stage or work related issues, health and biological issues, or relationship issues including issues related to sexual technique and habituation.

The reasons given for diminished desire are very varied, personalised, and multi-faceted, therefore, it is *recommended* that the practitioner listen to the woman herself describing her sexual problem to place it in context and gain an understanding of causal factors.

### 6.4.4.2 Assessment

Mattaini (1997:22) states: "*Although knowing how to intervene is the final test, the core of professional practice is the assessment*". Once a good understanding of the contributing factors of the lack of desire through a thorough evaluation is gained, treatment can be tailored for an individual/couple's needs (Beck, 1995).

Following a multi-factorial conceptualisation of the problem of sexual desire, most therapies are based on the hypothesis that these causal factors, once identified, must change to increase sexual desire (Trudel, Marchard, Ravart, Aubin, Turgeon & Fortier, 2001. Management of women's sexual problems is holistic, addressing the *present context*, including the *interpersonal relationship* and *nature of sexual stimulation*, as well as the *psychological* aspects and *biological* causes (Basson *et al.*, 2005). The focus is on whether the woman is motivated/willing to become sexually involved, and whether accompanying subjective sexual arousal can trigger desire, acknowledging the need for erotic stimuli and the extreme relevance and fragility of the motivational force of emotional intimacy. Whether the sexual aspect should be the prime target of treatment depends on whether it is the primary problem, or a symptom of some other condition, which then should be the focus. The key is identifying the underlying cause(s) of the problem.

It is therefore *recommended* that a thorough assessment be done of the lack of motivation to become sexually aroused before embarking on a personalised treatment plan.

#### **6.4.4.3 Choice of treatment model**

The design of treatment models and management strategies for the many factors affecting women's sexual desires is outside the scope of this study, nonetheless there are some general considerations that are applicable to the selection of a treatment model.

There are a *great* many approaches to therapy, including psychotherapy, behaviour therapy, educative approach, Gestalt, systemic, sexual scripting, interactional, pharmacy, and the integrative sex therapy and marital models (Wiederman, 1998, Kaplan, 1974, 1979, 1995, Leiblum & Rosen, 1988a, 1995; Lobitz & Lobitz, 1996; Rosen & Leiblum, 1995, LoPiccolo & Friedman, 1988; Evaraerd & Both, 2000; Daines & Hallam-Jones, 2007; Goldstein, 1986; Heiman, 2002; Trudel *et al.*, 2001; Masters & Johnson, 1966; 1970, 1979; Zilbergeld & Hammond, 1988; Leiblum & Rosen, 1988a; 1988b, 2000; Scharf, 1988; Apfelbaum, 1988, 1995; Lazarus, 1988, 1995; Schwartz & Masters, 1988; Straen, 1986; Verhulst & Heiman, 1988; Segraves, 1988a; 1988b; Bullard, 1988; McCarthy, 1995; Pridal & LoPiccolo, 1995; 2000; Nichols, 2000; Craig, 2002; Weeks, 2005). To date, *no* single favoured model has emerged from the research into low sexual desire in women. What has become clear, however, is that the models that adopt an *eclectic approach* directed at the identified causal factors are becoming increasingly popular.

In his analysis of sex therapy practices over the years, Wiederman (1998) noted that the leading sex therapists have taken progressively more integrative steps in their interventions. This trend towards an eclectic approach to sex therapy is likely to continue (Rosen & Leiblum 2000; Weeks, 2005), and the recent developments in therapy are mostly integration of the more commonly used approaches (Daines & Hallam-Jones, 2007). Gehring (2003:37), for instance, eloquently illustrated how the Sex Response model (Basson, 2001) can be integrated into a marital- and psychodynamic model to work on different aspects concurrently. Dependent on the main focus of intervention (albeit on psychological, relationship, biological or contextual factors) an appropriate treatment strategy will be chosen.

Thus, as there is no single model for the management of low sexual desire, it is *recommended* that the practitioner employ an integrative and personalised approach that best addresses the individual needs of each client.

#### **6.4.4.4 Addressing misconceptions about innate sexual desire**

Apfelbaum (1995:39) stated: “*All sex therapists recognise how common it is for people to feel the compulsion to fit the standard sexual script*”.

Many authors such as Tiefer (1995) and Barbach (2000) noted an erroneous belief that satisfying sex should occur “naturally”, so that those who do *not* respond automatically and instinctively end up feeling inadequate. Goldmeier (2001:384) noticed that 75% of women referred to him were complaining of responsive sexual desire, i.e. noticing the lack of spontaneous desire. He recommended explaining the perceived “normality” of responsive sexual desire as it “*usually comes as a great relief to the woman and her partner*”, which would clarify the aims of therapy and ensure that the expectations thereof were more realistic.

Apfelbaum (1988) found that, paradoxically, people must first be relieved of the pressure to respond positively to sex, to be able to derive pleasure from sexual engagements. He emphasised the importance of the practitioner’s endorsement of the legitimacy of a neutral or apathetic response to sexual stimulation, by affirming the woman’s reality (of *not* feeling desire or being aroused), supporting her in not feeling guilty about her response, and reducing

the pressure to feel sexual when she does not. Similarly, Barbach (2000:17) argued that the “*expectation of a positive response is the crux of the standard script*”.

This expectation of positive feelings to sexual advances cause therapist and clients alike to minimise feelings that sex may *not* always be valued or desired, and admitting to such feelings became socially unacceptable (Barbach, 2000) and is viewed as “unnatural”. It was indicated however that women do not necessarily experience innate sexual desire (i.e. “naturally”), and therefore might not always be inclined to be receptive to sexual stimuli, unless motivated by others factors, mainly intimacy based, to be so.

Moreover, the notion of a “natural” receptivity might be “delicate” and “vulnerable” (Basson, 2001:396) because:

- the motivation for women to respond positively to sexual cues is mainly based on their wish to enhance intimacy, which itself may decline for any number of reasons as “*emotional intimacy is precious but precarious*” (see also Basson, 2002b:23);
- an emotionally and physically rewarding outcome is needed to enhance intimacy, but numerous factors such as lack of tenderness, poor sexual technique, abuse, or physical or emotional discomfort can preclude the achievement of intimacy;
- sexual desire in women is induced by more than just physical stimuli. Other stimuli include caring, consideration and physical affection outside of the bedroom, which may be absent or lacking.

Regan and Berscheid (1999) gave an overview of other socio-cultural scripts of which informs cultural views of “normal” sexuality that presupposes that partners *should* feel some amount of desire for each other, otherwise something is deemed “wrong”. They cited, among others, scripts that dictate the appropriateness of an object of desire, the ways this desire should be communicated, in which life stage it ought to be experienced, and the appropriate places, settings, frequency and even time of day for desire. To counteract these, Apfelbaum (1995) and King (1998) proposed a broadened conception of sexuality (including non-genital sexual practices) rather than fit people to a compulsively restricted version of sex (according to scripts).

Thus, it is *recommended* that, as a point of departure, the clinician should seek to dispel misconceptions by providing clarification about women’s sexual responses, including the

distinction between spontaneous and responsive desire, and the legitimacy of feeling apathetic toward sex.

#### **6.4.4.5 Broadening incentives and sexual repertoire**

King (1998:72) concurred with other researchers (e.g. Levin, 2002) that sexual desire is but one of many motivators for sexual intercourse (as was evidenced also in this study in Section 5.3.2., for example “...*I feel so sorry for him*”;...“*owe him*”; ...*feel so guilty*”; “...*it’s good for him*”). By focussing on these “enhancers” and “willingness”, more options for sexuality become available (for example participants mentioned “... *try to train yourself to like it*...”; “*ek sal in my kop besluit ek wil dit nou meer kere doen*...”). By focussing on the many other motives for sex, the women may be more willing to be open for sex, which may lead to a pleasurable and satisfying experience (Both & Evaraerd, 2002). This would include acknowledgement and enhancement of the woman’s idiosyncratic frame of eroticism, including “*the mysterious, the novel and the unexpected*” (Perel, 2007:37), as alluded to by participants: “...*to have some mystery*...” and “...*their unavailability... the unknown*...”.

King (1998:253-280) promotes a broader sexual repertoire of sexual activities and non-penetrative sex (“outercourse”), which could be negotiated with the partner to make sexual activities more pleasurable for both. Both and Evaraerd (2002:14) emphasise that “*women who actively seek sexual stimuli in order to elicit feelings of arousal and desire are absolutely normal and should not be pathologised*”. This approach is useful for the management of responsive desire, and to assist those participants who felt that sexual intercourse is unpleasant, by changing the activities to those that they themselves find more pleasurable (such as cuddling, hugging, messaging, kissing, etc). It is therefore *recommended* that the practitioner takes an educative role in normalising motifs, other than sexual desire, for engaging in sexual activity, and informing about broadened sexual repertoire.

#### **6.4.4.6 Differentiation rather than merging**

“*Let there be spaces in your togetherness, let the winds of the heavens dance between you, love one another but not make not a bond of love and give your hearts, but not into each other’s keeping*” (Gibran, 1923).

The aim of therapy is enhanced sexual desire, therefore intervention should foster individuation and promote differentiation in order to avoid unhealthy intimacy and emotional

smothering (Schnarch, 1991). The reason being that this study, in accordance with many others (Morin, 1995; Lobitz & Lobitz, 1996; Perel, 2007), has demonstrated clearly that passion decreases over the length of a relationship (Morin, 1995) and that the more intimate the couple become, the less sexual desire and arousal they experience for each other (Lobitz & Lobitz, 1996).

It was pointed out that being too familiar or close, i.e. “fused”, decreases sexual intimacy. Tripp, (in Morin, 1995) explains that a person’s desire is seldom aroused unless something in the partner and situation is viewed as resistant to it. He also proposed that eroticism does not develop towards a fully accessible partner. In other words, to be desired, the object of desire should be somewhat “remote” (which clearly is not the case in the longer term relationships described in this study). Eroticism requires romance, obstacles, ambivalence, anticipation, teasing, conquering, the element of “forbidden fruit”, and “guilty pleasures” naughtiness, and the like, as stimuli of sexual desire (Money, 1986; Morin, 1995; Ogden, 1999). The lustful affairs and strong sexual desire as experienced by many participants was evidence of the interplay of these complex aspects. In the words of Perel (2007:37), “...*desire needs mystery*”, and these aforementioned aspects should be brought back into the relationship to act as aphrodisiacs and stimuli for the igniting of desire.

“Intimacy” is a paradoxical concept, and it is *recommended* that the practitioner gain a clear understanding of the intricacies of this concept as it plays a cardinal role in sexual desire. As an example, Schnarch (1991; 1997; 2000) and others (e.g. Scharff, 1988; Moore, 1985; Renshaw, 1996; Caretomuto, 1989; Hendrix, 1993; Hollis, 1998; Gehring, 2003) warn against emotional fusion, dependency, possessiveness or control being confused for “intimacy”. The practitioner should promote intimacy as the ability to holding on to the emotional connection/togetherness by the process of differentiation (Hollis, 1998; Schnarch, 2000; Perel, 2007) *without emotional merging*.

Thus, therapy that focuses on increasing a couple’s intimacy in isolation will not necessarily increase their sexual desire for one another – even at termination of therapy, some couples report enhanced feelings of closeness and intimacy, without any significant change in the sexual relationship (Perel, 2007). It is therefore *recommended* to correctly identify the underlying cause(s) of the problem and aims of the intervention before embarking on an integrated intervention strategy (as per Gehring, 2003).

### **6.4.5 Summary of recommendations for intervention**

Based on the overview of management strategies, the following *recommendations* are made:

- The practitioner requires clarity about how “desire” is perceived when faced with a client who indicates that she wishes to address difficulties with sexual desire, and needs an understanding of the complicity of the phenomenon;
- The practitioner should in an informed manner decide on the most applicable classification system in order to diagnose correctly, therefore have a good basic knowledge of the DSM-1V-TR shortcomings, and contributions of the New View perspective, and in particular the relevance of the ICAFUD definitions;
- Utilising the New View perspectives is proposed, in acknowledging the broader context of sexual problems, steering away from pathologising. The most contemporary ICAFUD proposed diagnostic systems are the most relevant to management of women with low desire, as they include the concept of “responsiveness”, which is highly relevant;
- A good knowledge and broad understanding of the latest models of women’s sexual response is required, including the Basson Sex Response Cycle, which recognizes the importance of women’s motivators being based on intimacy, with a distinction between spontaneous and responsive desire, as this particular model was found to be most useful in the understanding of the problems as described by the women in the current study;
- The practitioner should dispel misconceptions based on myths and social scripts is of particular importance to inform about sexual response and normalise the occurrence of lack of desire, in order for both the practitioner and the client to have realistic goals for the therapy;
- The practitioner should be able to identify low responsive desire, a lack thereof, and the lack of incentives, motivations and reasons to become sexually aroused by the partner, and make this the focus of intervention;
- The practitioner should conduct a thorough assessment based on the women’s account to ascertain main causes for the diminished desire, so as to shape the personalised treatment plan, taking eclectic and integrative steps in determining the best treatment models;
- The practitioner should provide the client with a broadened conception of sexuality and clarify the role of willingness and the array of reasons (other than desire) for partaking in sexual activities;

- The practitioner should encourage individuation and differentiation in the relationship in order to enhance possibilities for erotism.

## 6.5 RECOMMENDATIONS FOR FURTHER RESEARCH

I wondered about the effect of differences between the genders on the findings of the study. There is the notion that men have a higher sex drive and initiate sex more often than do women (i.e. Baumeister *et al.*, 2001). The question is then, how would the lack of this male “driving” force play itself out in homosexual women’s relationships, where both partners would be more focussed on the emotional components of their relationship.

I also noted that some participants expressed strong negative feelings about the experience of sexual intercourse, and avoided sex, even though they profess to love their partners. LoPiccolo and Friedman (1988) made the good point that many low desire patients have in fact an aversion to sex but do not recognise it. They argue that if these patients were feeling “neutral”, they would have engaged more readily in sex to avoid conflict – instead, they found that patients actively avoid sex, as did some participants in this study. This led me to question whether Sexual Aversion Disorder would have been a more clinically correct DSM-diagnosis for some of the participants, and if so, the aspect of aversion warrants further exploration.

Given the multitude of different approaches used to treat the problem of low desire in women, I wondered how the clinician could rate “success”. I also wondered if success would correlate with women enjoying more pleasant sexual experiences in which responsive sexual desire was evoked, even in longer-term relationships.

I wondered how women, who profess *not* to experience diminished sexual desire, experience their sex lives and sexual experiences, and which factors lead to their sustained desire.

The need for, and experience of, emotional intimacy plays an important role in the willingness of the women to engage in sexual activity. The sexual intimacy paradox was also prevalent in this study, wherein a couple increased their relationship intimacy, but the sexual desire continued to decline. Other contradictions around intimacy also surfaced, and the question could be posed what women want in terms of intimacy needs, and what this would mean for sexual desire *per se*.

Lastly, I became very aware that women often participate in sex because of the expectation of their partner and/or societal expectations that sexual activities define an intimate loving relationship and should continue in a long-term relationship. I wondered if that script could be challenged, so that women could be relieved of the burden of having to be available for sex when they do not want to do, and that women's choice *not* to engage in sex could be recognised as a legitimate option (as per Wood *et al.*, 2007; Perel, 2007) even in a partnership.

Following from the current research, and questions identified above, it is recommended that the following research be conducted:

- A replicate of this study with lesbian participants, to explore whether the lived experience of lesbian women with low desire differs from those of their heterosexual counterparts;
- Further research into the reasons why some women find the sexual experience as unpleasant as was indicated (to the extent of resembling an aversion);
- An assessment of approaches used to treat the problem of low desire in women, and their outcomes, in order to:
  - define the criteria for a “successful outcome”;
  - identify approaches or combinations of approaches that are most successful;
- A replicate of this study with women who sexually desire their long-term partners to explore their lived experience;
- Research into the lived experience of the phenomenon of “intimacy” and the role it plays in sexual desire for women;
- Research into the legitimacy of the societal expectation that women should provide their partners with sex, in other words, that women should relinquish their sexual agency to provide in their partners' needs whilst overriding their own

## **6.6 FINAL CONCLUSION**

This study renders insights into how women experience low sexual desire, and how low desire impacts on them personally and on their relationships. Sexual desire is a complex and multi-faceted construct, and it is clear that more research is needed to gain a fuller understanding of this phenomenon. Several findings of this study concurred with those of other research, the most significant of which is that low sexual desire in women (in relation to the life-partner specifically) is extremely common, and may represent normal behaviour or an appropriate response to circumstances. Nonetheless, its occurrence can and does pose some

discomfort or concern of differing intensities on a personal or relationship level. Another important finding is the contradictions and complexities around motivational factors, and in particular the paradoxes surrounding emotional intimacy. In attempting to address the issue of low desire, it is imperative that the healthcare professional obtains sufficient recent information about the phenomenon. In this regard, it is helpful to view low desire from feministic frameworks in order to normalise the situation, explain the response cycle, dispel myths and false expectations, and provide information about the concept of “responsive” desire.

In conclusion, I hope that this research and findings assist healthcare professionals and therapists to develop a deeper understanding of the lived experiences of women with low sexual desire and guide them to more efficient and appropriate interventions in its management.

## LITERATURE STUDY

American Psychiatric Association 1994. *Diagnostic and statistical manual of mental disorders* (4<sup>th</sup> ed). Washington, DC: American Psychiatric Association.

American Psychiatric Association. 1952. *Diagnostic and statistical manual of the American Psychiatric Association* (1st ed). Washington DC: American Psychiatric Association.

American Psychiatric Association. 1968. *Diagnostic and statistical manual of the American Psychiatric Association* (2nd ed). Washington DC: American Psychiatric Association.

American Psychiatric Association. 1980. *Diagnostic and statistical manual of the American Psychiatric Association* (3<sup>rd</sup> ed). Washington DC: American Psychiatric Association.

American Psychiatric Association. 1987. *Diagnostic and statistical manual of the American Psychiatric Association* (3<sup>rd</sup> ed-revised). Washington DC: American Psychiatric Association.

American Psychiatric Association. 2000. *Diagnostic and statistical manual of mental disorders* (4th ed – text revision). Washington, DC: American Psychiatric Association.

Apfelbaum, B. 1988. An ego-analytic perspective on desire disorders. **In:** Leiblum, S.R. & Rosen, R.C. *Sexual desire disorders*. New York: Guildford Press.

Apfelbaum, B. 1995. Masters and Johnson revisited: A case of desire disparity. 1995. **In:** Rosen, R.C. & Leiblum, S.R. *Case studies in sex therapy*. New York: The Guildford Press.

Appelt, I. 2006 *Narratives of hope: Trauma and resilience in a low-income South African community*. Pretoria: University of Pretoria.

Babbie, E. & Mouton, J. 2001. *The practice of social research*. Oxford: Oxford University Press.

Baldwin, J.D. & Baldwin, J.I. 1997. Gender differences in sexual interest. *Archives of Sexual Behaviour*, 26(2):181-210.

Bancroft, B. 2002. The medicalisation of female sexual dysfunction: The need for caution. *Archives of Sexual Behaviour*, 31(5):451-455.

Bancroft, B.J., Loftus, J., & Scott Long, J. 2003. Distress about sex: A national survey of women in heterosexual relationships. *Archives of Sexual Behaviour*, 32(3):193-208.

- Bancroft, J. 1989. *Human sexuality and its problems* (2<sup>nd</sup> ed). Edinburgh: Churchill Livingstone.
- Barbach, L. 1975. *For yourself. The fulfilment of female sexuality*. London: Penguin Books Ltd.
- Barbach, L. 2000. *For yourself. The fulfilment of female sexuality*. London: Penguin Books Ltd.
- Bass, E. & Davies, L. 1988. *The courage to heal. A guide for women survivors of child sexual abuse*. London: Harper & Row.
- Basson, R. 2000. The female sexual response: A different model. *Journal of Sex and Marital Therapy*, 26:51-65.
- Basson, R. 2001. Using a different model for female sexual response to address women's problematic low sexual desire. *Journal of Sex and Marital Therapy*, 27:395-403.
- Basson, R. 2002a. Rethinking low sexual desire in women. *British Journal of Obstetrics and Gynaecology*, 109:357-363.
- Basson, R. 2002b. Women's sexual desire – disordered or misunderstood? *Journal of Sex and Marital Therapy*, 28(s):17-28.
- Basson, R. 2004. General recommendation regarding assessment of sexual problems. *The North American Menopause Society*, 11(6):709-713.
- Basson, R. 2005. Women's sexual dysfunction: Revised and expanded definitions. *Canadian Medical Association Journal*, 10:172.
- Basson, R., Berman, A., Derogatis, L., Furgeson, D., Fourcroy, J., Goldstein, I., Graziottin, A., Heiman, J., Laan, E., Leiblum, S., Padma-Nathan, H., Rosen, R., Seagraves, K., Seagraves, R.T., Shalosigh, R., Sipski, M., Wagner, G. & Whipple, B. 2000. Report on the international consensus development conference on female sexual dysfunction: Definitions and classification. *The Journal of Urology*, 163:888-893.
- Basson, R., Brotto, L.A., Laan, E., Redmond, G. & Utian, W. 2005. Assessment and management of women's sexual dysfunctions: Problematic desire and arousal. *Journal of Sexual Medicine*, 2:291-300.

- Baumeister, R.F., Catanese, K.R. & Vohs, K.D. 2001. Is there a gender difference in strength of sex drive? *Personality and Social Psychology Review*, 5(3):242-273.
- Beck, J., Bozman, A. & Qualtrough, T. 1991. The experience of sexual desire: Psychological correlates in a college sample. *Journal of Sex Research*, 28(3):443-456.
- Beck, J.G. 1995. What's love got to do with it?: The interplay between low and excessive desire disorders. **In:** Rosen, R.C. & Leiblum, S.R. *Case studies in sex therapy*. New York: The Guildford Press.
- Berman J. & Berman, L. 2001. *For women only. A revolutionary guide to overcoming sexual dysfunction and reclaiming your sex life*. New York: Henry Hot and Company.
- Bertram, J.C. 2000. The science of sexual behaviour. *The Journal of Sex Research*, 37(3):284-287.
- Both, S. & Evaraerd, W. 2002. Comment on "the female sexual response: A different model". *Journal of Sex and Marital Therapy*, 28:11-15.
- Breznysak, M. & Whisman, M.A. 2004. Sexual desire and relationship functioning: The effects of marital satisfaction and power. *Journal of Sex and Marital Therapy*, 30:199-217.
- Bullard, D.G. 2000. The treatment of desire disorders in the medically ill and physically disabled. **In:** Leiblum, S.R. & Rosen, R.C. *Sexual desire disorders*. New York: Guildford Press.
- Carey, M., Koch, P., Barthalow, P., Mansfield, P.K. & Thereau, D. 2005. "Feeling frumpy": The relationship between body image and sexual response changes in midlife women. *The Journal of Sex Research*, 1:215-223.
- Carotemuto, A. 1989. *Eros and pathos. Shades of love and suffering*. Toronto: Inner City Books.
- Charmaz, C. 2006. *Constructing grounded theory. A practical guide through qualitative analysis*. Thousand Oaks: Sage Publications.
- Clement, U. 2002. Sex in long-term relationships: A systemic approach to sexual problems. *Archives of Sexual Behavior*, 31:241-246.

- Comfort, A. 2003. *The joy of sex*. London: Octopus Publishing.
- Cook, L.C. 2005. Meeting women's desire for desire. *The Washington Post*, September 20 2005.
- Craig, E. 2002. *The knowledge of social workers in private practice regarding human sexuality and sex therapy*. Pretoria: University of Pretoria. (Unpublished M.A. thesis in Social Work)
- Creswell, J.W. 1994. *Research design. Qualitative & quantitative approaches*. London: Publications.
- Creswell, J.W. 1998. *Qualitative inquiry and research design: Choosing among five traditions*. Thousand Oaks: Sage Publications.
- Daines, B. & Hallam-Jones, R. 2007. Multi-faceted intervention in sex therapy (MIST). *Sexual & Relationship Therapy*, 22(3):341-350.
- Davies, S., Katz, J. & Jackson, J.L. 1999. Sexual desire discrepancies: Effects on relationship satisfaction in heterosexual dating couples. *Archives of Sexual Behaviour*, 28(6):553-567.
- Davies, S.R., Davidson, S.L., Donath, S. & Bell, R.J. 2005. Circulating androgen levels and self-reported sexual function in women. *The Journal of Family Practice*, 54(10):91-96.
- De Vos, A.S., Strydom, H., Fouché, C.B. & Delpont, CSL. 2002. *Research at grass roots: For the social sciences and human service professions*. Pretoria: Van Schaik Publishers.
- DeAngelo, D. 2001. *Sudden menopause*. Dublin: Newleaf.
- Delvin, D. 2006. *10 minute consultation: Loss of libido*. Available: <http://search.ebscohost.com/login.aspx>.
- Dennerstein, L. & Lehert, P. 2004. Modelling mid-aged women's sexual function: A prospective, population-based study. *Journal of Sex & Marital Therapy*, 30:173-183.
- Derogatis, L.R. & Melisaratos, N. 1979. The DSFI: A multidimensional measure of sexual functioning. *Journal of Sex and Marital Therapy*, 5(3):244-281.

- Derogatis, L.R., Rosen, R.C., Leiblum, S., Burnett, A. & Heiman, J. 2002. The Female Sexual Distress Scale (FSDS): Initial validation of a standardised scale for assessment of sexually related personal distress in women. *Journal of Sex and Marital Therapy*, 28:317-330.
- Donnelly, D. 1993. Sexually inactive marriages. *Journal of Sex Research*, 30(2):171-179.
- Dunn, K.M., Croft, P.R. & Hackett, G.I. 2000. Satisfaction in the sex life of a general population sample. *Journal of Sex and Marital Therapy*, 26:141-151.
- Ellison, C.R. 2000. *Women's sexualities*. New York: New Harbinger Publishers.
- Erikson, E. 1963. *Childhood and society*. New York: Norton.
- Evaraerd, W. & Both, S. 2000. Memories of you: On women's sexual desire. *Sexual and Relationship Therapy*, 15(4):231-234.
- Evaraerd, W. & Both, S. 2001. Ideal female sexual function. *Journal of Sex and Marital Therapy*, 27:137-139.
- Evaraerd, W. & Laan, E. 1995. Desire for passion: Energetics of sexual response. *Journal of Sex and Marital Therapy*, 21:225-263.
- Fade, S. 2004. Using interpretative phenomenological analysis for public health nutrition and dietetic research: A practical guide. *Proceedings of the Nutrition Society*, 63(4):647-653.
- Fouché, C.B. & Delpont, C.S.L. 2002. Introduction into the research process. **In:** De Vos, A.S., Strydom, H., Fouché, C.B. & Delpont, C.C.L. *Research at grass roots: For the social sciences and human service professions* (2<sup>nd</sup> ed). Pretoria: Van Schaik Publishers.
- Fouché, C.B. 2002. Selection of a researchable topic. **In:** De Vos, A.S., Strydom, H., Fouché, C.B. & Delpont, C.C.L. *Research at grass roots: For the social sciences and human service professions* (2<sup>nd</sup> ed). Pretoria: Van Schaik Publishers.
- Fourie, M.C. 1984. *The training of sex therapists in South Africa*. Durban: University of Durban-Westville. (Unpublished D.Ed. thesis)
- Freud, S. 1949. *Three essays on the theory of sexuality*. London: Imago.
- Friday, N. 1973. *My secret garden*. New York: Pocket Books.

- Fromm, E. 1956. *The art of loving*. New York: Harper & Row.
- Gehring, D. 2003. Couple therapy for low sexual desire: A systemic approach. *Journal of Sex and Marital Therapy*, 29:25-39.
- Gibran, K. 1923. *The Prophet*. New York: Knopf.
- Giles, D.C. 2002. *Advanced research methods in psychology*. New York: The Guilford Press.
- Giorgi, A. & Giorgi, B. 2003. Phenomenology. **In:** Smith, J.A. (ed) *Qualitative psychology: A practical guide to research methods*. London: Sage Publications.
- Goldmeier, D. 2001. “Responsive” sexual desire in women- managing the normal? *Sexual and Relationship Therapy*, 16(4):381-387.
- Goldstein, A. & Brandon, M. 2004. *Reclaiming desire. A guide to finding your lost libido*. London: Rodale International.
- Goldstein, I. & Rosen, R.C. 2002. Female sexuality and sexual dysfunction. *Archives of Sexual Behaviour*, 31(5):391.
- Grinnell, R.M. 1988. *Social work research and evaluation* (3<sup>rd</sup> ed). Itasa, IL: Peacock.
- Grinnell, R.M. 1998. *Social work research and evaluation* (5<sup>th</sup> ed). Itasa, IL: Peacock.
- Hawton, K. 1985. *Sex therapy. A practical guide*. Oxford: Oxford University Press.
- Heiman, J.R. 2002. Psychological treatments for female sexual dysfunction: Are they effective and do we need them? *Archives of Sexual Behavior*, 31(5):445-452.
- Hendrix, H. 1993. *Getting the love you want*. London: Pocket Books.
- Henning, E. 2004. *Finding your way in qualitative research*. Pretoria: Van Schaik Publishers.
- Herbst, E. 2006. *The illness experiences of HIV-infected low-income coloured mothers in the winelands region: Theoretical and practical implications*. Stellenbosch: Department of Psychology, University of Stellenbosch. (Unpublished P.Hd. thesis)
- Herman, J. 1997. *Trauma and recovery. The aftermath of violence – from domestic abuse to political terror*. New York: Basic Books.

- Heron, J. 1996. *Co-operative inquiry: Research into the human condition*. London: Sage Publications.
- Hetherington, E.M. & Parker, R.D. 1979. *Child psychology. A contemporary viewpoint* (2<sup>nd</sup> ed). McGraw-Hill: Auckland.
- Hicks, K.M. 2005. *The “new view approach” to women’s sexual problems*. Available: [www.medscape.com](http://www.medscape.com).
- Higson-Smith, C., Lambrecht, L. & Jacklin, J. 2005. Access to specialised services and the criminal justice system: Data from the Teddy Bear Clinic. **In:** Richter, L., Dawes, W. & Higson-Smith, C. (eds) *Sexual abuse of young children in Southern Africa*. Cape Town: HSRC Press.
- Hite, S. 1976. *The Hite report of Female Sexuality*. New York: MacMillan.
- Hite, S. 1987. *Women in love: A nationwide study of female sexuality*. New York: A Knopf.
- Hollis, J. 1998. *The Eden project: In search for the magical other*. Inner City Books, Toronto.
- Hurlbert, D.F., Singh, D., Menendez, D.A. Fertel, E.R. Fernandez, F. & Salgado, C. 2005. The role of sexual functioning I the sexual desire adjustment and psychosocial adaptation of women with hypoactive sexual desire. *The Canadian Journal of Human Sexuality*, 14(1-2):15-29.
- Kaplan, H.I. & Sadock, B.J. 1998. *Kaplan and Sadock’s synopsis of psychiatry: Behavioural sciences, clinical psychiatry*. Maryland, USA: Williams & Wilkens.
- Kaplan, H.S. 1974. *The new sex therapy: active treatment of sexual dysfunctions*. Middlesex: Penguin.
- Kaplan, H.S. 1979. *Disorders of sexual desire and other new concepts and techniques in sex therapy*. New York: Simon & Schuster.
- Kaplan, H.S. 1995. *The sexual desire disorders. Dysfunctional regulation of sexual motivation*. New York: Brunner/Mazel Publishers.
- King, B.M. 1999. *Human sexuality today* (3<sup>rd</sup> ed). New Jersey: Prentice Hall.

- King, R. 1998. *Good loving, great sex. Finding the balance when your sex drives differ*. Sydney: Arrow.
- Kinsey, A. Pomeroy, W. & Martin, C. 1948. *Sexual behaviour in the human male*. Philadelphia: W.B. Saunders.
- Kinsey, A., Pomeroy, W. & Martin, C. 1953. *Sexual behaviour in the human female*. Philadelphia: W.B. Saunders.
- Koch, P.B., Mansfield, P.K., Thureau, D. & Carey, M. 2005. "Feeling frumpy": The relationship between body image and sexual repose changes in midlife women. *Journal of Sex Research*, 42(3):1-9.
- Kvale, S. 1996. *An introduction to qualitative research interviewing*. London: Sage Publications.
- Larkin, M. 2008. Available: <http://groups.yahoo.com/group/ipanalysis> [Retrieved: 26 April 2008].
- Laumann, E.O., Gagnon, J.H., Michael, R.T. & Michaels, S. 2006. The social organisation of sexuality: Sexual practices in the United States. **In:** Hicks, K.M. 2006. *The "New View Approach" to women's sexual problems*. Available: [www.medscape.com](http://www.medscape.com).
- Laumann, E.O., Paik, A. & Rosen R.C. 1999. Seal dysfunctions in the United States; prevalence and indicators. *The Journal of the American Medical Association*, 281(6):537-544.
- Lavie, M. & Willig, C. 2005. "I don't feel like melting butter": An interpretative phenomenological analysis of the experience of 'inorgasmia'. *Psychology and Health*, 20(1):115-128.
- Lazarus, A.A. 1988. A multimodal perspective on problems of sexual desire. **In:** Leiblum, S.R. & Rosen, R.C. *Sexual desire disorders*. New York: Guildford Press.
- Lazarus, A.A. 1995. Adjusting the carburettor: Pivotal clinical interventions in marital and sex therapy. **In:** Rosen, R.C. & Leiblum, S.R. *Case studies in sex therapy*. New York: The Guildford Press.
- Le Roux, P. 1986. Growing up an Afrikaner. **In:** Burman, S. (ed) & Reynolds, P. *Growing up in a divided society. The context of childhood in South Africa*. Johannesburg: Ravan Press.

- Leiblum S.R. & Rosen, R.C. 1988a. Introduction: Changing perspectives on sexual desire. **In:** Leiblum, S.R. & Rosen, R.C. *Sexual desire disorders*. New York: The Guilford Press.
- Leiblum, S.R. & Rosen, R.C. 1988b. Conclusion: Conceptual and clinical overview. **In:** Leiblum, S.R. & Rosen, R.C. *Sexual desire disorders*. New York: The Guilford Press.
- Leiblum, S.R. & Rosen, R.C. *Sexual desire disorders*. 1988c. New York: The Guilford Press.
- Leiblum, S.R. & Rosen, R.C. 2000 (eds). *Principles and practice of sex therapy* (3<sup>rd</sup> ed). New York: The Guilford Press.
- Leiblum, S.R. 2002. Reconsidering gender differences in sexual desire: An update. *Sexual and Relationship Therapy*, 17(1):57-68.
- Lemon, N. & Taylor, H. 1997. Caring in casualty: The phenomenology of nursing care. **In:** Hayes, N. (ed) *Doing qualitative analysis in psychology*. Buckingham: Psychology Press.
- Lesch, E. 2000. *Female adolescent sexuality in a Coloured community*. Stellenbosch: University of Stellenbosch. (Unpublished Doctoral dissertation)
- Levin, R.J. 2002. The psychology of sexual arousal in the human female: A recreational and pro-creational synthesis. *Archives of Sexual Behaviour*, 31(5):405-411.
- Levine, S.B. 1987. More on the nature of sexual desire. *Journal of Sex and Marital Therapy*, 13(1):35-44.
- Levine, S.B. 1988. Intrapsychic and individual aspects of sexual desire. **In:** Leiblum, S.R. & Rosen, R.C. *Sexual desire disorders*. New York: Guilford Press.
- Levine, S.B. 1995. The vagaries of sexual desire. **In:** Rosen, S.R. & Leiblum, R.C. *Case studies in sex therapy*. New York: The Guildford Press.
- Levine, S.B. 2002. Re-exploring the concept of sexual desire. *Journal of Sex and Marital Therapy*, 28:39-51.
- Levine, S.B. 2003. The nature of sexual desire: A clinician's perspective. *Archives of Sexual Behaviour*, 32(3):279-285.
- Lewis, C.S. 1960. *The four loves*. London: Geoffrey Press.

- Lief, H.I. 1977. What's new in sex research? Inhibited sexual desire. *Medical Aspects of Human Sexuality*, 11(7):94-95.
- Lief, H.I. 1995. Integrative therapy in a woman with secondary low sexual desire. **In:** Rosen, S.R. & Leiblum, R.C. *Case studies in sex therapy*. New York: The Guildford Press.
- Lister, L. & Shore, D.A. 1984. *Human sexuality in medical social work*. New York: The Haworth Press.
- Lobitz, W.C. & Lobitz, G.K. 1996. Resolving the sexual intimacy paradox: A developmental model for the treatment of sexual desire disorders. *Journal of Sex and Marital Therapy*, 22(2):71-84.
- LoPiccolo, J. & Friedman, J.M. 1988. Broad-spectrum treatment of low sexual desire. **In:** Leiblum, S.R. & Rosen, R.C. *Sexual desire disorders*. New York: Guildford Press.
- Mansfield, P.K. 2006. Women's sexual desire: A feminist critique. *The Journal of Sex Research*, 19(4):7-12.
- Masters, W.H. & Johnson, V. 1966. *Human sexual response*. Boston: Little, Brown and Company.
- Masters, W.H. & Johnson, V.E. 1970. *Human sexual inadequacy*. London: Churchill.
- Masters, W.H. & Johnson, V.E. 1979. *Homosexuality in perspective*. Boston: Little Brown.
- Mattaini, M.A. 1997. *Clinical practice with individuals*. Washington DC: NASW Press.
- McCarthy, B.W. 1995. Childhood sexual trauma and adult sexual desire: A cognitive-behavioural perspective. **In:** Rosen, S.R. & Leiblum, R.C. *Case studies in sex therapy*. New York: The Guildford Press.
- McIntosh, E. 2005. *Femina*, December: 28-30.
- Money, J. 1986. *Lovemaps*. New York: Irvington.
- Moore, T. 1994. *Soul mates. Honouring the mysteries of love and relationship*. Dorset, U.K.: Element Books.

Morin, J. 1995. *The erotic mind. Unlocking the inner sources of sexual passion and fulfilment.* New York: Harper Collins Publishers.

Moustakas, C. 1994. *Phenomenological research methods.* London: Sage Publications.

Mouton, J. 2001. *How to succeed in your master's and doctoral studies – a South African guide and resource book.* Pretoria: Van Schaik.

Moynihan, R. 2003. *The making of a disease: Female sexual dysfunction.* [Retrieved: [www.bmj.com](http://www.bmj.com) on 16 February 2006].

Nichols, M. 2000. Therapy with sexual minorities. **In:** Leiblum, S.R. & Rosen, R.C. (eds). *Principles and practice of sex therapy.* New York: The Guildford Press.

Northrup, C. 2004. *The wisdom of menopause. The complete guide to women's health and wellbeing.* London: Piathus Books.

Nurnberg, H.G., Hensley, P.L., Heiman, J.L., Croft, H.A., Debattista, C. & Paine, S. 2008. Sildenafil treatment of women with anti-depressant associated sexual dysfunction. *The Journal of the American Medical Association*, 300(4):395-404.

Ogden, G. 1999. *Women who love sex. An inquiry into the expanding spirit of women's erotic experience.* Cambridge: Womanspirit Press.

Perel, E. 2007. *Mating in captivity. Sex, lies and domestic bliss.* London: Hodder.

Pridal, C.G. & LoPiccolo, J. 1995. Joyce and Leonard: Sexual aversion or sexual addiction? **In:** Rosen, R.C. & Leiblum, S.R. *Case studies in sex therapy.* New York: The Guildford Press.

Pridal, C.G. & LoPiccolo, J. 2000. Multi-element treatment of sexual desire disorders: Integration of cognitive, behavioural and systemic therapy. **In:** Leiblum, S.R. & Rosen, R.C. (eds) *Principles and practice of sex therapy* (3<sup>rd</sup> ed). New York: Guilford Press: 58-59.

Psychiatric Time. 2003. Available: [www.psychiatrictimes.com/](http://www.psychiatrictimes.com/).

Regan, P.C. & Berscheid, E. 1996. Beliefs about the state, goals, and objects of sexual desire. *Journal of Sex & Marital Therapy*, 22:110-120.

- Regan, P.C. & Berscheid, E. 1999. *Lust. What we know about sexual desire*. Thousand Oaks, California: Sage Publications.
- Renshaw, D.C. 1995. Sexless marriages and sex therapy: The main factors in sexual avoidance. **In:** Rosen, R.C. & Leiblum, S.R. *Case studies in sex therapy*. New York: The Guildford Press.
- Rice, J.K. & Rice, D.G. 1986. *Living through divorce. A developmental approach to divorce therapy*. New York: The Guildford Press.
- Richardson, D., Goldmeier, D. & Kocsis, A. 2005. PDE5 inhibitors may help some women with sexual problems. *Sexual and Relationship Therapy*, 20(1):66-69.
- Richter, L., Dawes, W. & Higson-Smith, C. (eds) 2005. *Sexual abuse of young children in Southern Africa*. Cape Town: HSRC Press.
- Riley, A. 1998. Integrated approaches to sex therapy. *Journal of Sex and Marital Therapy*, 13:229-231.
- Robinson, T.M. 2005. *A critical assessment of the experiences and perceptions of the couple in an unconsummated marriage*. Stellenbosch: University of Stellenbosch. (Unpublished doctoral thesis)
- Rosen, R., Brown, C., Heiman, J., Leiblum, S., Meston, C., Shabsigh, R., Ferguson, D. & D'Agostino (Jnr), R. 2000. The Female Sexual Functioning Index (FSFI): A multi-dimensional self-report instrument for the assessment of female sexual function. *Journal of Sex and Marital Therapy*, 26:191-208.
- Rosen, R.C. & Leiblum, S.R. 1988. A sexual scripting approach to problems of desire. **In:** Leiblum, S.R. & Rosen, R.C. *Sexual desire disorders*. New York: The Guilford Press.
- Rosen, R.C. & Leiblum, S.R. 1995. *Case studies in sex therapy*. New York: The Guilford Press.
- Rosenthal, R. 2001. Female sexuality comes out of the psychiatric closet. *Journal of Sex and Marital Therapy*, 27:203-204.
- Scharff, D.E. 1988. An object relations approach to inhibited sexual desire. **In:** Leiblum, S.R. & Rose, R.C. *Sexual desire disorder*. New York: Guildford Press.

- Schnarch, D.M. 1991. *Constructing the sexual crucible. An integration of sexual and marital therapy*. New York: W.W. Norton & Company.
- Schnarch, D.M. 1997. *Love, sex, and intimacy in emotionally committed relationships*. New York: W.W. Norton & Company.
- Schnarch, D.M. 2000. Desire problems: A systemic perspective. **In:** Leiblum, S.R. & Rosen, R.C. *Principles and practice of sex therapy* (3<sup>rd</sup> ed). New York: The Guildford Press.
- Schwartz, M.F. & Masters, W.H. 1988. Inhibited sexual desire: The Masters and Johnson Institute Treatment Model. **In:** Leiblum, S.R. & Rosen, R.C. *Sexual desire disorders*. New York: Guildford Press.
- Segraves, R.T. 1988a. Hormones and libido. **In:** Leiblum, S.R. & Rosen, R.C. *Sexual desire disorders*. New York: Guildford Press.
- Segraves, R.T. 1988b. Drugs and desire. **In:** Leiblum, S.R. & Rosen R.C. *Sexual desire disorders*. New York: Guildford Press.
- Sgroi, S. 1982. *Handbook of clinical intervention in child abuse*. Toronto: Lexington Books.
- Shaw, R. 2001. Why use interpretive phenomenological analysis in health psychology? *Health Psychology Update*, 10(4):48-52.
- Slowinski, J. 2001. New classification in female sexual dysfunction: Some reflections on the consensus report. *Journal of Sex and Marital Therapy*, 27:217-220.
- Smit, L.S.B. 1997. *'n Opleidingsprogram in seksualiteitsopvoeding vir maatskaplikewerkstudente*. Johannesburg: Randse Afrikaanse Universiteit. (Unpublished masters thesis)
- Smith, D. 2003. Monitor on psychology. Women and sex: What is “dysfunctional”? APA online. Available: <http://www.apa.org/monitor/apr03/women.html> [Retrieved 28 August 2007].
- Smith, J.A. 1994. Beyond the divide between cognition and discourse: Using interpretative phenomenological analysis in health psychology. *Psychology and Health*, 11:261-271.
- Smith, J.A. 2003. *Qualitative psychology: A practical guide to research methods*. London: Sage Publications.

- Smith, J.A., Jarman, M. & Osborn, M. 1999. Doing interpretative phenomenological analysis. **In:** Murray, M. & Chamberlain, K (eds) *Qualitative health psychology: Theories and methods*. London: Sage Publications.
- Smyth, L.D. 2004. *A phenomenological inquiry into the lived experience of social support for Black South African women living with HIV*. Stellenbosch: University of Stellenbosch. (Unpublished M.A. thesis (Psychology))
- Strean, H.S. 1986. Psychoanalytic theory. **In:** Turner, F.J. (ed) *Social work treatment. Interlocking theoretical approaches* (3<sup>rd</sup> ed). New York: The Free Press.
- Strydom, H. & Venter, L. 2002. Sampling and sampling methods. **In:** De Vos, A.S., Strydom, H., Fouché, C.B. & Delport, CSL. *Research at grass roots: For the social sciences and human service professions*. Pretoria: Van Schaik Publishers.
- Stuart, F.M., Hammond, D.C. & Pett, M.A. 1986. Psychological characteristics of women with inhibited sexual desire. *Journal of Sex and Marital Therapy*, 12:108-115.
- Stuart, F.M., Hammond, D.C. & Pett, M.A. 1987. Inhibited sexual desire in women. *Archives of sexual Behavior*, 16(2):91-120.
- Swart, M. 2004. *The effect of genital self-image and body esteem on female sexual functioning*. Calgary: University of Calgary. (Unpublished Ph D thesis)
- Tallis, F. 2004. *Love sick. Love as mental illness*. United Kingdom: Century.
- Thompson, Dr. A. 2008. Sheffield University, U.K. 13 June 2008. Available: [ipanalysis@yahoo.com](mailto:ipanalysis@yahoo.com).
- Tiefer, L. 1995. *Sex is not a natural act and other essays*. Boulder, CO: Westview Press.
- Tiefer, L. 1996. The medicalisation of sexuality: Conceptual, normative, and professional issues. *Annual Review of Sex Research*, 7:252-272.
- Tiefer, L. 2000. Sexology and the pharmaceutical industry: The threat of co-optation. *Journal of Sex Research*, 37:273-283.
- Tiefer, L. 2001. A new view of women's sexual problems: Why new? *The Journal of Sex Research*, 38(2):89-96.

- Tiefer, L. 2007. The new view campaign. Available: [www.newviewcampaign.org/monitor3.as](http://www.newviewcampaign.org/monitor3.as). [Retrieved: 26 April 2008].
- Træn, N., Martinussen, M., Oberg, H. & Kavli, H. 2007. Reduced sexual desire in a random sample of Norwegian couples. *Sexual & Relationship Therapy*, 22(3):303-322.
- Trudel, G., Boulos, L. & Matte, B. 1993. Dyadic adjustment in couples with hypoactive sexual desire. *Journal of Sex Education and Therapy*, 19:31-36.
- Trudel, G., Landy, L. & Larose, Y. 1997. Low sexual desire: The role of anxiety, depression and marital adjustment. *Sexual and Marital Therapy*, 12(1):95-99.
- Trudel, G., Marchand, A., Ravart, M., Aubin, S., Turgeon, L. & Fortier, P. 2001. The effect of a cognitive-behavioural group treatment program on hypoactive sexual desire in women. *Sexual and Relationship Therapy*, 16(2):146-164.
- Van Staden, D. 1987. *My huwelik het misluk*. Hillcrest: Owen Burgess Uitgewers.
- Verhulst, J. & Heiman, J.R. 1988. A systems perspectives on sexual desire. In: Leiblum, S.R. & Rosen, R.C. *Sexual desire disorders*. New York: Guildford Press.
- Waterhouse, L. 1993. *Child abuse and child abuser. Protection and Prevention*. London: Bookcraft Ltd.
- Weeks, G. & Winters, J. 2002. What problem? *Psychology Today*, 35(5):56-61.
- Weeks, G. 2005. The emergence of a new paradigm in sex therapy: Integration. *Sexual and Relationship Therapy*, 20(1):89-103.
- Weerakoon, P. 2001. Female sexual dysfunction: Definitions and classifications. *Journal of Sex and Marital Therapy*, 27:245.
- Westheimer, R.K. & Lopater, S. 2005. *Human sexuality. A psychosocial perspective* (2<sup>nd</sup> ed). Philadelphia: Lippincott Williams & Williams.
- Whipple, B. & Brash-McGreer, K. 1997. Management of female sexual dysfunction. Available: [www.arhp.org/files/FSRfactsheet.pdf](http://www.arhp.org/files/FSRfactsheet.pdf). [Retrieved: 25 April 2008].
- Wiederman, M.W. 1998. The State of theory in sex therapy – the use of theory in research and scholarship on sexuality. *The Journal of Sex Research*, 35(1):88-99.

Willig, L.A. 2001. *Introducing qualitative research in psychology. Adventures in theory and method*. Buckingham: Open University Press.

Wood, J.M., Mansfield, P.K. & Koch, P.B. 2007. Negotiating sexual agency: Postmenopausal women's meaning and experience of sexual desire. *Qualitative Health Research*, 17(2):189-200.

Wood, M.W., Koch, P.B. & Mansfield, P.K. 2006. Women's sexual desire: A feminist critique. *The Journal of Sex Research*, 43(3):236-244.

World Health Organisation. 1975. *Education and treatment in human sexuality*. Technical report series, nr 572. Geneva, Switzerland.

Zilbergeld, B. & Hammond, C. 1988. The use of hypnosis in treating desire disorders. **In:** Leiblum, S.R. & Rosen, R.C. *Sexual desire disorders*. New York: Guildford Press.

Zilbergeld, B. 1999. *The new male sexuality. The truth about men, sex, and pleasure*. New York: Bantam Books.

#### **LITERATURE CONSULTED BUT NOT QUOTED IN TEXT**

Advanstar Communications Inc. 2005. Testosterone patch increases satisfaction in women with hypoactive sexual disorder. Source: 15<sup>th</sup> annual meeting of the North American Menopause Society Oct. 6-9, 2004, Washington, D.C. *Geriatrics*, 60(1).

Althof, S.E., Raymond, C.R., Derogatis, L., Corty, E., Quirck, F. & Symonds, T. 2005. Outcome measurement in female sexual dysfunction clinical trials: Review and recommendations. *Journal of Sex & Marital Therapy*, 31:153-166.

Cohler, B.J. 2000. The science of sexual desire. *The Journal of Sex Research*, 37(3):284-287.

De Vos, A.S. 2002. Qualitative data analysis and interpretation. **In:** De Vos, A.S., Strydom, H., Fouche, C.B. & Delpont, C.S.L. *Research at grass roots. For the social sciences and human service professions* (2<sup>nd</sup> ed). Pretoria: Van Schaik Publishers.

Dennerstein, L., Anderson-Hunt, M. & Dudley, E. 2002. Evaluation of a short scale to assess female sexual functioning. *Journal of Sex and Marital Therapy*, 28:389-397.

Giles, J. 2006. Social constructionism and sexual desire. *Journal for the Theory of Sexual Behaviour*, 36(3):25-238.

Goldstein, E. 1986. Ego psychology. **In:** Turner, F.J. (ed) *Social work treatment. Interlocking theoretical approaches* (3<sup>rd</sup> ed). New York: The Free Press.

Houle, T., Dhingra, L.K., Remble, T.A., Rokicki, L.A. & Penzien, D.B. 2006. Not tonight, I have a headache? *The Journal of Headache & Face Pain*, 46(6):983-990.

Interpretative phenomenological analysis – Wikipedia, the free encyclopedia. Available: [http://en.wikipedia.org/wiki/Interpretative\\_phenomenological\\_analysis](http://en.wikipedia.org/wiki/Interpretative_phenomenological_analysis). [Retrieved: 1<sup>st</sup> October 2007].

MacPhee, D., Johnson, S.M. & Van der Veer, M.M.C. 1995. Low sexual desire in women: The effects of marital therapy. *Journal of Sex & Marital Therapy*, 21(2): 159-183.

Maddi, S.R. 1980. *Personality theories. A comparative analysis*. Illinois: The Dorsey Press.

Mazza, J. 2007. *Product description*. Available: <http://www.amazon.ca/Sexual-Desire-Disorders-Singer-Kaplan>. [Retrieved: 7 July 2007].

McGuirl, K.E. & Wiederman, M.W. 2000. Characteristics of the ideal sexual partner: gender differences and perceptions of the preferences of the other gender. *Journal of Sex & Marital Therapy*, 26:153-159.

Pidgeon, N. & Henwood, K. 1997. Using grounded theory in psychological research. **In:** Hayes, N. (ed) *Doing qualitative analysis in psychology*. Buckingham: Psychology Press.

Pomeroy, W.B. 2007. *Editorial reviews*. Available: <http://www.amazon.com/New-Sex-Therapy>. [Accessed: 4 July 2007].

Riley, E. 2000. Controlled studies on women presenting with sexual drive disorder. Endocrine status. *Journal of Sex and Marital Therapy*, 26(3):269-283.

Rodway, M.R. 1986. Systems theory. **In:** Turner, F.J. *Social work treatment. Interlocking theoretical approaches* (3<sup>rd</sup> ed). New York: The Free Press.

Rosen, R.C., Taylor, J.F., Leiblum, S.R. & Bachman G.A. 1993. Prevalence of sexual dysfunction in women: Results of a study of 329 women in an outpatient gynaecological clinic. *Journal of Sex & Marital Therapy*, 19:171-188.

Simons, J.P. & Carey, M.P. 2001. Prevalence of sexual dysfunctions: A decade of research. *Archives of Sexual Behaviour*, 30(2):177-219.

Smith, J.A. 2008. Personal communication. <http://groups.yahoo.com/group/ipanalysis> [Retrieved: 26 April 2008].

Spector, I.P., Carey, M. & Steinberg, L. 1996. The sexual desire inventory: Development, factor structure, and evidence of reliability. *Journal of Sex and Marital Therapy*, 22(3):175-190.

Thomlison, R.J. 1986. Behaviour therapy in social work practice. **In:** Turner, F.J. (ed). *Social work treatment. Interlocking theoretical approaches* (3<sup>rd</sup> ed). New York: The Free Press.

Turner, F.J. 1986. A multi-theory perspective for practice. **In:** Turner, F.J. (ed). *Social work treatment. Interlocking theoretical approaches* (3<sup>rd</sup> ed). New York: The Free Press.

Wasserman Marlene (“Dr Eve”). (Personal communication, 4 March 2006).

Werner, H.D. 1986. Cognitive theory. **In:** Turner, F.J. (ed) *Social work treatment interlocking theoretical approaches* (3<sup>rd</sup> ed). New York: The Free Press.

Westpahl, S.P. 2004. Glad to be asexual. Exclusive from New Scientist Print Edition. Available : [www.newscientist.com/article.ns?id=dn6533](http://www.newscientist.com/article.ns?id=dn6533) [ Retrieved 12 March 2007].

What you should know. Female sexual response. Available: <http://www.arhp.org/flies/FSRfactsheet>. [Retrieved: 13th June 2008].

Zastrow, C.H. 1999. *The practice of social work* (6<sup>th</sup> ed). Pacific Grove, California, USA: Brooks/Cole Publishing.

### **Magazine covers referred to in Chapter 6**

Men’s Health, August, 2008. “Speak her sex language. Magic wife decoder”.

Men’s Health, July, 2008. “5 Red hot sex tricks to drive her wild”

Cosmopolitan, July, 2008. “First time with a guy? Get shag night right”

Vogue, June, 2008. “Let’s talk about sex”.

“O”, July, 2008. “Dance your way to sexy self-confidence”.

**STELLENBOSCH UNIVERSITY  
CONSENT TO PARTICIPATE IN RESEARCH**

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**A phenomenological inquiry into the lived experience of low sexual desire in women: implications for clinical social work practice.**

You are asked to participate in a research study conducted by Elzabé Dürr, BA Social Work, Hons Psych, M Soc Sci in Clinical Social Work) from the Department of Social Work at Stellenbosch University, for purposes of a Doctoral dissertation. You were selected as a possible participant in this study because fulfill the criteria for possible participants, in that you present with the phenomenon which is the focus of the study.

**1. PURPOSE OF THE STUDY**

The study aims to gain a better understanding of the subjective experience of women who present with low/ no sexual desire, and to explore the experience of distress and interpersonal difficulties, which may result because of the 'problem'. Furthermore the experience is to be explored in a historical, social and cultural context.

**2. PROCEDURES**

If you volunteer to participate in this study, we would ask you to do the following things:

2.1 You will be requested to meet with the researcher for a personal interview at a place where you feel comfortable (e.g. at the researcher's office in Claremont, or at your home).

2.2 You will be requested to sign a consent form indicating your willingness to participate. The in-depth interview will be of approximately an hour, during which the researcher will ask you questions about the topic under discussion. The interview will be audiotaped for further analysis.

2.3 You will be furthermore requested to fill in a questionnaire, either to be completed where the interview took place or to complete it at home.

The interview should take approximately an hour, and the questionnaire no longer than half an hour to complete. Only one interview will be required.

**3. POTENTIAL RISKS AND DISCOMFORTS**

Since the topic in a highly personal and private one, you may feel some discomfort in sharing some of details. The researcher is an experienced practitioner and will attempt to limit any such discomfort. Should anything come up on an emotional level that should be worked through, the researcher will either schedule two further sessions with you (free of charge) or refer you to another suitable therapist.

**4. POTENTIAL BENEFITS TO SUBJECTS AND/OR TO SOCIETY**

It is the experience of the researcher that women who talk about their experience of low sexual desire, feel relieved to get some clarity in discussing this topic. Further benefits may be that you gain a deeper understanding of yourself, and that the 'condition' is normalized as you gain more perspective.

The question may be asked as to whether women are being forced by societal expectation to perform sexually in a prescribed way – this research will hopefully address this issue and women in our society may benefit if this notion is challenged based on the result of research.

## **5. PAYMENT FOR PARTICIPATION**

You will not receive remuneration for your participation. Participation is voluntary.

## **6. CONFIDENTIALITY**

Any information that is obtained in connection with this study and that can be identified with you will remain confidential and will be disclosed only with your permission or as required by law. Confidentiality will be maintained by means of using codes on the audiotapes and the questionnaires, storing the data in the researcher's personal and private office. Only the researcher's supervisor will have access to the data.

The interview will be audiotaped in order for the data to be transcribed (by the researcher personally). You will have a right to the transcribed material, and this will be forwarded to you if you so request. You will be able to indicate whether you wish to edit some of the material. The tapes and questionnaires will be destroyed upon completion of the thesis.

Should the research be published, confidentiality will be maintained and the participants will in no way be identifiable.

## **7. PARTICIPATION AND WITHDRAWAL**

You can choose whether to be in this study or not. If you volunteer to be in this study, you may withdraw at any time without consequences of any kind. You may also refuse to answer any questions you don't want to answer and still remain in the study. The investigator may withdraw you from this research if circumstances arise which warrant doing so.

## **8. IDENTIFICATION OF INVESTIGATORS**

If you have any questions or concerns about the research, please feel free to contact Professor Sulina Green at 021-8082070 at the Department of Social Work.

## **9. RIGHTS OF RESEARCH SUBJECTS**

You may withdraw your consent at any time and discontinue participation without penalty. You are not waiving any legal claims, rights or remedies because of your participation in this research study. If you have questions regarding your rights as a research subject, contact Prof P Engelbrecht, by 021-808 4624, at the Unit for Research Development.

**SIGNATURE OF RESEARCH SUBJECT OR LEGAL REPRESENTATIVE**

The information above was described to me by Elzabé Dürr in Afrikaans/English and I am in command of this language. I was given the opportunity to ask questions and these questions were answered *to my satisfaction*.

I hereby consent voluntarily to participate in this study. I have been given a copy of this form.

\_\_\_\_\_  
**Name of Subject/Participant**

\_\_\_\_\_  
**Name of Legal Representative (if applicable)**

\_\_\_\_\_  
**Signature of Subject/Participant or Legal Representative**

\_\_\_\_\_  
**Date**

**SIGNATURE OF INVESTIGATOR**

I declare that I explained the information given in this document to \_\_\_\_\_ [*name of the participant*]. She was encouraged and given ample time to ask me any questions. This conversation was conducted in [*Afrikaans/English*] and no translator was used.

\_\_\_\_\_  
**Signature of Investigator**

\_\_\_\_\_  
**Date**

**INTERVIEW SCHEDULE**

[The questions in **bold** will be asked, and where necessary to explore for more information, the more specific probing questions will be used.].

The following **broad themes** need to be explored:

DSM 1V definition: *“Absent or deficient sexual fantasies, absent or deficient sexual desire, marked distress, interpersonal difficulties”*

Characteristics of desire: *physiological/psychological; desire/arousal; dimensions (varying frequencies and intensities); desire/activity; spontaneous/responsive desire*

Factors influencing desire: *biological; relationship; personal; social scripts.*

**PROFILE:**

Age:

How long have you been married/co-habiting:

Do you have children/how many/ages:

Career:

Highest level of education:

**SEXUAL DESIRE**

- **If I say the words “sexual desire”, what comes to mind?**
- How *often* do you experience desire?
- Compared to other people of your own age and sex, how do you rate your desire to behave sexually with your partner? On what do you base this comparison?
- Do you think desire changes in different phases in our lives? How? Why?
- Do you think men and women *experience* desire differently? If so, how?

**SEXUAL FUNCTIONING**

- **Can you describe your sex life at present?**
- Can you describe the role of desire? – (in the first part of your relationship as apposed to now?)
- Are you satisfied with your level of desire/or the lack thereof? If not, why are you not?

## RELATIONSHIP

- **Please describe your relationship**
- Is there anything in/about the *relationship* that cause you to feel any *negative* feelings? If so, what in particular causes the feeling(s)?
- Is there anything about *yourself* that causes any or some of the aforementioned feelings? How do you feel about yourself in general?
- Is desire, or lack thereof, a problem for *you?*/ your *partner?*

## REASONS FOR PARTICIPATING IN SEXUAL ACTIVITY

- **When/if *you* initiate sex, what are the reasons for doing so?**
- **If you do *not* initiate (only *respond* to your partner), why do you (agree to) have sex?**
- Is there anything (e.g. in the environment/ about your partner/ self) that *enhances* your feelings of sexual desire?
- Is there anything that really *puts you off sex*/decreases desire? (Reasons for not feeling up to it?-environment/partner/self)

## FANTASY LIFE

- **Do you think about sex?**

## SEXUAL ACTIVITY

Please describe what **you** understand under the concept “*sexual activity*”

**How long could/would you go comfortably without having any sexual activity?**

## ANYTHING ELSE TO SHARE ABOUT DESIRE?

**ETHICS COMMITTEE APPLICATION FORM  
UNIVERSITY OF STELLENBOSCH  
SUBCOMMITTEE A**

**6 September 2004**

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**Application to the University of Stellenbosch SUBCOMMITTEE A  
for clearance of new/revised research projects**

**This application must be typed or written in capitals**

**Name: Ms: Elzabe Dürr  
Position/Professional Status: Student  
Affiliation: Research Programme/Institution:  
Department of Social Work**

**Telephone and extension no.                      Code: 021      no.674 1295**

**Fax:    Code: 021      no.674 1295**

**Email address: elzabe@southernwaters.co.za**

**Title of research project:**

**A phenomenological inquiry into the lived experience of women with low sexual desire: implications for clinical social work practice.**

**Where will the research be carried out?**

**The researcher will interview the participants in her office, at their homes, or in a setting of the participant's choice, where the particular person would feel most comfortable (such as a doctor's surgery). The questionnaires will be given to them to fill out either at the researcher's office or at their homes.**

**1. FUNDING OF THE RESEARCH: How will the research be funded?**

The researcher will fund the research herself.

**2. PURPOSE OF THE RESEARCH:**

The purpose is to gain a better understanding of the subjective experience of women who present with low sexual needs. Their experiences of distress or interpersonal difficulties will be explored in a historical, cultural and social context.

**3. AIMS AND OBJECTIVES OF THE RESEARCH:**

1. To gain more knowledge on a very prevalent issue that presents itself at the clinician's office
2. To gain understanding of how the respondents themselves experience the phenomenon of low/ no sexual desire
3. To gain insight into the role of society of providing particular 'scripts' of how women should behave to be 'normal'.
4. To provide guidelines to practitioners of how to manage the issue when it arises in therapy.

**4. SUMMARY OF THE RESEARCH**

The researcher is going to identify 10 participants. These people will be asked to meet the researcher for an interview. The nature of the research will be explained over the telephone or via e-mail, depending on the circumstance. The participant will be requested to sign the Consent Form when they meet. During the semi-structured interview open-ended questions will be asked, and with the participant's permission, the interview will be audiotaped to be transcribed and analysed at a later stage. A questionnaire will be given for the participant to fill in. The analysis of the data (as per Interpretive Phenomenological Analysis) will result in a thick description of the participants' lived experience of the phenomena that is being researched.

## 5. NATURE AND REQUIREMENTS OF THE RESEARCH

5.1 How should the research be characterised (*Please tick ALL appropriate boxes*)

5.1.1 Personal and social information collected directly from participants/subjects	√
5.1.2 Participants/subjects to undergo physical examination	
5.1.3 Participants/subjects to undergo psychometric testing	
5.1.4 Identifiable information to be collected about people from available records	
5.1.5 Anonymous information to be collected from available records	
5.1.6 Literature, documents or archival material to be collected on individuals/groups	

5.2 Participant/Subject Information Sheet attached? (*for written and verbal consent*)

YES	√
NO	

5.3 Informed Consent form attached? (*for written consent*)

YES	√
NO	

5.3.1 If informed consent is not necessary, please state why:

\_\_\_\_\_Not Applicable\_\_\_\_\_

NB: If a questionnaire, interview schedule or observation schedule/framework for ethnographic study will be used in the research, it must be attached. The application cannot be considered if these documents are not included.

5.4 Will you be using any of the above mentioned measurement instruments in the research?

YES	
NO	√

## 6 PARTICIPANTS/SUBJECTS IN THE STUDY

6.1 If humans are being studied, state where they are selected:

\_\_\_The researcher will identify prospective participants through colleagues, friends, and clients from her practice. The participants will have to give their explicit permission to be referred for the research.

6.2 Please mark the appropriate boxes:

Participants/subjects will:	YES	NO
be asked to volunteer		
be selected	√	

6.2.1 State how the participants/subjects will be selected, and/or who will be asked to volunteer:

The researcher belongs to the South African Sexual Health Association, where she meets with a variety of professionals who work with people who experience sexual problems. Some of these professionals have indicated that they will select prospective participants, and after explaining to them the nature of the research project, obtain their permission for a referral to me.

6.3 Are the participants/subjects subordinate to the person doing the recruiting?

YES	
NO	√

6.3.1 If yes, justify the selection of subordinate subjects:

\_\_\_\_\_Not Applicable\_\_\_\_\_

6.4 Will control participants/subjects be used?

YES	
NO	√

6.4.1 If yes, explain how they will be selected:

6.4.2

Not Applicable\_\_

6.5 What records, if any, will be used, and how will they be selected?

\_\_\_\_\_Not Applicable\_\_

6.6 What is the age range of the participants/subjects in the study?

25-50 years of age

6.6.1 Was assent for guardians/consent for participants/subjects obtained?

YES	
NO	√

*If YES, please attach the appropriate forms.*

6.6.2 If NO, please state why:

Not Applicable\_\_

6.7 Will participation or non-participation disadvantage the participants/subjects in any way?

YES	
NO	

6.7.1 If yes, explain in what way:

\_\_Not Applicable

6.8 Will the research benefit the participants/subjects in any direct way?

YES	
NO	

6.8.1 If yes, please explain in what way:

\_\_It might be beneficial for participants to realise that they are not the only people who experience the problem, and to be verbalising the experience. They might gain some knowledge on the subject and will be informed of the outcome of the study.

## 7. PROCEDURES

7.1 Mark research procedure(s) that will be used:

Literature	√
Documentary	
Personal records	
Interviews	√
Survey	
Participant observation	
Other (please specify)	√
__Questionnaire_____	

7.2 How will the data be stored?

\_\_Both the audiotapes and the questionnaires will be kept at the office of the researcher, in safe place. There are no other people using her office and she will make very sure that the data are stored confidentially.

7.3 If an interview form/schedule; questionnaire or observation schedule/framework will be used, is it attached?

YES	√
NO	

**7.4 Risks of the procedure(s): Participants/subjects will/may suffer:**

No risk	
Discomfort	√
Pain	
Possible complications	
Persecution	
Stigmatisation	
Negative labeling	
Other (please specify)	
_____	
_____	

7.4.1 If you have checked any of the above except “no risk”, please provide details: The nature of the phenomenon under discussion is a highly personal one. The participant might feel some discomfort, but the researcher is an experienced counselor, and will use her professional skills to limit the discomfort.

**8. RESEARCH PERIOD**

(a) When will the research commence:

As soon as the researcher was given the go-ahead by the various committees (thus hopefully still in this year)

Over what approximate time period will the research be conducted:

Over a period of a year.

**9. GENERAL**

9.1 Has permission of relevant authority/ies been obtained?

YES	
NO	√

9.1.1 If yes, state name/s of authority/ies:

\_\_\_Not Applicable

9.2 Confidentiality: How will confidentiality be maintained to ensure that participants/subjects/patients/controls are not identifiable to persons not involved in the research:

No identifying details will be made available in a way that any one will be able to identify a participant. The researcher often presents cases in various settings where confidentiality is to be maintained, and is therefore knowledgeable in which way to make sure that the person is not identifiable. Pseudonyms will be used, as an example.

9.3 Results: To whom will results be made available, and how will the findings be reported to the research participants?

The results will be written up for a doctoral dissertation. Beforehand, the findings will be e-mailed through to the participants, to make sure that they feel comfortable that they will not be identified.\_

9.4 There will be financial costs to:

participant/subject	√
institution	
Other (please specify)	
_____	
_____	

9.4.1 Explain any box marked YES:

\_\_\_The participants may have to drive to the researcher.

9.5 Research proposal/protocol attached:

YES	√
NO	

9.6 Any other information which may be of value to the Committee should be provided here:

\_\_\_\_\_No\_\_\_\_\_

\_\_\_\_\_

---

Date: \_\_\_\_\_ Applicant`s signature

---

Who will supervise the project?

Name: Prof Sulina Green  
Department: Department of Social Work

Date: \_\_\_\_\_ Signature: \_\_\_\_\_

---

Director/Head/Research Coordinator of Department/Institute in which study is conducted:

Name: Prof Sulina Green

Date: \_\_\_\_\_ Signature: \_\_\_\_\_

**“Not tonight, dear ...  
I have a headache.”**

Does this sound familiar??? **Then please read on....**

When women choose not to engage in sexual activities, clinicians ascribe a diagnosis of “Hypoactive Sexual Desire Disorder”. *International* studies indicate that between 33% and 67% of all women present with low desire. This tendency is also found *locally*: Dr Elna McIntosh, a well-known therapist practicing in Johannesburg, stated, **“in my practice, 60% of women tell me that they love their husbands but they do not want sex”**.

Does this mean that half of *all* women are “suffering” from some “disorder”? Or is it possible that low desire is completely normal, but is being depicted as “a problem” for various reasons by the media, by societal ‘scripts’ or by pharmaceutical companies?

***I intend to find out, but I need your help:***

I invite you to take part in the research study and data collection (being conducted in November and December) for purposes of my Doctoral dissertation:

**THE PURPOSE OF THE STUDY:** To gain a better understanding of women who present with little/no desire, and to explore the experience of possible personal distress or/and interpersonal difficulties that may result because of the “problem”.

**PROCEDURE:** Meet with me for about an hour, either at your home or at my consulting rooms in Claremont, for a semi-structured interview. Your personal details will be kept entirely **confidential**.

**POSSIBLE BENEFITS TO RESEARCH SUBJECTS/SOCIETY:** As a relationship therapist, it is my experience that women who discuss the occurrence of low sexual desire gain clarity and perspective on the topic. The outcome of the research will address the question whether women are forced by societal expectations to perform sexually in a prescribed way that is not in line with the needs and inclinations of women themselves.

**PARTICIPANT CRITERIA** (Please contact me if you fit these criteria and are willing to partake in the study):

- You are between 35 and 55 years of age.
- You have been in a relationship your with present partner for more than two years and intend to continue with the relationship.
- You have low or no desire to engage in sexual activity with your partner.
- You know of no medical condition to account for this “condition”.

**ELZABÉ DÜRR**

**(Clinical Social Worker and Doctoral Candidate, University of Stellenbosch)**

**Cell: 082 259 1797**

**Private office line: 021 674 1295**

### TRANSCRIPT CONVENTIONS

The following transcripts were used:

...	Three dots indicate pauses in speech
....	Four dots indicate that I left out certain words/phrases in the sentence
<i>Terrible</i>	Words and phrases emphasised by the participant
Érg	The version of the emphasised cursive word in Afrikaans)
I <b>won't</b> /ek <b>sal nie</b>	Words and phrases accentuated even more strongly
I say <b>NO</b> / ek sê <b>NEE</b>	Words and phrases said very loudly
I say <b>NO!</b> / ek sê <b>NEE!</b>	Words screamed as exclamations and animatedly
...I won't... (have sex)	Explains what was indicated, but not verbalised
[laughs]	Explains an action by the participant, not what was said
<b>Must. Be. Joking.</b>	Said slowly with emphasis on each word

**“FEEDBACK FROM GWEN”**

The whole thing is a beautifully designed experiment. The idea of suffering being an integral part of growth – so we are given suffering in our childhoods that leave us scarred – we then fall in love with our beautiful selves – this rapturous time allows one to be blind to the other person while the biological urge to have children kicks in – this being in love bit lasts as long as necessary for regeneration in terms of children – the sex being essential for this – then the projection falls away and you are left with your self and some stranger really – so you either use the harsh connection with reality to look at yourself and grow from your wounds or you spend your life running to the next projection of your better self – or blaming everyone in sight for your unhappiness. If you choose to reclaim yourself and grow towards your full potential then your partner – if you are still together – becomes a person you share life’s joys and sorrows with, as well as your children and grandchildren.

This is the point of the experiment – to see what humans do with the various types of suffering and the opportunities to grow into themselves or not.

The sex bit allows you access to your real self in the deepest way possible if you use it as a path into yourself. Or you can remain on the surface and just have a physical thing with yourself – the sex – the immediate gratification, which lasts for a short time until next time. So it is the royal road to self-discovery and self-actualization. The coming into your own power being a big part of it too – becoming a warrior – not needy, dependent, blaming, accusing, etc. The great opportunity to use the mistakes your parents made to become fully who you are and not to make the same mistakes with your own children – only different ones!