Re-Considering Female Sexual Desire: Internalized Representations Of Parental Relationships And Sexual Self-Concept In Women With Inhibited And Heightened Sexual Desire

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RE-CONSIDERING FEMALE SEXUAL DESIRE: INTERNALIZED REPRESENTATIONS OF PARENTAL RELATIONSHIPS AND SEXUAL SELF-CONCEPT IN WOMEN WITH INHIBITED AND HEIGHTENED SEXUAL DESIRE

BY EUGENIA CHERKASSKAYA

A dissertation submitted to the Graduate Faculty in Clinical Psychology in partial fulfillment of the requirements for the degree of Doctor of Philosophy,

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Abstract

RE-CONSIDERING FEMALE SEXUAL DESIRE: INTERNALIZED REPRESENTATIONS OF PARENTAL RELATIONSHIPS AND SEXUAL SELF-CONCEPT IN WOMEN WITH INHIBITED AND HEIGHTENED SEXUAL DESIRE

by

Eugenia Cherkasskaya

Adviser: Margaret Rosario, Ph.D.

Background: Psychoanalytic and sociocultural thinkers and researchers suggest that the etiology of low female sexual desire, the most prevalent sexual complaint in women, is multi-determined, implicating biological and psychological factors, including women’s early relational experiences and sexual self-concept that stem from gender dynamics of a patriarchal culture. Further, recent studies indicate that highly sexual women exhibit heightened sexual desire, and high levels of sexual agency and sexual esteem. The study evaluated a model that hypothesized that sexual self-concept (sexual subjectivity, self-objectification, genital self-image) explains (i.e., mediates) the relations between internalized representations of parental relationships (attachment, separation/individuation, parental identification) and sexual desire in heterosexual women.

Methods: Six hundred participants completed self-report questionnaires, assessing the above-mentioned variables. Subsequently, 20 women (10 with inhibited desire, 10 with heightened desire) were individually interviewed about their experiences of sexual desire to examine the differences in the phenomenology of female sexual desire between highly sexual and sexually inhibited women. Results: The results partially supported the hypotheses: internalized
representations of parental relations (attachment and separation-individuation) significantly predicted sexual self-concept (sexual body esteem, self-objectification, genital self-image), which, in turn, was significantly related to sexual desire. Contrary to the study hypothesis, parental identification did not have a significant relationship with the construct of sexual self-concept. The narratives of highly sexual women embodied powerful and cherished experiences of bodily and relational desire, including a wish for merger, while those of the sexually inhibited women reflected negative affects and cognitions in a sexual context as well as a split between the bodily and the relational aspects of sexual desire. **Conclusions:** Current findings demonstrate the importance of investigating not only the sexually inhibited women but also the highly sexual women with a particular focus on women’s internalized working models of early parent-child relations and their experiences of their bodies in a sexual context in understanding the origins of female sexual inhibition. Treatment of low or absent desire in women would benefit from modalities that emphasize early object relations as well as interventions that foster mind-body integration.
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“The great question that has never been answered and which I have not yet been able to answer, despite my thirty years of research into the feminine soul, is ‘What does a woman want?’” (Freud & Strachey, 1925)

Re-Considering Female Sexual Desire: Internalized Representations of Parental Relationships and Sexual Self-Concept in Women with Inhibited and Heightened Sexual Desire

Introduction

The meaning, expression, and underlying processes of sexual desire has puzzled the study of sexuality, especially with respect to women, since Freud posed “The great question that has never been answered…‘What does a woman want?’” (Freud & Strachey, 1925). In basic terms, sexual desire can be defined as the wanting, wishing, craving, longing for sexual activity, physical intimacy, physical contact, closeness, passion, sexual pleasure, and a temporary merger/fusion with another, in which the boundaries of self are momentarily obliterated. However, sexual desire is anything but basic and empirical work and psychoanalytic theories offer divergent conceptualizations of sexual desire. The current study synthesizes psychoanalytic theory, empirical psychological research, and feminist theories of female sexuality in order to elucidate the psychological factors that contribute to enhancing or inhibiting female sexual desire in heterosexual premenopausal women. The study focuses on early and critical psychological experiences in the context of early relations with one’s parents as well as women's sexual self-concept, which refers to women’s feelings about their sexuality and their bodies. Specifically, the present study evaluated the model in which sexual self-concept (self-objectification, sexual subjectivity, and genital self-image) mediated the relations between the internalized representations of parental relationships (attachment, separation/individuation, and parental
identification) and *sexual desire* in women. Identifying forces that enhance or inhibit female sexual desire will not only add to the theory and research on female sexuality but also inform clinical practice for those working with women experiencing sexual difficulties.

The question of female sexual desire weaves through the history of the study of human sexuality, remaining impervious to the inquiries of some of the most prominent figures in the field, including Freud (1923, 1931, 1933), Masters and Johnson (1966, 1970), and Helen Singer Kaplan (1979). While Freud attempted to unravel the dynamics of female sexual desire by contrasting femininity with masculinity in psychosexual development, empirical research in the field of sexuality did not focus specifically on the topic of desire until H. S. Kaplan (1979) expanded the sexual response cycle developed by Masters and Johnson (1966) to include the phase of desire. Although Kaplan’s addition of the desire phase was a necessary and essential contribution to the understanding of sexual functioning and disorders, she did not further elaborate on the psychological or physiological processes that were specific to women’s experiences of desire.

The resultant triphasic sexual response cycle of desire, excitement and orgasm (with resolution) has served as the model for sexual disorders categories in the *Diagnostic and Statistical Manual of Mental Disorders* since 1980 (DSM-III; (American Psychiatric Association, 1980). The three categories are Sexual Desire Disorders, Sexual Arousal Disorders and Orgasm Disorders. Sexual Pain Disorders were added as a fourth category without a specific rationale in the DSM-III-R in 1987 (American Psychiatric Association, 1987). Besides the distinctions based on anatomy and physiology, differences in sexual functioning between men and women were not highlighted in the sexual response cycle or the DSM, including the differences that may lie in the realm of sexual desire. Further, the DSM does not provide a definition of sexual desire or
distinguish how it may differ in men and women in terms of subjective experience and baseline level of frequency and intensity.

Over the past decade, female sexual dysfunction, including low sexual desire, has been a topic of debate and investigation, which intensified in the context of the preparation of the DSM-5 (Brotto, 2010a). In the DSM-5, the previous diagnoses of Female Hypoactive Sexual Desire and Female Sexual Arousal Disorder have been merged while Sexual Aversion Disorder was deleted. The current criteria for the newly introduced diagnosis of Female Sexual Interest/Desire Disorder in the Diagnostic and Statistical Manual of Mental Disorders (DSM-5) are based on those of hypoactive sexual desire disorder. In addition to absent or decreased (1) sexual interest, and (2) erotic thoughts or fantasies, there are four new criteria, which account for absent or decreased activity in four additional aspects of sex life: absent or decreased (3) initiation of sexual activity or responsiveness to a partner’s attempts to initiate it, (4) excitement and pleasure during sexual activity, (5) response to any internal or external sexual or erotic cues (e.g. verbal, visual, written), and (6) genital and/or nongenital sensations during sexual activity. Three out of six criteria are required to receive the diagnosis. The problem must cause significant distress or impairment and is not attributable to a non-sexual psychiatric disorder, to substance/medication side-effects, to another medical condition, to severe relationship distress (e.g. partner violence), or other significant stressors (Diagnostic and statistical manual of mental disorders: DSM-5™ (5th ed.), 2013).

Hypersexuality has never carried the status of diagnosis in the DSM and was represented in the DSM-IV only as Psychosexual Disorder, Not Otherwise Specified, which includes a condition in which an individual engages in repeated sexual relations with a succession of sexual partners whom he/she perceives as things to be used. The proposed criteria for the diagnosis of
Hypersexuality, which was rejected by the DSM-5, included repetitive and intense sexual fantasies, urges and behaviors that may interfere with other important aspects of life, may be used to relieve stress or other negative affect, and may pose harm to self or others in the presence of marked distress and interpersonal difficulty, and in the absence of exogenous substances that would otherwise be responsible for these symptoms (Kafka, 2010).

The conceptualizations of sexual interest/desire disorder and hypersexuality do not adequately establish standards of normalcy when it comes to the appropriate level of sexual desire in women. While the individual’s experience of distress is a necessary component of both disorders, it is conceivable that the reported distress in women may stem from cultural and relational expectations rather than a woman’s sense about her own sexuality. Further, relational and emotional factors are not adequately addressed in terms of etiology, only as symptoms of the disorder, as is the norm in the DSM. Based on these deficiencies in the diagnostic criteria, the labels of hypoactive and hyperactive desire appear somewhat arbitrary.

Over the past decade, studies have examined the characteristics of highly sexual women (Blumberg, 2003; Wentland, Herold, Desmarais, & Milhausen, 2009), finding that highly sexual women express sexual agency with respect to their sexuality, have high levels of confidence about their sexuality, and are not dependent on their partner for sexual arousal. These women show significantly higher levels of sex drive, sexual fantasy, masturbation and sexual self-esteem than less sexual women, indicating that autonomous sexual desire may be a defining characteristic of highly sexual women (Wentland et al., 2009). Examining differences between highly sexual women and women reporting low or absent sexual desire may elucidate the factors that characterize sexual inhibition and/or high sexual desire in women.
In traditional psychoanalytic literature, the question of female sexual desire has not received proper attention but has emphasized male sexuality as active and powerful in contrast to passive and submissive femininity. Psychoanalytic thinkers, ranging from Freud (1925, 1931, 1933) to Kernberg (1995) and contemporary feminist psychoanalysts (Benjamin, 1988; Dimen, 1997, 2003; Elise, 2000, 2008) converge on the idea that female sexuality tends to be inhibited due to gender dynamics that are characteristic of a patriarchal culture. Furthermore, object relations theory, such as that of Kernberg (1995), assumes that extreme forms of sexual desire, including inhibition and hypersexuality, may be pathological conditions reflecting psychic conflicts as well as different levels of character pathology, ranging from Borderline and Narcissistic personality organization to Masochistic and Hysterical pathologies. While Kernberg acknowledges that female sexual inhibition may stem from the girl’s early experience with her mother as a normative developmental process, he describes it as delayed genital/sexual maturation, suggesting that women do eventually overcome this lacking desire. Yet, Kernberg does not explain how women achieve this higher level of psychosexual development, neglecting to enumerate the necessary events that must occur for the girl to overcome the mother’s rejection of and prohibition against her daughter’s sexuality. Contemporary feminist psychoanalysts such as Diane Elise (2000, 2008), Jessica Benjamin (1988), and Muriel Dimen (1997, 2003) approach female sexual inhibition from a more normative stance, arguing that patriarchy, which forms the basis of psychoanalysis itself, is in part responsible for low or even absent female desire. While theoretical literature hardly addresses heightened desire in women, based on the writings of Ruth Stein (Stein, 1998a, 1998b, 2008), Diane Elise (2000, 2008) and Muriel Dimen (1997, 2003), there is an argument to be made that high sexual desire may be an adaptive and healthy condition of (female) sexuality.
Empirical literature offers certain etiological models for the inhibition of female sexual desire but does not address the reason behind the high prevalence of low desire in women across cultures, which ranges from 26% to 42% (Laumann, Paik, & Rosen, 1999). Further, studies have neglected to contrast highly sexual women with women with inhibited sexuality in order to understand some underlying mechanisms that may be enhancing or diminishing women’s sexual desires. Importantly, studies have not looked at early and critical psychological experiences that may contribute to the level of sexual desire in adulthood, such as parent-child attachment, parental identification, and the separation/individuation processes. While researchers have examined the role of relationships and medical, psychological and cultural factors in diminishing female sexual desire, few studies have considered sexual self-concept constructs such as sexual subjectivity, self-objectification, sexual body esteem, and sexual body image, which are essential to women’s experiences of their sexuality (I will elaborate on these terms in subsequent sections of this proposal).

The response to the question that Freud (1925) asked almost a century ago – “What does a woman want?” – remains elusive. The gaps in theoretical and empirical literature indicate that our conceptualization of sexual desire in women requires further elaboration and investigation. Inherent in this deficient understanding of female sexual desire are the inequitable gender power dynamics that permeate patriarchal culture, science, and psychoanalysis, which privilege the desiring, penetrating male phallus as the benchmark for optimal sexual experience.

The proposed study aims to synthesize the empirical and psychoanalytic conceptualization of female sexuality to further investigate factors that may diminish or enhance sexual desire in healthy heterosexual premenopausal women who report either low or high levels of sexual desire. While the empirical literature emphasizes behavioral markers of desire that are
predicated on environmental cues, the psychoanalytic literature focuses on internal psychological processes that may or may not be reflected in behavioral strategies. The following proposal will highlight the gaps and limitations of both psychoanalytic and empirical literature while building a research model for the current proposal. Part I will review the empirical and the object relations formulation of sexual desire, with an emphasis on the meaning of desire in women. Part II will provide an overview of female sexual dysfunction, including definitions, epidemiology, and etiology. Part III will focus on early and critical psychological events that may be implicated in sexual inhibition in women. Part IV will examine the sexual self-concept variables, which may contribute to enhancing/diminishing female sexual desire and therefore explain the relationship between the early and critical psychological events and diminished or enhanced sexual desire in women. Part V will address the highly sexual woman from both empirical and psychoanalytic theoretical perspectives. The conclusion of this proposal will highlight the gaps and limitations of the current literature and outline the hypotheses of the present study.

Part I: Definitions of Sexual Desire in the Empirical and Psychoanalytic Literatures

Considering its elusiveness, it is not surprising that desire lacks a single unified definition within the psychoanalytic and empirical literatures on sexuality, especially in the context of female sexuality. While the empirical literature emphasizes behavioral markers of desire that are predicated on environmental cues, the psychoanalytic literature focuses on internal psychological processes that may or may not be reflected in behavioral strategies.

**Empirical definition of sexual desire.** Defining and operationalizing the concept and construct of sexual desire in such a way that it would be useful for both clinical and empirical purposes has proven to be a challenge for researchers, clinicians, and theoreticians. This confusion likely stems from the ambiguous markers of sexual desire, since behavior is not
always representative of one’s subjective wanting, especially for women, while the internal, subjective experience of desire is difficult to measure. Nonetheless, some definitions have been adopted to conceptualize sexual desire.

In the empirical literature, human sexual desire indicates the presence of sexual fantasies, urges, or activities, and the subjective conscious motivational determination to engage in sexual behavior in response to relevant internal and external cues (American Psychiatric Association, 2000; Bancroft, 2009; Kafka, 2010; Kaplan, 1995; Levin, 1994; Levine, 2002; Singer & Toates, 1987). Conceptualizing desire as a behavioral construct, Levine (2002) defines desire as the “sum of forces that incline us toward and away from sexual behavior” (p. 47). Levine emphasizes that sexual desire is quite variable, ranging from aversion to passion, and can be characterized by two distinct components: an interest in behaving sexually and the intensity of that interest. Such conceptualization of desire is contingent on one’s behavior, which is problematic, especially when considering female sexual desire. Research has shown that women’s tendency to engage in sexual activity is not always correlated with their wish to be sexual, as they may feel desire in the absence of sexual activity (Brotto, Heiman, & Tolman, 2009) or they may engage in sexual activity in the absence of desire (Cain et al., 2003). Multiple factors may motivate women to engage in sexual activity, including their wish to please their partner, a sense of obligation, the wish to feel loved and desired, etc. At the same time, a woman who experiences sexual desire may engage in less sexual activity due to certain deterrents, such as the risks of sexually transmitted diseases, pregnancy, or violence as well as the unavailability of a sexual partner. Further, women’s desires may be ignited in a certain context, such as in the company of partner or in the presence of sexually explicit material, but lay dormant in the
absence of contextual cues, and thus spontaneous urges and yearnings as well as fantasies also do not necessarily represent women’s sexual desire.

Brotto (2010b) argues that an overriding problem in understanding female sexual desire is the divergence between the definitions adopted by clinicians and researchers and those endorsed by women. While the DSM includes absence of fantasy as part of its definition of hypoactive desire, according to participants’ report, women rarely discuss fantasy in their experiences of desire (Brotto et al., 2009); rather, they enlist fantasy in the service of eliciting desire. Further, King and colleagues (2007) found a low degree of concordance between diagnostic measures of sexual dysfunction and women’s perceptions of their own sexual problems specific to disorders of desire and arousal. Recent studies and clinical investigations reported by Basson (2001a, 2001b, 2002a, 2002b, 2002c, 2003a, 2003b, 2005, 2010) indicate that our current understanding of the sexual response cycle based on the work of Masters and Johnson (1966, 1970) and Kaplan (1977) may not be applicable to women as previously assumed, calling into question our current theoretical framework and definitions for women’s sexual problems, especially that of desire.

**Brief history of the sexual response cycle.** At the end of his lecture on Femininity, Freud conceded that his account is “…certainly incomplete and fragmentary and does not always sound friendly…If you want to know more about femininity, enquire from your own experiences of life, or turn to the poets, or wait until science can give you a more coherent information” (Freud & Strachey, 1933, p. 135). Enter Masters and Johnson who advanced the study of female sexuality in their seminal works, Human Sexual Response (1966) and Human Sexual Inadequacy (1970), the former presenting the four-phased sexual response cycle. Conducting physiological assessments of sexual responses of men and women, Masters and Johnson outlined a linear
sequence of arousal, a plateau of excitement, followed by orgasm and resolution. The arousal phase in women became synonymous with genital arousal (vaginal lubrication and swelling) although the original description included both the subjective and physiological experience.

While Masters and Johnson primarily focused on the physiology of sexual responses in men and women and developed a model that equalized the sexes in such a way that obfuscated many gender differences, they did make some interesting observations about female sexuality. Specifically, they debunked Freud’s idea of the superiority of the vaginal orgasm over the clitoral orgasm, claiming to demonstrate a unitary orgasm (Masters & Johnson, 1966). This began the process of the reclaiming of the female sexual body – specifically the clitoris – legitimizing one source of female sexual pleasure and possibly liberating an aspect of female sexual desire. While Masters and Johnson focused exclusively on the functions and dysfunctions of genitalia, they did not significantly differentiate between male and female processes. Furthermore, they did not include in their work on human sexuality the studies of sexual desire and desire disorders.

Following the work of Masters and Johnson, Kaplan (1977) revised the model of the human sexual response, adding desire as the first phase of the cycle. She differentiated between desire that could be triggered during the sexual experience, called “extrinsic/responsive” desire, and desire that would precede any sexual activity, termed “intrinsic/biological” desire. However, the linear model of the four phases of the human sexual response excluded the idea of desire as a response to sexual stimuli, favoring extrinsic, spontaneous desire, in which the “activation of the sex-regulatory centers in the hypothalamus and limbic system is associated with the subjective urge to copulate and to engage in sexual fantasy” (Kaplan, 1995, p. 111). While Kaplan made significant strides in expanding our understanding of desire, certain gaps remained. First, she
conflates motivation and desire, disregarding the idea that motivation to be sexual, which may stem from the partner’s expectations and societal pressures, may exist in the absence of sexual desire. Kaplan also uses the terms “sexual desire” and “sexual fantasy” interchangeably, as she considers the latter to be a “mental representations of a person’s ardent sexual wishes and desires” (Kaplan, 1995, p. 46). While this may be true for men, as mentioned previously, fantasy is not necessarily indicative of desire in women but rather is evoked to enhance sexual arousal once sexual activity is initiated (Bancroft, Loftus, & Long, 2003; Brotto et al., 2009; Cain et al., 2003). Apart from considering gender differences in phylogenetic determinants, Kaplan does not find much difference between men and women in their respective experiences of desire – its development, functions, and dysfunctions.

In the past decade, Rosemary Basson (2001a, 2010) has published numerous papers that challenge the sexual response cycle developed by Masters and Johnson and later expanded by Kaplan. Basson argues that women’s sexual response cycle is not linear but circular, in which there are overlapping phases that follow a variable order. Desire does not necessarily precede arousal but may be triggered during sexual activity once the woman has become subjectively aroused and sexually excited. Desire and arousal thus emerge simultaneously and compound one another. The woman then begins to desire sexual satisfaction, which may or may not involve one or more orgasms. An emotionally and physically positive outcome allows the woman to realize her original goal, such as feeling closer to her partner, which augments subsequent sexual motivation. Basson does not eliminate initial apparent spontaneous sexual desire, but argues that such desire is not as common in women as it is in men and more importantly, is not necessary for a healthy and satisfying sexual experience. Once exposed to sexual stimuli, the woman takes
appraisal of her subjective arousal by how sexually exciting she finds the stimulus and by concurrent emotions and cognitions generated by the arousal.

The experience of subjective arousal thus overlaps with desire, while the physiological arousal, exhibited by vasocongestion and lubrication, appears to contribute relatively little to the level of desire (Basson, 2010). The correlation between subjective arousal and objective genital engorgement is highly variable for sexually healthy women, which is very different from men for whom subjective and objective arousal is highly correlated. Furthermore, women with sexual dysfunction often do not lack physiological arousal but report an absence of subjective arousal accompanied by negative cognitions when presented with erotic stimuli (Everaerd, Laan, Both, & van der Velde, 2000; Laan, van Driel, & van Lunsen, 2008). Other studies have found low correlation between awareness of genital throbbing, tingling, swelling and lubrication with objective assessment of vasocongestion, indicating that the latter is not the primary determinant of subjective arousal. Of note are the findings of women experiencing objective sexual arousal in response to sexual but not erotic stimuli, such as a video of primates engaged in mating activities (Chivers & Bailey, 2005). Basson (2010) concludes that for women, the genital response is an unconscious, involuntary reflex rather than a reflection of subjective arousal or desire.

Citing previous research (Cain et al., 2003), Basson argues that women begin to engage in sexual activity or refrain from sex for complex reasons other than the presence or lack of desire. A woman may decide to be sexual as a way to increase emotional intimacy with her partner and/or in order to feel attractive, feminine, loved, appreciated and desired (Basson, 2001b; Brotto et al., 2009; Cain et al., 2003). A recent study found that women are more likely to feel desire once they become aroused then vice versa, especially if they are in long term relationships (Carvalheira, Brotto, & Leal, 2010b). In a qualitative study of women with and
without sexual arousal disorder, 80% of all women defined their goal of sexual intercourse as sharing emotional contact whereas far fewer endorsed the goal of orgasm. Women enumerated several triggers of desire, including physical touch, visual images, the partner’s behavior or their own memories (Basson & Brotto, 2009). Throughout her work, Basson reiterates the importance of considering the woman’s sexual context and environment, including her current relationships and developmental or medical history when diagnosing disorders of desire and arousal (Basson, 2010).

An interesting difference emerges between the definitions of desire of Basson and Kaplan in that while the latter equated desire and motivation, Basson distinguishes between the two as distinct concepts. Women may be motivated to engage in or avoid sexual activity for reasons other than their desire to be sexual. For a woman who is motivated to seek out sexual situations, desire may emerge once she is in the presence of appropriate sexual stimuli that are conducive to physical intimacy. On the other hand, a woman may feel desire to engage in sexual activity but lacks the motivation due to inter- or intrapsychic conflicts or other factors. The problem in conflating desire and motivation lies in the ambiguity of the term desire and highlights the gaps in the current formulation of sexual desire. As illustrated by Basson and aforementioned research, women’s level of sexual activity and genital arousal are not good determinants of desire. On the other hand, women’s evaluations of desire also may be complicated by the standards against which they assess their level of desire. Conceivably, a woman may feel that her level desire is below her partner’s expectations or the expected norm as propagated by perceived societal standards. Integrating the relational and social context into the assessment of women’s sexual desires may therefore enhance our understanding of her experience of desire.
Sand and Fisher (2007) conducted a study to assess the extent to which women in a community sample endorse different sexual response cycle models. Women filled out a self-report questionnaire, which assessed their perception of the correspondence between their sexual experience and the current models of sexual function, based on Masters and Johnson, Kaplan, and Basson. The authors also were administered the Female Sexual Function Index (FSFI) (Rosen et al., 2000) to determine women’s levels of sexual functioning. An approximately equal number of women endorsed each of the three models of female sexual response as reflecting their own sexual experience. Women who endorsed Basson’s model had lower sexual functioning as assessed by the FSFI scores than the women who endorsed Kaplan’s or Master and Johnson’s models. This study indicates that women’s sexual response cycle is quite heterogeneous and may not be captured by one model. Further, Basson’s model may best identify women with sexual concerns, so that compared to women who have spontaneous sexual desire, women who do not experience spontaneous desire may report more sexual inhibition. Such heterogeneity in the female sexual response highlights the gap in the literature concerning the contributing factors that differentiate the women who experience different levels of sexual desire, and how these factors may be related to sexual dysfunction in women.

While recent empirical studies of female sexuality have developed a more nuanced conceptualization of sexual desire that is specific to women, several problems remain. The definition of sexual desire continues to be based primarily on observable behavior or the motivation to be sexual. The difficulty with this definition lies in the fact that women’s feelings about engaging in sexual activity are inextricably linked to contextual factors, including relational and sociocultural variables. Apart from sexual desire indicating the wish to behave sexually, the current empirical definition does not address other intrapsychic components of what
it means to experience sexual desire – a consideration that is captured by the psychoanalytic formulation of sexual desire, to which I will now turn.

**Psychoanalytic definition of sexual desire.** While Freud employed the term libido to indicate sexual desire grounded in drive theory and characterized infantile sexual desire as polymorphously perverse, object relations theory places human sexuality and specifically, desire, in a more relational context, in which the self and the object are central to the conceptualization of sexual desire. Kernberg remains unequivocal in his meaning of erotic desire – it is about the object, sexual excitement, transcendence of self, and the fusion of self and other. In his theory, desire does not seem so elusive after all – that is until, we invite the woman into the discourse and then Kernberg’s concept of sexual desire becomes opaque, requiring further consideration and elucidation.

Muriel Dimen (2003) addresses this very issue when she proclaims,

Desire is ambiguous. Sometimes it is focused and precise, sometimes it’s elusive and inconclusive. Desire is discontinuous, shifting. It is what waits to be given definition within and between selves. Among the diverse meanings it has received, all situationally plausible, are the classic linkage to reproduction goals; the equally classic Freudian delinking of drive, aim, and object; the Lacanian gap between Imaginary and the Symbolic; and object-relational yearning for attachment. When desire emerges as an indeterminate end in itself, as, with its passions, impossibilities, and pain, it often is; a quantum leap has been taken, and the rest is history—and psychoanalysis. (p. 109)

Dimen argues that women’s desire embodies multiplicity of contradictory states and meanings: “present here and absent there, flaring here, doused there, flickering still elsewhere, its ambiguity, difficulty, and elusiveness the alternate truth of all, of anyone’s desire” (Dimen, 1997, p. 543).

Putting desire in the context of object relations, Dimen argues that desire exists between the two worlds of the interpsychic and intrapsychic – the intrapsychic takes on its meaning in the desiring field between people, and that field is realized through the internal psyches of the
individual participants. Dimen further suggests that desire can only be defined by what it is not: “Desire is about lack, absence, longing…it is fundamentally unsatisfiable, a permanent, driving incompleteness” (Dimen, 2003, p. 107). Importantly, desire takes on meaning once the cultural context is introduced. Glibly, she jokes that “desire is like invisible ink: it won’t show up unless it gets wet” and what “wets” it is culture, without which it embodies no meaning or significance (Dimen, 2003, p. 107). Dimen references both Freud’s (1905) ideas of polymorphous perversity and anthropologist Margaret Mead’s (1928) ideas on sexual flexibility, and argues that desire is multiple; however, she debunks psychoanalytic determinism and argues for desire’s independence from nature in favor of cultural variability. And thus, Dimen concludes that sexual desire is flexible, multiple, contingent and culturally variable – generating space for us to consider female sexual desire from the multiple vantage points described below.

For Kernberg (1995), erotic desire is “a search for pleasure, always oriented to another person, an object to be penetrated or invaded or to be penetrated or invade by” (p. 22). It includes the wish for closeness, merger, and fusion that entails “crossing a barrier and becoming one with the chosen object” (p. 22). Erotic gratification occurs if and only if the sexual act serves the larger unconscious longing for fusion with an object. Kernberg defines the intensity of sexual desire as “reflected in dominance of sexual fantasy, alertness to sexual stimuli, desire for sexual behavior, and physiological excitement of genital organs” (p. 5). He distinguishes between erotic desire and sexual excitement, considering the latter as a basic affect that is subsumed by the more complex psychological phenomenon of erotic desire, in which sexual excitement is bound to an emotional relationship with a specific object. Erotic desire thus involves the wish for a sexual relationship with a particular object while sexual excitement is without object. The latter exists in relation to a primitive part-object that stands as an unconscious representation of the
early experiences of symbiosis with the mother and the wishes of the separation-individuation phase of subsequent development. Erotic desire, on the other hand, is the desire for merger with the oedipal object through sexual connection and thus in mature, well-integrated individuals, sexual excitement is triggered in the presence of erotic desire.

According to Kernberg, erotic desire, linked to a particular object, is the wish to transcend the boundaries of self and to merge with another. Erotic desire thus transforms the sexual experience into one of fusion and the transcendence of one’s own limits, achieving a sense of oneness. Sexual experience not only provides the transcendence from the “experience of the self to the fantasied union with the oedipal parents” but also the transcendence from the “repetition of the oedipal relation to the abandonment of it” in a new dyadic experience in which one can retain autonomy and integrity of self (Kernberg, 1995, p. 41). In sexual passion, the boundaries of self are crossed and the world of early object relations is transformed into a new one.

Ruth Stein (1998a, 1998b), delving into the idea of sexuality as excess, argues in favor of multiplicity of sexual desire. She considers excess to be an essential part of the sexual experience – the excess of excitation and sexual desire that overcomes the boundaries and limits of self, shatters psychic structures and generates the formation of new ones. In her paper, “The Otherness of Sexuality,” Stein (2008) culls from the theories of Bataille, Benjamin, and Fonagy, among others, to argue that these types of excess embody a transformative potential for the self – and thus, transformation stands at the crux of sexual desire. The transformative potential of erotic union and the nature of sexual desire are multiple – to overcome the state of separateness and inner limits (Bataille), to release intrapsychic tension and aggression (Benjamin), and to expel the alien self (Fonagy).
Stein (1998b, 2008) refers to the ideas of George Bataille (1957; 1976) who expounds on ideas of discontinuity of the human condition, which necessitates sexual union as a way to assume the desired state of continuity. The human experience is one of limits and the ultimate limit is death. Erotic union, which in itself is a form of momentary death, provides a way to deal with death through the excess of sexuality that obliterates the boundaries of self and reinstates continuity. While it is impossible to completely shed one’s boundaries and merge with another, the mere possibility arouses sexual excitement. Sexual desire or eroticism becomes the wish to return to a state of non-separateness, which allows human beings to “fill the gap between ourselves and all that is not us” (Stein, 1998b, p. 255). Sexual desire is the craving for excess, which transforms powerful emotions and facilitates the transcendence of one’s inner limits, at least temporarily.

Stein (2008) further refers to the theories of Jessica Benjamin (1995, 2004) who redefines Freudian ideas about the release of tension by placing it in the intersubjective realm. The desire for sexual union becomes the wish to release intrapsychic tension and aggression into the other, where it can be absorbed, metabolized and transformed into pleasure. In the absence of erotic union with another, the individual turns this tension against oneself as aggression and omnipotence while the sexual act relocates the tension from the mind, where it is excessive and unbearable, into the body, where aggression comes to be saturated with sexual pleasure.

Stein also offers Peter Fonagy’s (2006, 2008; Fonagy & Target, 2004) ideas on excess in sexuality, in which sexual desire is the wish to achieve psychic integration by expelling one’s alien self into the object. Fonagy argues that the strange and incongruous events that happen between the mother and her infant produce the experience of discordance and excess, which constitute the alien self and cannot be tolerated and thus need to be expelled through sexuality.
Fonagy, like Benjamin and Kernberg, believes that this sexual discharge of one’s alien self occurs in the context of object relations.

In integrating these varying theories of sexuality as excess, Stein concludes that the craving for a sexual encounter is about “striving toward the “excessive” other, needing to make sense of his or her imposition and thereby grow and integrate” (Stein, 2008, p. 64). Sexual excess allows one to transgress her boundaries, to expel negative affect, and to replace existing ego structures with more advanced and integrated ones. Stemming from French ideas of sexual orgasm as *la petit mort*, Stein conceptualizes sexual desire as a striving towards the shattering of the old self through the union with another object out of which a new self emerges. Unlike Kernberg, Stein does not privilege the object in the context of erotic desire. Instead, she perceives sexual desire as the desire for excess, which has the potential to release the renewed, restructured, and more integrated self.

In *The Bonds of Love*, Benjamin (1988), focusing specifically on female sexual desire, locates it in the intersubjective realm, and offers a new perspective on woman’s desire that does not stem from penis envy as had been proposed by Freud. Rather than wishing for a phallus, Benjamin’s woman wishes for an open space in which she can be known and where she can find her own inner space. Benjamin (1988) argues that a woman can be in possession of sexual desire only if she is able to occupy the positions of both subject of her own desire and the object of the male desire – rather than only the latter, which is frequently the case for women. Similarly to Kernberg, Stein and other object relational theorists, Benjamin characterizes sexual desire as the striving for merger with the other through sexual union; however, the ultimate aim of this union is for mutual recognition. Distinct bodies and minds become so intensely attuned that self and other momentarily merge, and thus both individuals experience a similar feeling in one another
and achieve a sense of mutuality and recognition. This sexual desire that is simultaneously the “desire for loss of self and for wholeness (or oneness) with the other,” Benjamin argues, signifies the desire for recognition, which is an essential component of differentiation and autonomy (Benjamin, 1988, p. 126). Achieving recognition of the self in the other allows the woman to attain a sense of herself as a separate and autonomous being. In formulating the nature of female desire, Benjamin focuses on the self, and just as Stein argues that the erotic union may foster advanced restructuring and integration of the ego, Benjamin defines a woman’s sexual desire as the desire for recognition through which the “interior self may emerge, like Venus from the sea” (Benjamin, 1988, p. 129).

The object relations theorists thus converge on the idea that sexual desire reflects the craving for merger and transcendence of self. Kernberg focuses on erotic desire being directed at a particular object in order to achieve what he believes to be mature love, in which integration of total object relations has occurred. Stein, along with the theorists she references, also places sexuality in the intersubjective realm but she does not necessarily privilege the object as a requirement for the presence of erotic desire. Further, she does not distinguish between sexual excitement and erotic desire. In her formulation, there is a need for the other to be the receptacle for the alien self, intrapsychic tension and aggression, and the obliteration of the limits of the human condition. For Benjamin, the other must be present to fulfill the woman’s need for recognition. The emphasis in their conceptualization of sexual desire is on the self – not on the other. The other is there in the service of the self.

The empirical literature focuses on the behavioral aspect of sexual desire and how it relates to the other components of the sexual experience, such as arousal and orgasm. Further, studies indicate the heterogeneity of the sexual response cycle in women, suggesting that a single
definition that focuses on sexual behaviors or the motivation for sexual behaviors would not adequately capture the phenomenon of female sexual desire (Sand & Fisher, 2007). Rather than focusing on behaviors and external motivating factors of desire, psychoanalytic writers consider sexual desire as the unconscious wish to fuse with another and transcend the boundaries of self. As Kernberg asserts, the individual must be able to maintain the integrity of self in the face of such fusion and obliteration of boundaries between self and other. This suggests that the capacity for sexual desire requires the development of an autonomous identity and therefore successful achievement of separation and individuation. Furthermore, Stein and Benjamin consider sexual desire to act in the service of the ego, and focus on the needs of the self. In this way, it is important to consider sexual self-concept in the study of the psychological forces that characterize sexual desire.

In the current study, based on the psychoanalytic and empirical literatures, sexual desire is conceptualized as a multifaceted phenomenon that weaves together elements from the interpsychic, intrapsychic, and behavioral/manifest domains and would apply to both male and female experiences of sexual desire; however, the former is beyond the scope of the current study. Sexual desire is the wish to engage in sexual activity in either a solitary or partnered context; it is the longing to merge with the fantasied or real other; it is the want to experience physical pleasure and excitement; it is the need to express one’s agency and ownership over one’s body and sexuality; it is the yearning to connect with oneself; it is the striving towards the transformation of self. Importantly, this definition does not solely consider the frequency of a woman’s sexual activity, which often does not adequately convey the level of her sexual desire (as discussed above). Rather, the current conceptualization aims to capture the conscious and unconscious subjective experience of sexual desire.
As will be apparent in the following review of the empirical investigations into sexual desire in women, there is a scarcity of studies on the relationship between early and critical experiences, such as separation and individuation and attachment, and sexual desire in women. Further, research does not sufficiently address sexual self-concept – how women perceive and internally represent their own sexuality, their sexual bodies, and their sexual agency – in the investigation of female sexual desire.

**Part II: Overview of Female Sexual Dysfunction (FSD)**

**Female Sexual Dysfunction.** Female Sexual Dysfunction (FSD), an umbrella term for disorders of desire, arousal, orgasm, and pain in women, has become quite prevalent in studies of sexuality, and has received mixed responses from clinicians, theoreticians, and researchers. The problematic issues that concern FSD range from the definitions and diagnostic criteria that identify these disorders to the overlap between the different dysfunctions, which call into question the current classification system for female sexual dysfunctions. Further, the pharmaceutical industry, striving to design a drug to treat FSD, has elicited much criticism from prominent figures in the field of female sexuality, such as Leonore Tiefer (2003) and has called into question the utility and conceptualization of FSD. The recent DSM-5 resulted in a reevaluation and reorganization of the diagnostic criteria for sexual dysfunctions that could potentially better facilitate the assessment and treatment of women’s sexual problems (Brotto, 2010a). As mentioned previously, the DSM 5 merged the hypoactive sexual desire and arousal disorders in female sexual interest/desire disorder while creating a separate hypoactive sexual desire disorder for men, deleted sexual aversion disorder, combined vaginismus and dyspareunia into genito-pelvic pain/penetration disorder, and retained the female sexual orgasm disorder. A major change that was advocated by multiple sexologists, such as Brotto and colleagues (2010),
was the integration of the arousal and desire disorders into a single diagnosis since these disorders are not independent of one another, and numerous studies have demonstrated that a high level of comorbidity exists between them (Brotto, 2010a; Brotto et al., 2010; Brotto, Graham, Binik, Segraves, & Zucker, 2011; Carvalheira, Brotto, & Leal, 2010a).

The Working Group for a New View of Women’s Sexual Problems chaired by Lenore Tiefer presented a novel way of understanding female sexual disorders that is based on etiology rather than symptomatology and incorporates multiple levels of context (cultural, interpersonal, and internal) (Tiefer, Hall, & Tavris, 2002). The New View offers a feminist, antimedicalization critique of the classification system for and a redefinition of women’s sexual problems, as “discontent or dissatisfaction with any emotional, physical or relational aspect of sexual experience” (Tiefer et al., 2002, p. 229). In line with Basson’s circular sexual response cycle (discussed in the previous section), Tiefer (2003) argues that there is no “normal” sexual response or experience, which also indicates that there is no “normal” level of desire. Rather, there are four major aspects of women’s sexual lives that potentially contribute to difficulty in any realm of sexual functioning, including that of desire. The New View provides four categories of causes that the authors believe should be incorporated into diagnostic criteria of sexual disorders: (1) sexual problems due to sociocultural, political, or economic factors; (2) sexual problems relating to partner or relationship factors; (3) sexual problems due to psychological factors; and (4) sexual problems due to medical factors. Since there is very little evidence for innate (biological) dysfunction of desire (Stuckey, 2008), women’s experience of low or lacking desire may be in response to problematic stimuli. In this way, focusing on the context of women’s problems may elucidate the reported disorders of desire. One study, to date, has empirically tested and found significant correspondence between women’s reports of their sexual
problems and the classification system of women’s sexual difficulties defined in The New View by asking women to describe their sexual difficulties in their own words (Nicholls, 2008). Women were more likely to attribute sexual difficulties to relational and contextual/external factors than to individual psychological or medical factors. The New View overhauls the linear, medicalized model of sexual functioning in the DSM by focusing on etiology. While it highlights certain gaps in the current definition of desire and disorders of desire, namely the need for inclusion of cultural, relational and individual factors, it may be problematic in the diagnosing of women’s sexual problems, since specific etiological causes or reasons are rarely apparent and multiple factors may interact in complex ways (Basson, 2006). Also, it is problematic to consider etiology without addressing specific symptoms. Further, it leaves out early and critical experiences as well as women’s sexual self-concept components.

**Prevalence of desire difficulties in women.** The prevalence rates of FSD are problematic because the ways in which the different disorders have been measured and the study samples that have been assessed have been inconsistent. In the largest study population of 31,581 women over the age of 18 years, 40% reported sexual problems; however, sexual problems associated with personal distress occurred in only 12% of the participants (Shifren, Monz, Russo, Segreti, & Johannes, 2008). Hayes and colleagues (2006) reviewed prevalence studies to investigate FSD and related difficulties. They distinguish between dysfunction and difficulties, reserving the term sexual dysfunction for instances in which personal distress and low sexual functioning are present. The term, sexual difficulties, refers to the more general phenomenon of reduced sexual functioning without a clear indication of distress. They found that the majority of studies did not assess sexual distress and used simple questions rather than multi-item instruments to assess sexual dysfunction, the former being a less reliable measure than the
former. They concluded that the current literature appears to be too heterogeneous to establish overall prevalence rates. Nonetheless, they were able to draw some conclusions about women’s sexual problems. Desire complaints are the most frequently reported sexual difficulties endorsed by women. Among women with any sexual difficulty, 64% (range 16-75%) experienced desire difficulty compared to 35% for orgasm and 31% for arousal. In another review of the epidemiology of sexual dysfunctions, Lewis and colleagues (2010) reported that the prevalence of low sexual desire in women ranges from 17% to 55%, with an increase in prevalence as women age – 10% of women up to the age of 49 years having low desire, 22% for women between 50 and 65 years, and 47% for women between 66 and 74 years of age.

Referring to specific studies, Laumann and colleagues (1999) found that 43% of American women between the ages of 18 and 59 experience some form of sexual dysfunction, with decreased sexual desire being the most prevalent disorder, affecting 32% of U.S. women. Further, 27% of European women suffer from sexual dysfunction, with a lack of sexual desire as the most common disorder (Laumann et al., 2005). In a study of 703 Austrian women between the ages of 20 and 80, 9% of women had no desire to engage in sexual activity in the past 4 weeks, 46% reported that they occasionally or rarely had the desire, while 33% of women reported a frequent desire to engage in sexual activity; the latter group was between the ages of 20 and 40 years (Ponholzer, Roehlich, Racz, Temml, & Madersbacher, 2005). In the study of Women’s Health Across the Nation (SWAN), looking at 2,400 women of different ethnicities (African-American, Caucasian, Chinese, Hispanic, Japanese) between the ages of 42 and 52 years, 40% reported either never or infrequently having sexual desire. Chinese women reported the least desire, followed by Japanese women, then by Caucasians, African-American, and Hispanics. This study indicates that prevalence of sexual desire difficulties may vary as a
function race and ethnicity (Cain et al., 2003). These studies did not address the confounds of both biological factors (e.g. menopause, hormonal profile) and psychological and relational issues (e.g. quality of sexual relations) in their investigations of prevalence of FSD.

Importantly, there is a high incidence of overlap between different sexual dysfunctions. Hypoactive Sexual Desire Disorder and Female Sexual Arousal Disorder, which used to be separate diagnoses in the DSM-Ⅵ, are often comorbid, and some have argued that the majority of disruptions in female sexual functioning is associated with arousal difficulties. For example, orgasm is impossible without sexual arousal, and absent or impaired arousal may diminish desire, given that sex is not enjoyable without adequate arousal. Sexual pain disorders also may be linked to lacking arousal, given that sex without lubrication can be painful, and repeated intercourse without arousal can lead to vulvar infections, irritation, vaginismus, fear of sex and a complete avoidance of sex (Meston & Bradford, 2007).

The conflicting prevalence rates and the inconsistency of measures, study samples, specifically by age, suggest that women’s sexual inhibition may not be as common in adult, premenopausal women as current research findings suggest. As will be discussed below, grouping pre- and post-menopausal and menopausal women when studying prevalence of sexual desire disorders may generate misleading findings, since physiological and psychological shifts associated with menopause may alter women’s sexual experiences. The etiology of low desire in pre- and post-menopausal women may be quite different and requires separate investigations, as the latter is more likely to be associated with the physiology of the aging process while the former is more likely to result from psychological causes. That is not to discount that postmenopausal decline in sexual desire also may stem from psychological processes, and biology may be implicated in deficient desire in premenopausal women.
Etiology of disorders of desire. H. S. Kaplan (1995) suggests that desire disorders, including hypoactive and hyperactive desire, indicate that the normal controls of sexual motivation have been disrupted. Using the terms motivation and desire interchangeably, she explains that sexual desire, along with other motivations such as hunger or thirst, is governed by neurobiological mechanisms of the central nervous system and that malfunctions of these mechanisms lead to disorders of sexual desire; however, such biological explanation is not sufficient to account for sexual inhibition. At the same time, she suggests that on an unconscious level, individuals with low sexual desire suppress their sexual feelings by engaging negative cognitive and perceptual processes, accentuating their partners’ negative qualities while ignoring their positive attributes. She argues that at the root of desire disorders lie severe intrapsychic sexual conflicts and relational difficulties that are more severe than those observed with other sexual dysfunctions, such as anorgasmia. Such discrepancy indicates that these individuals develop disorders earlier in the sexual response cycle, namely in the desire phase, which results in the halting of the sexual experience prior to its inception.

Consistent with Kaplan’s thinking, research investigations over the past 10 to 15 years have demonstrated that women’s sexual problems are multidetermined, with biological, psychological and sociocultural variables potentially interfering with female sexual functioning.

Biological Factors. Research on the role of biology in FSD has not reached a consensus about its contribution to inhibiting or enhancing female sexual desire. Biological factors include fatigue, stress, sexually negative effects of medications, reduced sex hormone activity, and less frequently, hyperprolactinemia (elevated serum prolactin hormone) and hypothyroidism (reduced thyroid hormone). Some evidence suggests an association between women’s sexual desire and levels of sex steroid hormones, specifically androgens and estrogens; however, researchers
disagree on which sex hormones – estrogen, progestin, or testosterone – have the greatest influence over female sexual desire (Guay & Spark, 2006). These hormones are produced in the adrenal glands and ovaries in women via two distinct processes. Disorders of ovarian function and of the hypothalamic-pituitary-adrenal axis interfere with the production of these hormones and have been linked to reduced sexual desire and problems with sexual arousal (Guay & Spark, 2006). Sexual problems also tend to arise during menopause when women’s ovarian function begins to decline, resulting in decreased ovarian production. Epidemiological studies indicate that surgical menopause, caused by oophorectomy (removal of ovaries) is a greater risk factor for decreased desire than natural menopause (Dennerstein, Koochaki, Barton, & Graziottin, 2006; Leiblum, Koochaki, Rodenberg, Barton, & Rosen, 2006). Since estrogen is necessary to maintain vaginal tissue, estrogen deficiencies may result in genital arousal problems, such as decreased lubrication and atrophy of vaginal tissues, which may reduce sexual desire as well.

Stuckey and Bronwyn (2008) conducted a review of the literature on female sexual function in the reproductive age range to examine the influence of the menstrual cycle, pregnancy, the oral contraceptive pill, and endogenous and exogenous testosterone. Confirming previous reviews that sexual disinterest is the most common sexual complaint in premenopausal women, they found that lacking sexual desire is prevalent in women despite being “hormone replete” (p. 2282). They found that studies of menstrual cyclicity indicate an increase in sexual desire during the periovulatory phase of the menstrual cycle, as well as a decline in sexual function with the progression of pregnancy. Further, they did not find a consensus on the influence of the oral contraceptive pill on sexual desire, with most prospective controlled studies finding no adverse effect.
One of the most controversial topics in this area of study is the role of androgens in regulating female sexual desire, with studies yielding contradictory results. While one large cross-sectional study did not find a correlation between levels of endogenous androgens and sexual desire, some case-controlled studies show low levels of androgens in women with sexual dysfunction. One of the major problems in studying the role of androgens on female sexual functioning is the lack of reliable testosterone assays within the female range (Taieb et al., 2003). Davis and colleagues (2005) conducted a large-scale study of 1,021 women between the ages of 18 and 44 years and found no relationship between total or free testosterone and low sexual function. While a low score for desire, arousal, or responsiveness was correlated with a dehydroepiandrosterone (DHES; a type of androgen) below the 10th percentile, most women with low DHES reported normal sexual functioning. Other researchers using different methodologies have found different results. One study looking at 18 menopausal women with low sexual function and 14 controls found a significant difference in total and free testosterone between the groups (Guay et al., 2004). Turna and colleagues (2005) compared low libido premenopausal women with controls, showing significantly lower levels of testosterone in the former; however, there was a considerable overlap in women’s level of sexual functioning as reported by the Female Sexual Function Index (FSFI) between the two groups. Finally, another case control study (Nyunt et al., 2005), comparing androgens in 29 women with reduced libido and 12 healthy controls found no differences in levels of androgens. The study was constrained by the limited number of control participants; nonetheless, the study substantiated other findings that psychosocial and health factors (Nazareth, Boynton, & King, 2003) play a greater role in sexual functioning than androgen status.
Problems with sexual desire also result from various pharmacological treatments that affect neurotransmitter levels, such as serotonin and dopamine. Some of the most typically cited medications that tend to reduce desire as well as arousal are selective serotonin reuptake inhibitors (SSRI), suggesting that serotonin may play a role in women’s sexual problems. Other drug treatments such as antiadrenergic drugs (e.g. beta blockers), selective estrogen receptor modulators, as well as cancer treatments (e.g. radiation therapy) may result in sexual impairment (Meston & Bradford, 2007). General health status also is an important etiological factor in women’s sexual desire, as fatigue, pain and mood disturbance resulting from chronic illness compromise sexual function (Leiblum et al., 2006; Meston & Bradford, 2007). Physical activity also seems to contribute to sexual wellbeing and requires further investigation (Dennerstein & Lehert, 2004; Gerber, Johnson, Bunn, & O’Brien, 2005).

In this way, the contribution of biological forces to the differences in women’s sexual desire remains unclear. While illnesses, medications, and the normal aging process likely impacts female sexual function, including desire, the current research findings with respect to the role of hormonal differences in determining the levels of sexual desire in women are inconsistent. The way in which biology is implicated in sexual desire in healthy, premenopausal women requires further investigation with more reliable testosterone assays that are sensitive to the subtle differences in women’s hormonal profiles and larger study samples.

**Psychological Factors.** Althof and colleagues (2005) distinguish between predisposing, precipitating, maintaining, and contextual factors that may contribute to sexual dysfunction. Predisposing factors refer to constitutional (e.g. anatomic deformities, congenital disorders) and prior life experiences, such as disordered attachments, neglectful or critical parents, strict upbringing, and history of sexual and physical abuse and violence. These predisposing factors
often are correlated with a greater occurrence of sexual problems in adulthood. Precipitating factors are those that trigger sexual difficulties, and are much more variable and individual, depending on one’s vulnerability to a particular set of circumstances. These may include a partner’s extramarital affair or repeated humiliation by the partner; however, for one individual these events may disrupt sexuality by reducing desire, for example, while for others it may be motivating enhanced sexual activity, or it may exert no influence. These are not necessarily long-lasting outcomes, but chronic traumatic/negative sexual experiences may result in sexual dysfunction even in relatively resilient individuals. Maintaining factors perpetuate sexual difficulties, which may result due to predisposing and/or precipitating factors. These include both interpersonal (e.g., relationship conflict, discord, loss of sexual chemistry between partners, poor communication, inadequate sexual information about one another, restricted foreplay) and intrapsychic issues (e.g. performance anxiety, guilt, fear of intimacy, impaired self-image or self-esteem). Maintaining factors also include contextual factors that may contribute to sexual difficulties, such as environmental restrictions or anger/contempt toward one’s partner. Each of these four factors may interfere or interrupt people’s capacity to maintain active and satisfying sexual relationships. There is a lot of overlap between predisposing, precipitating and maintaining factors. Anxiety, for example, may be a predisposing and a maintaining factor for absent or diminished sexual desire.

While there is clearly a strong association between sexual issues and relationship problems (Bancroft et al., 2003; Hayes, Dennerstein, Bennett, & et al., 2008; King et al., 2007; Oberg & Fugl-Meyer, 2005), it is difficult to determine the direction of the causal relationship. The research in this field is conflicting and clinical observations indicate that both instances are likely, such that sexual problems are sometimes the result and sometimes the cause of
relationship difficulties. Possibly, additional mediating and moderating variables may account for the link between sexual and relationship issues, such as each partner’s early relational experiences with their parents, sexual self-concept and other psychological and biological factors that contribute to individuals’ sexual functioning. Nonetheless, the literature suggests that sexual and relationship problems should be addressed concurrently so that lingering relational issues do not undermine the efficacy of sexual dysfunction treatment (Althof, Dean, Derogatis, Rosen, & Sisson, 2005). In a sample of Swedish women, Oberg and Fugl-Meyer (2005) found that women reporting low relationship satisfaction were six times more likely to have a distressing sexual problem rather than a nondistressing sexual problem. Stephenson and Meston (2010) argue that relational intimacy, referring to openness, honesty, and trust in a relationship, moderates the association between women’s sexual functioning and sexual distress such that sexual problems are less distressing in a good relationship and more distressing in a poor relationship.

Cognitive and emotional factors are significantly associated with sexual dysfunction. In their research, Nobre and Pinto-Gouveia (2003, 2006a, 2006b, 2008a, 2008b, 2008c) have found several cognitive and emotional factors that may result in sexual dysfunction. They studied the role of erroneous sexual beliefs, maladaptive cognitive schemas activated in sexual situations, and negative automatic thoughts in women’s sexual functioning. They found that sexually dysfunctional women present with more age-related beliefs (“with age women decrease their sexual desire”) and body-image beliefs (“an ugly woman can’t be sexually happy) (Nobre & Pinto-Gouveia, 2006a), which make them more susceptible to activate incompetence self-schemas (“I’m a failure, “I’m incompetent”) whenever they engage in an unsuccessful sexual situation (Nobre & Pinto-Gouveia, 2008b). These negative self-schemas elicit negative automatic thoughts, such as failure/disengagement thoughts (“I'm not satisfying my partner,” “I'm not
getting turned on,” “when will this be over?”) and sexual abuse thoughts (“this is disgusting,” “he only wants to satisfy himself”), that interfere with their focus on erotic stimuli, resulting in lack of erotic thoughts, and promote negative emotions of sadness, guilt, disillusion, lack of pleasure and satisfaction, thereby undermining or interrupting the sexual response cycle (Nobre & Pinto-Gouveia, 2006b, 2008a).

In one study specifically addressing women’s problems with sexual desire, Nobre (2009) found that conservative sexual beliefs, failure/disengagement sexual thoughts, and lack of erotic thoughts during sexual activity significantly predicted diminished sexual desire in women. Andersen and Cyranowski (1994), on the other hand, found that more liberal sexual attitudes or the proclivity to experience romantic/passionate emotions were significantly related to higher levels of sexual desire. Aiming to identify cognitive and emotional variables that best predict specific sexual problems, Nobre and Pinto-Gouveia (2008a) found that sexual conservatism and the belief that sexual desire and pleasure are sinful as well as sadness, disillusion, guilt and lack of pleasure and satisfaction were strongly associated with hypoactive sexual desire. Further, they found that most women with any type of sexual dysfunction, including low desire, activate incompetence schemas when encountering an unsuccessful sexual situation with significantly higher frequency compared to women without sexual problems. Once this occurs, women are more likely to search for stimuli that are congruent with the negative schema, ignoring any signs that point to the contrary. Additionally, these women experienced a lack of erotic thoughts and an increased attentional focus on failure and disengagement thoughts during sexual activity. In an integrative study considering psychological, medical and relationship dimensions in female sexual desire, Carvalho and Nobre (2010) assessed 277 women for psychopathology, dysfunctional sexual beliefs, automatic thoughts and emotions during sexual activity, dyadic
adjustment and presence of medical problems. The authors found that cognitive factors, specifically automatic thoughts during sexual activity, were the most optimal predictors of sexual desire. They demonstrated that age, failure/disengagement thoughts and lack of erotic thoughts during sexual activity exerted a significant direct effect on diminished sexual desire. On the other hand, sexual conservatism beliefs and medical factors exerted indirect effects on sexual desire via failure/disengagement sexual thoughts and lack of erotic thoughts.

While the empirical literature on the sexual desire disorders is extensive, the etiology of low sexual desire in women appears inconclusive. The role of biology remains unclear, especially in healthy premenopausal women. Nonetheless, studies indicate that relational and cognitive-emotional variables are significant contributors to women’s experiences of their sexual desire. In efforts to bridge some of the gaps in previous research, the current study addresses women’s internal representations of self and other to further our understanding how women’s desires come to be inhibited or enhanced in adulthood. Specifically, the proposed study investigated the association between women’s internalized representations of relationships with their parents with their adult sexual desire, and how these early relational processes and events may shape women’s sexual self-concept – their internal subjective experiences of their sexuality and their sexual bodies – which in turn influence their level of sexual desire.

Part III: Internalized Representations of Parental Relationships and Female Sexual Desire in Adulthood

Kaplan (1995) posits that the evolution of human sexual desire has been shaped by phylogenetic and ontogenetic influences such that the phylogeny of our species explains our basic erotic objective, which is based on reproduction, while ontogeny, or the individual’s personal psychosexual development, incorporates individual and idiosyncratic differences in
sexual desire. Citing Freudian theories of psychosexual development and learning theory, Kaplan explains that the ontogeny of sexual desire stems from childhood experiences in which early erotic experiences with the mother (and father) provide the individual with “his or her lifetime erotic program or “love-map.” Infants and small children normally enjoy a great deal of sensual contact with their caretakers, such as holding, caressing, and kissing, which may be mildly erotically arousing to infants and young children, forming “the psychological origins of normal sexual fantasies and desires” (p. 41). On the other hand, early experiences can be inappropriate, intrusive, and painful and thus the normal sexual “imprinting” process can go awry, resulting in the association of negative affect and pain with sex, thereby disrupting the development of normal sexual desires and fantasies.

While Kaplan’s sexual response cycle continues to be applied widely in the study of sexuality and sexual dysfunctions, her ideas about the contribution of early childhood relationships with one’s parents to sexual dysregulation are insufficiently addressed in empirical literature. Nonetheless, attachment researchers (reviewed in Mikulincer & Shaver, 2007) suggest that internalized representations of early childhood experiences with caregivers may influence sexual relations in adulthood, while psychoanalytic theorists (Benjamin, 1988; Elise, 2000; Kernberg, 1995) converge on the idea that female sexual inhibition may originate in the context of early object relationships with caretakers. The following review will address the empirical and theoretical literature on the relations between the early and critical psychological experiences of attachment, separation/individuation, and parental identification with sexual problems.

**Attachment and sexuality.** Attachment theory, developed by John Bowlby (1969, 1973), conceptualizes the biological tendency of infants to establish an affectional bond with their primary caretakers within the first year of life. Bowlby proposed that early attachment
experiences with one’s caretakers form the basis of people’s internal working models of close relationships that persist from early childhood throughout adulthood. The resulting attachment system, albeit somewhat malleable, provides an organizational structure for expectations for oneself and for others and for behaviors exhibited in various types of relationships with romantic partners, offspring, and peers.

Bowlby (1969, 1973) believed that due to biological pressures, children form attachments to their caregivers even if the caregiver is insensitive, unresponsive, rejecting or abusive, and develop internal representations of self and other based on these relationships. Further, he argued that the attachment system may be disrupted by experiences of trauma, such as physical, sexual or emotional abuse, separation from, or loss of the attachment figure, throughout a child’s development, which may revise a child’s internal working model of relationships and therefore her attachment style. Bowlby indicated that disruptions in the attachment system will lead to vulnerability in the child’s sense of self and of others, and in the ability to regulate affective experiences. While Bowlby maintained the distinction between attachment and sexuality as separate instinctive systems, he also emphasized their mutual influences; however, few of his followers sought to elaborate on the overlap between the attachment and the sexual systems with the exception of a handful of researchers such as Phil Shaver and his colleagues (Mikulincer & Shaver, 2007) who investigate the interplay of attachment and sexuality systems in adult romantic relationships (D. Diamond, Blatt, & Lichtenberg, 2007).

Bowlby (1969, 1973) suggested that the quality of one’s experiences with significant others in times of need informs relational goals and cognitions, and interpersonal behavior. Shaver and Mikulincer (2006) describe a similar process in the sexual system, in which positive and negative sexual experiences generate distinct sexual strategies in the individual. When the
person perceives her attachment figure as available and responsive to proximity-seeking behavior, she experiences a sense of attachment security, which indicates her capacity to perceive the attachment figure as trustworthy and reliable, and experience intimacy and nurturance. These positive experiences foster positive internal representations of self and others that enhance self-confidence and trust in the attachment figures’ readiness to offer support, which characterize securely attached individuals. Bowlby (1988) believed that attachment security not only engendered a positive self-image and facilitated the development of mutually satisfying relationships but also allowed the individual to explore and pursue nonattachment activities, such as sex. Similar to positive attachment experiences, positive sexual experiences, in which an individual successfully pursues sexual engagement resulting in mutual gratification, produce feelings of vitality and self-efficacy as well a deepening sense of intimacy and connection with another (Shaver & Mikulincer, 2006).

When the person perceives her attachment figure as inconsistently responsive and unavailable, she may experience doubts and insecurities about the relationship, develop negative internal working models of self and others, and adopt one of two defensive strategies of insecure attachment: hyperactivation or deactivation of the attachment system (Cassidy & Kobak, 1988; Mikulincer & Shaver, 2003). Shaver and Mikulincer (2006) argue that responses of the sexual system to failure and frustration also can be understood in terms of hyperactivation and deactivation.

Hyperactivation, which Bowlby called “protest” (Bowlby, 1969) entails frenzied, unrelenting attempts to elicit caretaking behaviors in the attachment figure, including clinging, controlling, and forceful behaviors. Anxious about abandonment and separation, the individual seeks to achieve a merger with the partner and experiences a sense of overdependence on the
partner. A hyperactivated individual remains hypervigilant to any threats of abandonment, separation and betrayal, which inadvertently and inevitably generates relational conflict thereby reinforcing feelings of insecurity. Similarly, hyperactivating strategies in a sexual context constitute a compulsive, intrusive, and, at times, coercive effort to engage the partner in sexual activity. These behaviors are accompanied by exaggerated concerns over one’s sexual attractiveness and sexual esteem. Just as with attachment related hyperactivating behaviors, the effortful attempts at persuasion may result in more rejection from the partner and an exacerbation of sexual-system dysfunction (Mikulincer & Shaver, 2007; Shaver & Mikulincer, 2006).

Deactivation, on the other hand, is characterized by inhibition of proximity seeking behaviors, disregard for threats to the relationship, and resolve to handle stressful situations alone, in a stance that Bowlby termed “compulsive self-reliance” (Bowlby, 1969). The individual tends to maintain physical and emotional distance from others, avoid intimacy and interdependence, deny thoughts of attachment-related threats, and exhibits self-reliant attitudes (Mikulincer, 1998; Shaver & Hazan, 1993). Likewise, deactivating sexual strategies entail inhibition of sexual desire and an erotophobic or avoidant attitude toward sex or an emotionless and cold approach to sex that decouples sex from intimacy, warmth, or kindness. Sexual deactivation includes a disregard of one’s sexual needs, suppression of sexual thoughts, fantasies, desire, arousal, and orgasm, and distancing from a partner or devaluing a partner when he or she initiates sex. Paradoxically, sexual deactivating strategies, in certain individuals, may involve sexual promiscuity driven by narcissistic needs to elevate one’s self- or public image; however, such sexual engagements are usually carried out in the absence of sexual desire and without much sexual satisfaction (Schachner & Shaver, 2004).
In studying differences in attachment styles in infancy, adolescence and adulthood, researchers have identified that attachment can be measured along two orthogonal dimensions: avoidance and anxiety (Brennan, Clark, & Shaver, 1998). Anxiously attached individuals tend to engage in hyperactivating attachment behaviors and worry that the attachment figure will be unavailable to meet their needs while avoidantly attached individuals will engage in deactivating behaviors when coping with attachment needs and exhibit distrust of others. People who score low on both dimensions have a secure attachment style and are likely to exhibit a security-supporting attachment history and reflect positive internal representations of self and other.

Mikulincer and Shaver (2007) argue that even though sexual and attachment systems are functionally independent, they nonetheless influence one another and contribute to relationship quality and stability. Shaver and Hazan (1988) proposed that attachment system functioning shaped by early childhood experiences with one’s caretakers may significantly influence the sexual system, which becomes apparent in later development when hormonal changes activate genital sexuality. A securely attached individual with positive internal representations of self and other is more likely to experience sexual partners as loving, have more capacity to enjoy sex and to be intimate, maintain a sense of confidence in one’s capacity to satisfy her own and her partner’s needs, and be less preoccupied with sexual performance (Shaver & Hazan, 1993). In this way, secure individuals are more likely to lower their defenses and experience sexual desire.

In contrast, insecurely attached individuals, who harbor negative representations of self and/or other, are more likely to experience conflictual feelings with respect to sex; however, individuals with anxious and avoidant styles differ in their types of sexual responses. Anxiously attached people, harboring a negative representation of the self, may rely on sex to gain acceptance and relieve abandonment anxiety, which may make it difficult to focus on their own
needs and lead them to misconstrue their partner’s sexual motives and behaviors (Mikulincer & Shaver, 2007). Interestingly, studies indicate that while anxious men tend to have sex for the first time at an older age and engage in sex less frequently, anxiously attached women tend to initiate sex at a younger age (Bogaert & Sadava, 2002) and are more likely to become sexually active in adolescence (Cooper, Shapiro, & Powers, 1998). While both anxiously attached and avoidant individuals report experiencing negative feelings during sex (Birnbaum, Reis, Mikulincer, Gillath, & Orpaz, 2005; Gentzler & Kerns, 2004; Tracy, Shaver, Albino, & Cooper, 2003), less enjoyment of sex (Hazan, Zeifman, & Middleton, 1994) and less positive appraisals of their sexual selves (Cyranowski & Andersen, 1998), anxious individuals report a strong wish for their partner’s emotional involvement during sex (Birnbaum et al., 2005) and endorse an erotophilic attitude toward sex (Bogaert & Sadava, 2002). Furthermore, studies indicate that adolescents (Tracy et al., 2003) and adults (D. Davis, Shaver, & Vernon, 2004; Schachner & Shaver, 2004) of both sexes with anxious attachment styles pursue sexual relations in order to minimize their fears of rejection and abandonment while enhancing their feelings of reassurance, closeness, and love from a partner.

Avoidant individuals, harboring negative representations of the other, tend to exhibit erotophobic attitudes and sexual abstinence, and pursue short-term sexual relationships whose purpose is to fulfill narcissistic wishes for enhancing self-esteem, gaining social prestige, and achieving control over others (Mikulincer & Shaver, 2003). Studies have found that avoidant adolescents are less likely to ever have sex, engage in less non-intercourse sexual behaviors, and have sex with less frequency once they do become sexually active than less avoidant individuals of the same age (Tracy et al., 2003). Avoidant young adults also engage in sex less often (Bogaert & Sadava, 2002; Gentzler & Kerns, 2004; Hazan et al., 1994); however, they
masturbate with more frequency, which likely diminishes worries about intimacy, vulnerability or mutuality and appears to be in line with Bowlby’s idea of “compulsive self-reliance” that is characteristic of avoidant individuals. Further, studies indicate that avoidant individuals have more positive attitudes toward casual sex (sex without love, acceptance, or commitment) (Brennan & Shaver, 1995; Feeney, Noller, & Patty, 1993; Gentzler & Kerns, 2004; Simpson & Gangestad, 1991), are more interested in emotionless sex (Bogaert & Sadava, 2002; Cooper et al., 1998; Feeney, Peterson, Gallois, & Terry, 2000; Gangestad & Thornhill, 1997; Hazan et al., 1994), engage in “mate poaching” (stealing someone else’s partner) or be available for “poaching” in the context of short-term relationships (Schachner & Shaver, 2002), and express a preference for short-term rather than long-term mating strategy (i.e. brief sexual encounter vs. a long-term romantic relationship) (Gillath & Schachner, 2006). Notably, Schachner and Shaver (2002) found that sexual promiscuity in avoidant individuals cannot be explained by differences in libido or sex drive. In line with these findings, studies investigating sexual motives in insecurely attached adolescents (Tracy et al., 2003) and adults (Cooper et al., 2006; D. Davis et al., 2004; Schachner & Shaver, 2004) found that avoidant individuals pursue sex to minimize intimacy and obtain social prestige and power over their partner without any desire for intimacy or expression of love.

Taken together, these findings indicate that individuals with attachment anxiety and avoidance employ sexual strategies to fulfill their attachment related needs. Anxious individuals exhibit ambivalence about sex, such that they simultaneously experience aversive feelings as well as the desire for intimacy and closeness; however, enjoyment of sex per se does not appear to be the motivation to engage in sexual activity for this population. They sexualize their desire for love and intimacy and therefore convert their sexual desire into a yearning for attachment.
security. The psychoanalytic idea that the desire for sexual union involves fusion with another while retaining the integrity of self would be quite problematic for anxiously attached individuals who yearn for merging as a way to affirm their self-worth and obtain reassurance from their partner. Avoidant individuals, harboring negative representations of others and seeking to escape closeness, abstain from partnered sexual activity, engage in masturbation, or pursue casual sex for prestige and power over others without actually experiencing sexual desire.

**Separation-individuation between mother and daughter.** Psychoanalytic literature on sexual inhibition in women implicates the separation-individuation process of the little girl with respect to her mother in the development of the capacity for sexual desire (Benjamin, 1988; Chodorow, 1978; Holtzman & Kulish, 2000, 2003). Separation is central to psychic development and entails the separation of self from object in infancy, establishing object constancy and basic sense of self, the realization of a solid core gender identity, and a sense of bodily autonomy (Holtzman & Kulish, 2000). Further, separation tasks punctuate all stages of development throughout one’s life cycle (Colarusso, 1997).

Separation-individuation refers to the individual’s capacity to psychologically separate from her primary caretaker, often the mother, and establish an identity as an autonomous individual. Mahler (1968) conceptualizes the process of separation-individuation during infancy as composed of two independent lines of transformation. One transformation is behavioral, referring to the degree and flexibility of the child’s independent behavioral activity. The other transformation is the change in mental representation, referring to the degree and stability of differentiation between self and other object representations. The experience of separation-individuation in infancy continues to reverberate throughout the life cycle, as Mahler stated (1974),
One could regard the entire life cycle as constituting a more or less successful process of distancing and introjection of the lost symbiotic mother, an eternal longing for the actual or fantasied ‘ideal state of self’ with the latter standing for a symbiotic fusion with the ‘all good’ mother who was at one point part of the self in a blissful state of well-being. (p. 305)

In the elaboration of separation-individuation theory in the years beyond childhood, Colarusso (2000) agrees with Mahler that the early mother/child dyad forms the basis for all future relationships; however, he differentiates between the separation-individuation phenomena in childhood and adulthood, and outlines five individuations that occur throughout the life cycle.

The first individuation, referring to the psychological birth of the human infant, is characterized by the emergence, by age three, of the capacity for self and object constancy, which constitutes the foundation for all future object relationships (Mahler, Pine, & Bergman, 1975). The second individuation (Blos, 1968) of adolescence is based on the psychic structures formed during the first phase, and refers to the effect of developmental processes of adolescence, including physical and sexual maturation and the development of the capacity for cognitive abstraction. Through this psychophysical transformation, the adolescent gains a greater consciousness of self and develops the capacity for the first psychosexual fusion with another through the progressive steps of infatuation, sexual intercourse and the inchoate stages of mature adult intimacy. The third individuation reflects the physical and psychological separation from infantile objects along with significant experiences with romantic partners and offspring. In this stage, experiences of self and other are, for the first time, experienced through relationships with individuals other than the primary objects. The fourth and fifth individuations, which are beyond the scope of this proposal, concern the growing awareness of a personal end, including being left by growing children and aging parents while merging with new objects, such as one’s grandchildren, and the acceptance of the nearness of death and the loss of all human relatedness.
(Colarusso, 2000). While Colarusso (2000) delineates these different phases of separation-individuation process, he maintains that the original experience of separation-individuation that occurs in infancy forms the basis of subsequent separations – i.e. the later phases of separation can be conceptualized as derivatives of the original mother-infant separation-individuation process.

Merger and lack of differentiation between mother and daughter has been central to understanding women’s lack of autonomy and agency with respect to their experiences of sexuality, aggression, achievement and other aspects of desire that reflect the wish to establish relational bonds (Benjamin, 1988; Holtzman & Kulish, 2000, 2003). Chodorow (1978) argues that the girl’s separation from her mother is complicated by the fact that she also identifies with her as the same-sexed object, which results in a certain permeability in the boundaries between mothers and daughters that is not present in the relations between mothers and sons (or fathers and daughters). An important issue lies in the fact that in the oedipal situation when the child must rival the same-sexed parent for the love of the opposite-sexed parent, the little girl’s rival is her mother who is also her primary source of nurturance (Person, 1982).

Holtzman and Kulish (2000) argue that problematic pre-oedipal relations between mothers and daughters that interfere with the separation-individuation process render later separations in adolescence and adulthood more difficult. The authors suggest that engaging with a man in adult relationships is another level of separation, which women may experience as threatening to their merger with the mother. As a result women who exhibit difficulties in separating from their mothers often cannot enjoy sex, and experience symptoms of sexual dysfunction.
Holtzman and Kulish (2000) indicate that the problem lies in the perceived division of allegiance between mother/caretaker and father/lover. The authors suggest that these difficulties do not necessarily reflect pathology, regressions or fixations but are inherent to gender differences. The girl perceives that sexuality belongs to her mother and not to herself, which generates a psychic compartmentalization of internal representations of sexual and non-sexual aspects of the self. The authors characterize this compartmentalization as defensive in the efforts to preserve the bonds with the mother while initiating an erotized relation with the father. In this way, erotic desire and genitality are sequestered to the secret part of the self that is separate from the mother. The female body facilitates this process with its “unseen inner cavities and passages,” (Holtzman & Kulish, 2000, p. 1431), which will be addressed in the next section of this literature review.

Benjamin (1990) argues that the problem of sexual desire in women lies in the gender division in the family. During the rapprochement phase of the separation-individuation process, the child’s awareness of her separateness intensifies and she becomes conscious of her will and agency, and of desiring. The difference between the mother and father becomes important in the conflict between separation and connectedness, and independence and dependence. Benjamin suggests that the father comes to represent freedom, separation and desire. Torok (1970), Chasseguet-Smirgel (1970), and Chodorow (1978) concur that in their struggle to separate from the original maternal power, children of both sexes wish to possess the power of the father and his phallus, because the latter represents separation. The father offers the boy toddler “his first model of desire” and enables separation by recognition through gender identification that is not available to the girl (Benjamin, 1990, p. 464). Girls, on the other hand, experience conflict in their wish to separate from their attachment to the mother while seeking to find another object
with whom to identify. The other object would be the father but his otherness represented by his other genitals impedes this identification. As a result, little girls cannot employ their connection with the father “to forge a genuine sense of separate selfhood” (Benjamin, 1990, p. 466).

Hiller (1996) suggests that over-intrusive mothering with the daughter is especially problematic in its lack of boundaries that perpetuates a mutual relationship of primary identification and infantile dependence. Further, she suggests that the father has the potential for tempering the effects of the mother’s intrusive parenting and can encourage the girl’s identification with him, providing his daughter with support in her struggle to separate from the mother. A father who is able to engender such identification while also seeing his daughter as female will be more likely to facilitate her differentiation from her mother, establishing ego boundaries and “a separate gender-based sense of autonomy” (Hiller, 1996, p. 61). Hiller suggests that a woman with unresolved separation-individuation issues towards her mother may experience unconscious inhibition of her sexuality as a way to ward off the anxiety that she experiences when a potential coital union with a man threatens to impinge on her early attachment to her mother.

In formulating their definitions of sexual desire, Kernberg (1995), Benjamin (1988, 1990), and Stein (2008), among others, converge on the idea that the essential component of the subjective experience of sexual passion is merger and fusion with the other under the condition that autonomy and the integrity of self are retained. While such fusion is much longed for and sought after, it also embodies the threat of aggression, the blurring of boundaries between self and other, and the loss of self, which become especially problematic in individuals who struggle with issues surrounding separation-individuation. As reviewed above, girls and women face
tremendous difficulties in their separation from their mothers, which often may remain unresolved and therefore inhibit their sexual desires in adulthood.

**Parental identification and female sexuality.** As alluded to in the previous section, the girl’s identification—“taking something in from the object, by assimilating the other to the self” (Benjamin, 1988, pp. 42-43)—with primary caretakers is an important psychological process in the development of her sexuality. According to Benjamin, the child’s identification with an idealized, all-powerful parent allows her to develop a sense of self as “I who desires.” Benjamin further argues that because of the gender division in the family, the paternal and maternal figures offer children different aspects of themselves and thus suggests that the child needs to be able to identify with both parents in order to adequately develop the capacity for sexual desire.

The concept of identification, which primarily derives from the work of Freud (1917, 1921, 1933), is a confusing one, because Freud’s writings on the subject changed tremendously over the course of his career. Further, later developments and modifications of Freudian theory on identification often employ similar terminology but provide further revision of concepts and processes originally described by Freud. Specifically, later theories on identification incorporate basic elements of the learning theory, such that children’s identities, including their gender identities, develop through the mechanisms of learning, such as reward and punishment.

Whatever the exact characterization, identification appears to be based on “an emotional tie with an object,” typically the parent (Bronfenbrenner, 1960). In his first formal definition of identification, Freud (1921) stated that “identification endeavours to mould a person’s own ego after the fashion of one that has been taken as a “model”” (p. 106). Freud described two types of identifications, which for a long time remained fused in his thinking. **Anaclitic identification** occurs as a function of loss of love, in which the child identifies with the object within a
dependency relationship, typically the mother. *Aggressive identification*, on the other hand, occurs as a function of fear of the aggressor, i.e. identification with the aggressor (Bronfenbrenner, 1960). Freud’s writings focused on aggressive identification as the primary force that brings about the resolution of the Oedipus Complex for the boy who, fearing a punitive, castrating father, identifies with the father and internalizes the superego (Freud, 1924).

Freud (1925) recognized that such conceptualization has implications for the girl who has less incentive to identify with a parental figure and develop the superego. Because the girl did not have to deal with the threat of castration, Freud suggested that the girl identified with the mother based on her fear of loss of a loved object in *anaclitic identification*. This mode of identification is based on a dependency relationship with the mother or a caretaker who provides feeding, care and protection for the child. The girl’s identification with the mother appears to have two levels – the preoedipal, which is “based on the affectionate attachment to the mother and which takes her as a model and the later one, derived from the Oedipus complex…” (Freud & Strachey, 1933, p. 134).

While Freud describes identification as an imitation of a model, he indicates that this model is not the actual image of the parent but the ideal representation of the parent’s aspirations, “on that of the parents’ superego…” (Freud & Strachey, 1933, p. 67). The child therefore models herself not only after what the parent appears to be but what the parent wishes the child to be. At the same time, as described earlier, Freud defines identification as moulding “one’s ego after the fashion of one that has been taken as a model,” suggesting that identification entails internalization of the motives as well as the overt behavior of the parent. In this way, identification in Freud’s writings appears to occur in three different ways, such that the child models herself on the parents’ overt behavior, their motives, and their aspirations for the child.
While the first refers to modeling an overt action, the second refers to the disposition to act like another, and still the third considers identification as mechanism through which behavior and motives are learned (Bronfenbrenner, 1960).

In applying these ideas to the development of female sexuality, the problem lies in the fact that much of the theory does not specifically address the girl’s identification with either the mother or the father. Rather the focus is on the boy’s identificatory processes, and the ideas about the girl’s identification appear to be derived from the conception of male development. For example, according to the boy, the father takes on the instrumental role of the one who has mastered the environment and can offer the child adventure and autonomy, while the mother remains the source of love and nurturance but not the bearer of agency and success. How does the girl then gain access to the agentic, successful, and autonomous aspects of her identity? This is precisely the question that Jessica Benjamin takes up in her discussion of identificatory processes in the girl as they relate to sexual desire in adult women.

Benjamin (1988) argues that the inhibition of female sexual desire stems from the woman’s incapacity to occupy the position of the subject of her own desire as well as the object of the male desire in the context of sexual relations with a man. She postulates that both the holding and containing mother and the exciting and exuberant father are important for the development of desire with the former allowing the girl/woman to experience desire as truly inner and the latter empowering the child’s sense of agency and subjective desire. She argues that fathers offer separation, agency, subjectivity, power, difference, and desire while mothers offer attachment, merging, holding, containment, and sameness. The identification with the father, who represents the outside world, allows the child to become aware of “will and agency, of being the one who desires” and the child wants recognition of that will and desire (Benjamin,
Identification with the father is thus essential to form a sense of autonomy and therefore the capacity for sexual desire in which the woman can shift between the roles of the object of another’s desire and the subject of her own desire. In other words, for a woman to fully experience her sexual desire, she must be able to move between the modes of being desired by another and desiring the other.

The girl, like the boy, strives to develop identificatory love with the father, which Benjamin defines as the wish to be like the father, to admire him, and love him “as a subject, as an admired agent” (Benjamin, 1988, p. 106). The boy is able to engage in a relationship of identificatory love with the father while the girl cannot. When identificatory love is not realized, it later appears as ideal love, “the wish for a vicarious substitute for one’s own agency” (Benjamin, 1988, p. 122). In this way, ideal love is a form of submission and surrender of one’s will to that of the other. For Benjamin, the missing father is the missing link and is central to women’s lack of or diminished sexual desire. She argues that fathers often do not recognize their daughters as anything other than “nascent sex object[s],” pushing the girl back to the mother without the girl’s sense of autonomy or agency (Benjamin, 1988, p. 109). Further, the girl can derive what she needs from the father only if she can “draw a sense of self from her mother” (Benjamin, 1988, p. 114). In this way, to resolve the dilemma of her desire – to free her desire – she must be able to identify with a mother as a sexual subject who possesses and expresses her own desire and to develop an identificatory love for the father. Unfortunately, the mother often does not exhibit sexual agency with respect to her own desire and therefore cannot acknowledge the girl’s sexuality. Given the gender dynamics characteristic of a patriarchal culture, these two identificatory conditions with the maternal and paternal figures are rarely met, leaving the girl with no means to develop sexual subjectivity, autonomy, or sexual desire. In this way, the
reliance on the father as a route to differentiation generates a split between autonomy and sexuality that is apparent in the contemporary lives of women and interferes with women’s capacity for sexual subjectivity and therefore sexual desire.

Benjamin calls for integration and expression of both male and female counterparts of self through identification with both parents. Such integration of the masculine and feminine in the little girl echoes Kernberg’s ideas of integration of aggression and tenderness. Psychoanalytic theory characterizes masculinity as active, dominant, and sadistic and femininity as passive, masochistic, and tender. In this way, both Benjamin and Kernberg argue that the capacity for erotic desire requires the integration of the masculine and the feminine or aggression and tenderness, which is more difficult for a woman to achieve given the gender constraints of western culture.

**Conclusion.** In conceptualizing sexual disorders of desire, Kaplan suggested that negative early life experiences with parents are detrimental to adult sexuality and the development of sexual desire; however, this has not been sufficiently addressed in the research on female sexuality. Nonetheless, attachment theory and research indicate that people’s internal working models of relationships, which originate in the context of early parent-child relationships, serve as the basis for sexual relations and strategies in partnered and masturbatory activities. Still, to the best of my knowledge, no previous study has specifically investigated the relationship between attachment orientation and sexual desire in adult women. Psychoanalytic conceptualizations on separation-individuation suggest that the girl’s unsuccessful differentiation from the mother may impair the development of female sexual desire in adulthood. While these theories converge on the idea that girls encounter more obstacles to successful separation from the mother than boys, thereby resulting in sexual inhibition, research studies have not addressed
the interplay between the resolution of the separation-individuation process and the capacity for sexual desire in adult women. Parental identification is an important aspect of development through which the child is able to internalize aspects of the parent in forming her own identity. Given the gender divisions that currently characterize the family structure that reflect phallocentric and patriarchal ideas of masculinity and femininity, the father and the mother likely offer the child distinct models for identification. While the maternal figure represents nurturance and care but lacks subjectivity and agency, the father stands for power, autonomy, desire, and subjectivity, which the girl needs for the development of her own sexual desire. Again, the link between sexual desire and parental identification in women has not been the subject of empirical research and therefore requires investigation. As will be addressed in the subsequent section of this review, these early and critical psychological events likely influence important aspects of the individual’s identity, including her sexual self-concept, and therefore, the development of sexual desire in adulthood.

**Part IV: Sexual Self Concept: Sexual Subjectivity, Self-Objectification, and Genital Self Image**

Up until this point, I have been discussing sexual desire as a psychological phenomenon; however, sexual desire does not merely function in the domain of the mind. It also occurs in the body, and therefore, it is important to consider the physical body and its role in our understanding of sexuality. Freud (1923) proclaimed that the ego is “first and foremost a bodily ego” (p. 26). The child develops sense of self through the body and the genitals are a prominent part of the body. The type of genitals – male or female – is essential in defining one’s body ego and therefore one’s sense of self (Elise, 2008). It is thus quite significant that the male (the little boy’s, the man’s) phallus is omnipotent and ubiquitous as the symbol for sexual desire in the
psychoanalytic theory and the greater cultural milieu. The phallus represents libido, desire, and power. It is the thing that women lack and the reason behind their missing desires, as was propagated by Freud. The clitoris, on the other hand, is the inferior female version of the phallus – smaller, hidden, and retracting under its prepuce – it is no wonder that women’s desires are so diminished and even absent. In fact, Freud believed that the clitoris was the inferior organ as compared to the vagina – an even more veiled and elusive organ that conceals its existence – its width, depth, and elasticity – until it has been penetrated. And so the little girl and the grown woman lack the penis and therefore lack sexual desire – or so believed Freud. In many ways, such formulation is counterintuitive in the discussions of sexual desire, which originates in and pleasures the physical body, along with the psyche. The clitoris and the vagina (along with the entirety of the woman’s body), sensitive to sexual stimulation, are both instruments of sexual arousal and the site of sexual pleasure, and are therefore integral to the understanding of sexual desire. This is not to say that it is all about the body. As Dimen states, “Women don’t want just the genitals. They, we, want whatever is erotic, you name it” (Dimen, 1997, p. 544). The tendency in psychoanalytic literature to disregard the parts that women actually have and to focus on the parts that they lack serves to perpetuate the inhibition of women’s desires. Contrary to Freud’s thinking, the nature of female desire is more complex than the woman’s envy of the male penis; however, a discussion about female sexual desire must engage the woman’s body – the sexual, genital body – and the role it plays in fostering, deflating and possibly enhancing female sexual desire. Importantly, the woman’s body often appears missing from the discourse on sexuality, which emphasizes what the female body lacks rather than what it has. In fact, the woman’s body – such as the maternal body – appears desexualized in psychoanalytic theory and in certain ways, stripped of its physicality. To the male gaze where the woman is the object of his
sexual desire, the female body is not really a physical body – it is the pure, unadulterated, un-
penetrated virginal vessel that does not burp, fart, shit, excrete, secrete or vomit – and thus
lacking its physical properties, how can it contain sexual desire?

In what follows, I will address the relationship between early and critical psychological
events and the woman’s sexual body, and then explore the association between sexual function
and three constructs of women’s sexual self-concept, including sexual subjectivity, self-
objectification, and genital self-image, which can be conceptualized as aspects of a woman’s
experience of her sexual body.

As discussed in the previous section, Benjamin (1988) argues that sexual subjectivity is
essential to women’s ownership of their sexual desires. Horne and Zimmer-Gembeck (2006)
describe sexual subjectivity as capturing one’s sexual self-conception with respect to sexual body
esteem, entitlement to sexual desire and pleasure, and capacity for sexual self-reflection. Martin
(1996) defines sexual subjectivity as “the pleasure we get from our bodies and the experiences of
living in a body” (p. 10) while Tolman (2002) describes it as the entitlement to sexual pleasure
and sexual safety and the awareness of social obstacles to those entitlements. Inherent in this
term is the capacity to be the subject of one’s own rather than the object of another’s sexual
desire. The flip side of subjectivity is self-objectification, which refers to women’s monitoring of
and preoccupation with their physical appearance. Frederickson and Roberts’ (1997)
objectification theory argues that women’s repeated subjection to physical scrutiny and
examination in Western culture has resulted in women internalizing the observer’s perspective of
their bodies such that they regard themselves as objects to be looked at and desired. This process
of self-objectification renders women vulnerable to mental health disorders, including sexual
dysfunction. Studies also have shown that genital self-image, which assesses women’s
perception of their external genitalia is related to sexual function, including sexual desire (e.g., Herbenick et al., 2011).

**Internalized representations of parental relationships and the body ego.** Freud viewed female sexuality as inherently inhibited due to the anatomical differences between the genders. He believed that the woman’s missing penis rendered her as passive, lacking, and envious of the penis, which is bestowed upon the boy. One consequence of the girl’s growing awareness of her anatomical inadequacy, Freud observed, is that women do not willingly surrender to the pleasures of masturbation but “more frequently fight against it…unable to make use of it in circumstances in which a man would seize upon it as a way of escape without any hesitation” (Freud & Strachey, 1925, pp. 254-255). Early in their development, women’s desires to derive pleasure from their bodies are thus inhibited. Freud believed that in the course of female sexual development, the girl must give up her leading genital zone – the clitoris – in favor of the vagina, which, until puberty, lies dormant and produces no sensations. Because of her intense penis envy, the girl can no longer enjoy her phallic sexuality, which is far superior in boys, and thus “she renounces her masturbatory satisfaction from her clitoris, repudiates her love for her mother and, at the same time, not infrequently represses a good part of her sexual trends in general” (Freud & Strachey, 1933, p. 126). Freud thus strips women of their desire for sexual satisfaction, claiming that in order for proper development of femininity to take place, the girl must abandon the pleasures of the body and substitute the desire for orgasmic release of masturbation with the desire for a child, the “most powerful feminine wish” (Freud & Strachey, 1933, p. 128). Defining the libido, and thus sexual desire, as inherently male, Freud finds that the nature of female sexual desire as being to some degree lesser than that of men: “it is our impression that more constraint has been applied to the libido when it is pressed into the service
of the feminine function” (Freud & Strachey, 1933, p. 131). Perhaps, this is the reason for the high frequency of women’s frigidity, postulates Freud. It is thus the woman’s awareness of the missing penis that contributes to her sense of anatomical and psychical inadequacy and inferiority, resulting in diminished sexual desire. Such is the framework psychoanalysis espouses and the feminists attempt to dismantle in seeking to recapture and resexualize the female body. Yet, such theory further illustrates how the patriarchy of western culture and of psychoanalysis itself serves to perpetuate the inhibition of female sexuality.

While Freud devoted significant attention to anatomical “deficiencies” of the female body in his attempts to unravel the “dark continent” of female sexuality, attachment and object relations and relational psychoanalytic theorists focus on the relational context in which the girl’s body develops in understanding female sexual inhibition. Bowlby and Kernberg, along with other prominent figures in the field, indicate that the mother’s physical handling of the infant’s body is central to the development of secure attachment, internalized representations of sensitive and responsive caregivers, self-other differentiation, and a sense of oneself as a separate, boundaried self (Bowlby, 1969, 1973; Kernberg, 1995). Furthermore, the ways in which the mother handles the child’s physical body influences how the girl and later the adult woman come to experience and represent her own body, including her sexual body, and therefore an aspect of her sexual self. In this way, the physical and psychological elements of the mother-daughter relationship intertwine in their shaping of the girl’s sexuality – as the latter experiences it in her mind and in her body.

In attachment research, studies indicate that attachment security also is associated with body image and sexual competence. Findings show that individuals with insecure attachment have lower confidence in their sexual attractiveness and sexual prowess than securely attached
people (Bogaert & Sadava, 2002; D. Davis & Vernon, 2002; Shafer, 2001; Tracy et al., 2003). For example, studies have found that both attachment avoidance and anxiety are correlated with lower self-appraisals of the ability to satisfy one’s sexual needs, lower sexual self-esteem, and physical attractiveness and sensuality (Bogaert & Sadava, 2002; Shafer, 2001; Tracy et al., 2003). Further, Davis and Vernon (2002) found that anxiously attached women are more likely to have cosmetic surgery to enhance their physical attractiveness than less anxious women, suggesting that anxiously attached individuals are quite preoccupied with their physical appearance. In this way, women’s early experiences with their caregivers influence their feelings about their sexual competence and attractiveness.

Erotic stimulation in adulthood may harken back to the mother’s physical handling of the girl’s body in childhood, thereby alarming her to the threat of separation from her mother as she embraces her adult sexuality (Hiller, 1996). The girl’s mastery over her bodily functions and genital anxieties through identification and dependence on the mother conflicts with her need to move away from the mother during the separation-individuation phase. Exploring the significance of the hymen and loss of virginity, Holtzman and Kulish (1997) suggest that the girl’s initiation into adult sexuality is often accompanied by thoughts of the mother’s prohibitions against her sexuality, “because of their uneasiness about taking on the role of adult woman and oedipal competitor and losing the mother’s protection” (p. 138). Referencing literary works describing female sexual initiation, the authors demonstrate how often the mother appears in the girl’s thoughts as she experiences the loss of her virginity, indicating the ubiquitous anxiety about maternal loss in the face of a woman’s sexual awakening, which is accompanied by bodily injuries – physical pain, tearing of the hymen, and loss of blood.
Kernberg (1995) and Elise (2000, 2008) elaborate on how the mother’s differential treatment of the boy and girl bodies may result in sexual inhibition in females. Kernberg (1995) references the work of Chassegue-Smirgel (1970) and Braunschweig and Fain (1971; 1975) to distinguish between the mother’s relationship with her daughter and with her son. The mother’s caring and handling of the infant’s body fosters the infant’s body surface eroticism, which later evolves into erotic desire. For both sexes, the mother’s ministrations result in early sexual excitement; however, for the boy, this erotic relation endures throughout his early development while for the girl, the mother’s subtle and unconscious rejection of her child’s genitality increasingly inhibits the little girl’s sexuality. Kernberg notes that studies of little girls’ masturbatory activities and vaginal erotic responsiveness indicate that “a very early vaginal awareness exists in the little girl and…is inhibited and later repressed” (Kernberg, 1995, p. 50). The mother’s unconscious prohibitions against her daughter’s sexuality fosters in the woman unconscious guilt as she has internalized the self-representation of inhibited and repressed sexuality. Contrary to Freud who attributed inhibition of masturbatory activities and sexual desire to the girl’s missing penis, these writers link sexual inhibition to the early mother-child interaction and how this affects the girl’s bodily self-representations.

While Kernberg focuses more on the mother’s prohibition against the girl’s genitality, Elise (2008) emphasizes the girl’s experience of maternal rejection as the first object loss. Elise argues that in response to the mother’s rejection, the girl experiences “bodily-based narcissistic injury,” and a sense of inadequacy and shame, which she internalizes as part of her sexual identity (Elise, 2008, p. 74). She references Andrew Morrison (1989), who defines shame as the failure to realize one’s ego ideal, narcissism and grandiosity, which result in self-devaluation and a sense of worthlessness. Since one’s self representation is developed through the body ego,
argues Elise, the failure to live up to one’s ego ideal is the failure of the body, and the part of the body that carries the shame in the oedipal romance is the genitals. Both boys and girls experience such shame due to the failure of the ego ideal, which stems from their bodies being too small to realize their oedipal erotic longings. The girl, however, experiences double oedipal loss as she realizes that “the penis is the key to a woman’s heart” (Elise, 2008, p. 85). She suffers loss in her most intense love affair with the mother and likely registers “this defeat as her inadequacy on a bodily level” (Elise, 2008, p. 85). This rejection is then followed by the oedipal loss of the father and so the girl “can come to feel that her body is inferior to everyone’s” and unacceptable to all (Elise, 2008, p. 85). In response to this experience of shame, the girl deflates her genitals and sexual desire while the boy deals with his sense of inadequacy by inflating his genitals. The defensive strategy of the girl is thus to inhibit her sexuality by silencing her body.

Elise (2000, 2008) argues that female anatomy perpetuates the imagery of the hidden, veiled, and absent, and that women have unconsciously yielded to this form of protection against their own desires by deflating their genitals and desire, with the aid of culture and psychoanalysis. Anatomy and physiology facilitate this process, as the clitoris retracts into its prepuce and the vagina contracts inwards while the penis erects and extends. The boy cannot hide his penis while the girl can hide her genitals, and culture reaffirms these anatomical qualities and metaphors for male and female desire. The female deflated genitality and desire, rendered invisible, allows theorists, clinicians, culture and women themselves to “believe the quality of absence, hiddenness, diffusiveness to be actual, inherent fact about the female genitals and about women’s seemingly flimsy desire” (Elise, 2000, p. 137).

Highlighting the importance of the woman’s physical body with respect to her sexuality and sexual desire, attachment and psychoanalytic writers demonstrate how early mother-
daughter relations influence women’s internal representations of their sexual bodies. They suggest how the resultant deflated genityality may interfere with female sexual desire. The subsequent sections (below) will address the empirical literature on the relationship between sexual function and women’s experiences of their bodies conceptualized here as sexual self-concept, which incorporates the constructs of sexual subjectivity, self-objectification and genital self-image.

**Sexual subjectivity and self-objectification.** Aiming to understand the components of positive or healthy female sexuality with a particular focus on late adolescence and early adulthood, Horne and Zimmer-Gembeck (2006) conceptualize sexual subjectivity as a multifaceted phenomenon that consists of sexual body esteem, entitlement to sexual desire and pleasure from self and other, and sexual self-reflection. The authors hypothesize that sexual subjectivity contributes to sexual and general well-being in girls and young women. Martin (1996) indicated that sexual subjectivity requires an understanding and experience of sexual pleasure within the body, and thus the capacity to embody one’s body is essential to sexual subjectivity. In formulating a model of adolescent sexual health, Tolman and colleagues (2003) suggest that the girl is less likely to experience sexual pleasure if she objectifies her sexuality and permits others to determine her right to feel attractive and sexually desirable based on social norms for feminine beauty. Yet, media constantly bombards girls with images of socially acceptable and desirable but often-impossible forms of sexual appeal and beauty. In a phenomenological study of the forces that shape female sexuality, Daniluk (1993) found that women experience themselves as insufficient due to the media projections of what society considers beautiful and desirable. Feelings of inadequacy dominate their perceptions of their bodies as women introject impossible and unreachable standards of female bodily acceptability.
In a study of patterns of sexual self-perceptions in Australian adolescents, Buzwell and Rosenthal (1996) found that individuals classified as sexually competent endorsed more confidence in their sex appeal and appearance as compared to participants classified as sexually unassured or sexually naïve. The authors concluded that perceived attractiveness shapes an aspect of an individual’s conceptualization of her sexuality. Specifically, Horne and Zimmer-Gembeck (2006) emphasize self-perceptions of body esteem in a sexual context. What these studies generally do not address is how some girls come to develop the capacity for sexual subjectivity while others do not.

Sexual desire and pleasure constitute another important component of sexual subjectivity, because it involves experiencing pleasure from the body (Horne & Zimmer-Gembeck, 2006; Martin, 1996). Further, the capacity to acknowledge and take ownership of sexual desire appears to be an important aspect of how women interpret their sexual experiences and make sexual decisions (Tolman, 2002; Welsh, Rostosky, & Kawaguchi, 2000). Rather than focusing on sexual desire, arousal, and pleasure as these terms usually appear in the literature, Horne and Zimmer-Gembeck (2006) consider an individual’s sense of entitlement to feelings of sexual desire and pleasure and self-efficacy in achieving sexual pleasure. Tolman (1994, 1999, 2002) and Welsh and colleagues (2000) indicate that adolescent girls’ sexual explorations are often stymied by cultural disempowerment of women’s entitlement to sexual desire and pleasure by propagating beliefs such as “boys want sex, girls want relationships.” Nonetheless, Tolman (2002) found that while some girls either approach their desires with much fear and apprehension or resist their desires to remain physically and socially safe, other girls are able to reject the double standard and gender inequalities and choose to acknowledge and act on their sexual
desires. The latter group appears more likely to recognize and escape sexual violence than their peers (Tolman, 1999).

Horne and Zimmer-Gembeck (2006) postulated that sexual self-reflection also is an important component of sexual subjectivity. Self-reflection is an important process in helping individuals to examine their experiences, understand different aspects of the behaviors and generate strategies for future behaviors. Cyranowski and Andersen (1998) suggest that the capacity to reflect critically on sexual experiences and make choices about future sexual engagements is an important achievement of healthy sexual development. Tolman (1994) proposed that girls require the ability for critical self-reflection in order to come to know their sexual selves. Holland and colleagues (1992) found that girls who are able to reflect on their experiences are more likely to gain control over their responses to men, to attain sexual empowerment and to transform sexual experiences. Being able to own one’s experience, even a negative one, allows one to accept responsibility for it and to make an appropriate choice in the future.

In evaluating the validity of their measure of female sexual subjectivity, Horne and Zimmer-Gembeck (2006) found significant associations between sexual subjectivity and sexual consciousness and safe sex efficacy in adolescent girls. Participants, who scored high on the Female Sexual Subjectivity Inventory (FSSI), indicating higher levels of sexual subjectivity, were more attuned to the internal aspects of their sexuality, including sexual feelings, motivations, desires, tendencies and preferences. Further, those with higher FSSI scores were more likely to purchase, carry, know how to use, and discuss condom use with a sexual partner. Girls with less sexual subjectivity were more likely to engage in self-silencing in close relationships and to embrace double standards compared to those with higher levels of sexual
subjectivity. The authors suggest that these findings support previous claims that girls who are aware of and are resilient against social pressures are more likely to possess sexual subjectivity (Martin, 1996; Tolman, 2002). The results also showed differential correlations between different aspects of the FSSI and self-esteem. Components of sexual subjectivity were negatively correlated with sexual anxiety, and assuming that sexual anxiety has an inverse relationship with sexual functioning, higher scores on the FSSI likely indicate more positive sexual wellbeing (Horne & Zimmer-Gembeck, 2006). A recent study looking at the change of sexual subjectivity in adolescent girls over one year found that sexual subjectivity increased over the 12-month period and that these changes were greatest for girls with no history of sexual intercourse and for girls who had their first intercourse during the course of the study. The authors conclude the sexual subjectivity tends to increase as girls gain more sexual experience in the context of a relationship. Further, the study found that sexual subjectivity increased as a function of more diverse sexual experience, such that girls who had a greater range of sexual experience were higher on all components of sexual subjectivity. Nonvirgins scored higher on all measures of sexual subjectivity with the exception of body esteem than virgins and those who initiated first coitus during the course of the study fell in between pre-study nonvirgins and virgins. Self-efficacy and self-reflection increased only for those who did not report sexual intercourse and for those who had their first coitus during the study while entitlement to sexual desire and pleasure increased for all participants, suggesting that the novelty of sexual experience generates the quickest rise in sexual subjectivity (Zimmer-Gembeck, Ducat, & Boislard-Pepin, 2011).

In this way, sexual subjectivity, consisting of sexual body esteem, entitlement to desire and pleasure from self and other, sexual self-efficacy, and sexual self-reflection, are associated with positive mental health and psychosocial functioning as well as with greater level of sexual
experience in female adolescents and emerging adults (Horne & Zimmer-Gembeck, 2005, 2006; Zimmer-Gembeck et al., 2011). Much of the theoretical and empirical literature on sexual subjectivity addresses adolescent female sexuality, citing the social forces that interfere with girls achieving sexual subjectivity, and the resultant adverse outcomes, including absent or unacknowledged sexual desire (Tolman, 2002). Nonetheless, considering the high prevalence of sexual inhibition in adult women, it is important to investigate the capacity for sexual subjectivity in adult women.

While sexual subjectivity indicates sexual empowerment, entitlement, and esteem, self-objectification represents women’s submission to societal pressures, such that they relinquish their agency, ownership and embodiment of their sexuality and become the object of the other’s (male) gaze and desire. The adverse impact of women’s preoccupation with their appearance on their physical and psychological wellbeing, including sexual function, has been addressed by Frederickson and Roberts’ (1997) objectification theory. The authors posit that women’s repeated subjection to physical scrutiny and examination in Western culture has resulted in women internalizing an objectifying gaze thereby taking on the observer’s perspective of their bodies. In this way, women come to regard themselves as objects to be looked at, inspected, and desired – as a collection of parts meant to be consumed by others – in a process that has been termed self-objectification, which has been found to be the cause of negative psychological (e.g. depression, sexual dysfunction) and physical (e.g. eating disorders and their sequelae) health problems.

Specifically, repeated self-monitoring of the body’s outward appearance, or self-surveillance (McKinley & Hyde, 1996) may result in increased body shame and appearance anxiety. Women are likely to experience body shame when their bodies do not match up to the
idealized bodies propagated by the media. Further, women have no control over the scrutiny to which their bodies are subjected and thus they may feel tremendous anxiety, constantly checking and readjusting their appearance. Moreover, these cognitive preoccupations with their bodies and appearance may interfere with women’s experiences of positive emotions and with their cognitive performance (Fredrickson, Roberts, Noll, Quinn, & Twenge, 1998). Frederickson and Roberts (1997) suggest that these negative consequences of self-objectification renders women vulnerable to mental health disorders, including sexual problems. Specifically, the authors propose that self-objectification may trigger negative feelings about the sexual aspects of the self, sexual dissatisfaction, and/or sexual dysfunction. Subsequently, several studies have demonstrated the link between higher levels self-objectification and less sexual esteem (Calogero & Thompson, 2009b; Fredrickson & Roberts, 1997; Wiederman, 2000) and less sexual pleasure (Calogero & Thompson, 2009a) in women.

Steer and Tiggemann (2008) conducted a study to address the role of self-objectification in women’s sexual functioning, focusing on self-consciousness during sexual activity, body shame, appearance anxiety, and sexual functioning. They argued that objectification theory may be especially relevant to the sexual domain, given that sexual activity involves the experience of another person exploring one’s body. The authors found that self-objectification and self-surveillance are significantly correlated with self-consciousness during sexual activity, suggesting that women, who generally monitor their bodies, also do so in sexual situations. Further, they showed that higher levels of body shame and appearance anxiety are related to higher self-consciousness during sexual activity, supporting Frederickson and Roberts’s (1997) claim that shame and anxiety that a woman experiences with respect to her body generalize to the sexual context. In addition, the results demonstrated that more self-consciousness during
sexual activity is related to poorer current and general sexual functioning, indicating that being self-conscious about one’s appearance during a sexual encounter is not conducive to optimal sexual function. Finally, the authors showed that self-consciousness during sexual activity fully mediated the relationship between body shame and appearance anxiety, and general sexual functioning. In this way, self-consciousness during sexual activity appears to be the underlying process by which body shame and appearance anxiety interfere with sexual functioning. Although this study demonstrated only an indirect relationship between body surveillance and female sexual function, Calogero and Thompson (2009a) found that chronic body monitoring directly results in less sexual satisfaction.

**Body image and genital self-image in empirical literature.** In the empirical literature on female sexuality, body image also is a significant contributing factor to sexual function. Body image is a multidimensional construct that refers to affective (e.g. shame, dysphoria), cognitive (e.g. discontent, desire for change), and behavioral (e.g. avoidance, concealment) facets of an individual’s response to her perceived physical appearance (Cash & Pruzinsky, 2002; Davison & McCabe, 2005). The prevalence of body image dissatisfaction among young women is quite high, with 90% of female college students reporting dissatisfaction with their body weight (Neighbors & Sobal, 2007).

Specific to sexual health, body image self-consciousness during a sexual encounter and sexual esteem are two constructs that have been linked to negative body image (Wiederman, 2000; Wiederman & Hurst, 1998). Wiederman (2000) defines body image self-consciousness during sexual activity as a heightened sense of awareness of how one’s body looks to a sexual partner during sexual activity. Such cognitive preoccupation with one’s appearance, termed ‘spectatoring’, may result in dissociation from the immediate moment and detract from the
sexual experience in all ways, including sexual desire, arousal, physical sensation and therefore satisfaction (Masters & Johnson, 1970). Studies show a correspondence between lower self-rated body attractiveness, greater body dissatisfaction, and increased body shame to heightened body image self-consciousness during heterosexual sexual activity (Sanchez & Kiefer, 2007; Wiederman, 2000). Sanchez and Kiefer (2007) found that women’s body shame is associated with greater sexual self-consciousness, which in turn predicts lower sexual arousability and sexual pleasure.

Sexual esteem refers to “the value one places on oneself as a sexual being,” (Mayers, Heller, & Heller, 2003, p. 270) or as “a positive regard for and confidence in the capacity to experience one’s sexuality in a satisfying and enjoyable way” (Snell & Papini, 1989, p. 256). Sexual esteem may address one’s self-assessment in relation to another, such as a sexual partner, or focus on aspects of one’s own sexuality. Women’s cognitive absorption with their appearance during sexual activity may interfere with the quality of their sexual experience by diminishing sexual esteem. Wiederman (2000) has found that body image self-consciousness during sexual activity is negatively related to sexual esteem, which the author defined as the tendency to evaluate oneself positively as a sexual partner (Wiederman & Allgeier, 1993). Dove and Wiederman (2000) also showed that cognitive distraction during sexual activity due to self-consciousness about both appearance and performance within a sexual context predicts sexual esteem, above and beyond general affect, self-focus, sexual attitudes, and body dissatisfaction. In turn, sexual esteem has been associated with multiple psychological and behavioral aspects of sexual function, including sexual health and satisfaction (Snell, Fisher, & Andrew, 1993). In this way, there appears to be a clear pathway from body image to body image self-consciousness in a
sexual context to sexual esteem and to psychological and physical components of sexual wellbeing.

A related construct to body image that specifically relates to female sexuality is genital self-image, which addresses women’s perception of their external genitalia. Berman and colleagues (2003) first explored the relationship between genital self-image and sexual function, showing a relationship between their measure of female genital self-image and the Desire domain of the Female Sexual Function Index (FSFI). Subsequently, Herbenick and Reece (2010) investigated the relationship between women’s feelings about their genitals (the vulva and the vagina), in terms of appearance, smell, function, embarrassment, and comfort with allowing a partner or a healthcare provider look or examine, respectively, their genitals and multiple domains of female sexual functioning. Contrary to Berman and colleagues, the authors found that genital body image was related to all studied domains of sexual function with the exception of the Desire domain, such that women who had positive genital body image were more likely to experience arousal, orgasm and less sexual pain. In a subsequent study in a nationally representative sample of women in the US between the ages of 18 and 60, Herbenick and colleagues (2011) found that women’s feelings about their genitals were significantly related to all measures of sexual function, such that women with more positive genital body image experienced more desire, arousal and orgasm. Further more positive genital body image also was positively related to women’s frequency of masturbation and having used a vibrator in the past month. Together, these results suggest that women’s feelings and beliefs about their genitals may be associated with their affective-evaluative orientation toward sexuality and with their comfort or willingness to engage in behaviors that involve close contact with their genitals. In this way,
genital image may be a better determinant of women’s sexual esteem and therefore sexual function than general appearance satisfaction.

**Conclusion.** The theories reviewed above offer an elaborate explanation for why women are sexually inhibited and while approximately 40% of women do report low or absent desire, there are the 60% that experience adequate or even heightened sexual desire. These women appear to have ownership of and agency with respect to their sexuality, desire, and pleasure. They are able to embody their bodies rather than monitor their physical appearance in a dissociated stance of the spectator. They tend to place great value on the sexual domain of their lives and reflect on their sexual experiences. The literature on female sexuality and psychosexual development offers a plethora of empirical and theoretical support for female sexual inhibition. In reframing Freud’s question, “what does a woman want?”, the current study aims to address how women come to want, i.e. how does the desirous woman overcome or perhaps circumvent the forces that inhibit sexual desire?

Research adequately demonstrates that women’s internal experience of their sexual selves – their bodies, sexual agency, awareness of and ownership of their desire, to name a few – is significantly linked to their sexual functioning. Importantly, how women experience and embody their bodies likely originates in their early relationships with their primary caretakers, frequently the mother, whose interaction with the child occurs on both psychic and physical levels. These early dyadic experiences as well as the cultural attitudes towards the female body likely serve to inhibit female sexuality by deflating the importance of women’s genitals and by fostering self-consciousness about their appearance thereby impairing their sexual subjectivity and promoting self-objectification. While studies have investigated elements of this process, demonstrating that sexual subjectivity, self-objectification and poor body image, including genital self-image, may
interfere with optimal sexual function, previous research has not integrated all of these elements into the construct of sexual self-concept. Further, studies have not addressed the early and critical psychological processes that may influence the development of women’s sexual self-concept in adulthood.

To fill these gaps in the literature, the current study investigated how internalized object relations, namely attachment orientation, level of separation-individuation from the mother, and parental identification with both maternal and paternal figures, affect sexual desire in women via the underlying mechanisms of female sexual self-concept, including sexual subjectivity, self-objectification, and genital self-image. In the current research, self-objectification will be operationalized as body image self-consciousness in a sexual context rather than a global assessment of self-objectification. The study, which involved self-report assessments of the aforementioned constructs and a qualitative interview on the phenomenology of sexual desire, aimed to address how women’s early relational experiences with their parents influence their sexual desire in adulthood by considering the links between internalized representations of parental relations, sexual self-concept, and sexual desire in healthy premenopausal heterosexual women. Further, the current research sought to gain further understanding into the differences in the phenomenology of sexual desire between sexually inhibited and highly sexual women.

Part V: The Highly Sexual Woman: A Sign of Health or Pathology?

The empirical and theoretical literature converges on the idea that sexual inhibition is ubiquitous in the course of the girl’s psychosexual development – whether in her relationship with the mother, the father, her body, or culture. While Kernberg (1995) alluded to the fact that women eventually do develop erotic desire, albeit later than men, the route to the resolution of female sexual inhibition remains unclear. Further, while up to 40% of women complain of low
desire, there are still the 60% who do not experience this problem, indicating that women do, in fact, possess sexual desire. We have elaborate theories on how women’s desires come to be doused, but we lack the understanding of how they are ignited. Stein suggests that inherent in the excess of sexuality is the restructuring and amelioration of the self while Tolman indicates that sexual subjectivity provides young girls with access to, ownership of, and awareness of their sexual desires. Heightened desire may thus be one way, in which women resolve their sexual conflicts. Yet, because of the dearth of literature and theory in this area, heightened desire constitutes another part of the “dark continent” of female sexuality.

Importantly, terms such as promiscuity and hypersexuality do not differentiate between the internal experience of sexual desire and observable sexual behavior, as has been discussed throughout this proposal. Sexual activity is not necessarily indicative of desire and thus promiscuity, which derogatively refers to excessive sexual activity, may occur in the absence of sexual desire. It is therefore necessary to distinguish between the different forms of sexual expression for clinical and research purposes to better determine the origins, underlying mechanisms and the nature of the woman’s sexuality and sexual expression (or its absence). Furthermore, comparing women with heightened and inhibited sexuality may highlight some differences that would aid in characterizing and understanding the various factors that may enhance or diminish sexual desire in women.

In what follows, I will examine the terms associated with heightened sexuality as well as the presence of high sexual desire in the DSM and the critiques of pathologizing enhanced sexuality. I will then review the research findings on the characteristics of highly sexual women in the empirical literature. The final component of this section will focus on psychoanalytic
conceptualization of heightened sexuality as both a normative and a pathological form of sexual expression.

**Heightened sexuality in empirical literature.** The clinical significance of high levels of sexual urges, fantasies, and behaviors has garnered interest in attempting to distinguish between pathological and normative sexuality when encountering individuals who experience what has been termed dysregulated sexuality – “sexual thoughts, feelings, and behaviors that are experienced as distressingly out of control by the individual” (Winters, Christoff, & Gorzalka, 2010, p. 1029). Terms such as hypersexuality, sexual addiction, sexual compulsivity and sexuality impulsivity have pathologized sexual tendencies that may entail high risk behaviors and result in adverse outcomes, such as sexual offending and sexually transmitted diseases. The primary criticism of the sexual addiction and impulsivity models is that they do not differentiate between patterns of sexual feelings, thoughts, wishes and behaviors that may be experienced by healthy individuals and those that may be exhibited in disordered people. Sexual compulsivity, characterized by intense, recurrent, and distressing sexual thoughts, fantasies, and desires that interfere with one’s life functioning, has been shown to be associated with sexual behaviors that are most risky (e.g. multiple partners and unprotected sex). At the same time, sexual compulsivity appears to be related to increased sexual activity of all types, not just those that are risky (Dodge, Reece, Cole, & Sandrot, 2004; Kalichman et al., 1994; Kalichman & Rompa, 1995, 2001). One of the most fundamental issues surrounding heightened sexuality that is pertinent to the topic of this study is the nature of the relationship between sexual dysregulation and sexual desire (Bancroft & Vukadinovic, 2004; Dodge et al., 2004; Kafka, 2000; Kafka & Hennen, 2003).

Winters and colleagues (2010) conducted a study to differentiate dysregulated sexuality from high sexual desire in a sample of 6,458 men and 7,938 women some of whom had sought
treatment for sexual compulsivity, addiction or impulsivity. The authors found that dysregulated sexuality was associated with increased sexual desire, suggesting that dysregulated sexuality as it is currently conceptualized (see above) and assessed may be a marker of high sexual desire and the distress associated with managing a high level of sexual feelings, thoughts, and needs. More importantly, high levels of sexual desire may result in distress for those who lack acceptable ways of satisfying high levels of sexual desire, especially when faced with social sanctions on heightened sexuality.

**Hypersexuality in the DSM.** While hypersexuality, sexual addiction, sexual compulsion or impulsivity, have never appeared as a diagnosis in the DSM, features of hypersexuality have had a presence in the DSM since 1980 in the diagnosis of Psychosexual Disorder, Not Otherwise Specified (NOS) (American Psychiatric Association, 1980). In the DSM-III, Psychosexual Disorder, NOS included “distress about a pattern of repeated sexual conquests with a succession of individuals who exist only as things to be used (Don Juanism and nymphomania)” (American Psychiatric Association, 1980, p. 283). The DSM-III-R (American Psychiatric Association, 1987) added the concept of non-paraphilic sexual addiction for the first time by indicating “distress about a pattern of repeated sexual conquests or other forms of nonparaphilic sexual addiction, involving a succession of people who exist only as things to be used“ (p. 296). In the DSM-IV sexual addiction terminology was removed because of absence of empirical evidence verifying sexual behavior as an addiction (Kafka, 2010). In the DSM-IV-TR, the original DSM-III formulation of this diagnosis was reestablished, including a condition that entails “distress about a pattern of repeated sexual relationships involving a succession of lovers who are experienced by the individual only as things to be used” (American Psychiatric Association, 1987). The DSM-5 also did not include the diagnosis of hypersexuality, which was initially
being considered for inclusion in the sexual disorders section. Heightened sexuality in the DSM thus far has referred to sexual behavior and relations rather than the experience of sexual desire. Further, the diagnostic criteria emphasize how the individual tends to perceive her sexual partners “as things to be used.” Just as behavior cannot be the prime marker for low desire, it also should not be a reflection of heightened desire.

Martin Kafka (2010), a prominent American psychiatrist in the study of sexual offenders, paraphilias, and “paraphilia-related disorders” argues that Hypersexual Disorder is a “Sexual Disorder associated with increased or disinhibited expressions of sexual arousal and desire in association with a dimension of impulsivity as well” (p. 393). While he finds that hypersexuality may entail behavioral dysregulation analogous to an addiction disorder, an impulse control issue, and a compulsion, he argues that the increased fantasies, sexual urges and behaviors that precede the adverse consequences of hypersexual behavior are more consistent with a Sexual Desire Disorder. A large-scale study investigating sexual compulsivity, sexual desire and associated behaviors in 14,396 men and women found that dysregulated sexual behavior was the primary marker of increased sexual desire (Winters et al., 2010). Extrapolating from these findings, Kafka suggests that Hypoactive Sexual Desire Disorder and Hypersexual Disorder occupy the polar opposites of a continuum of sexual appetitive behavior, including sexual desire, motivation, and arousal. Contending that hypersexuality belongs in the DSM as an autonomous sexual disorder, Kafka (2010), proposed the following diagnostic criteria for Hypersexual Disorder for the DSM-5 (which were rejected):

A. Over a period of at least 6 months, recurrent and intense sexual fantasies, sexual urges, or sexual behaviors in association with 3 or more of the following 5 criteria: 1) Time consumed by sexual fantasies, urges or behaviors repetitively interferes with other important (non-sexual) goals, activities, and obligations; 2) Repetitively engaging in sexual fantasies, urges, or behaviors in response to dysphoric mood states (e.g. anxiety, depression, boredom, irritability; 3)
Repetitively engaging in sexual fantasies, urges, or behaviors in response to stressful life events; 4) Repetitive but unsuccessful efforts to control or significantly reduce these sexual fantasies, urges or behaviors; 5) Repetitively engaging in sexual behaviors while disregarding the risk for physical or emotional harm to self or others. B. There is clinically significant personal distress or impairment in social, occupational or other important areas of functioning associated with frequency and intensity of these sexual fantasies, urges or behaviors. C. These sexual fantasies, urges, or behaviors are not due to the direct physiological effect of an exogenous substance (e.g., a drug of abuse or a medication) (p. 379).

While Kafka suggests that “excessive” sexual behavior or hypersexuality based on persistent and increased frequency rates of enacted sexual behavior can be ascertained and may be predictive of sexual dysfunction, he indicates that “excessive, repetitive or hypersexual behavior without significant personal distress” does not reflect a pathological condition. Although such distinction is important in differentiating pathology from health, it does not account for those individuals who may experience significant distress because their heightened sexual desire remains unsatisfied in a society that negatively judges hypersexual individuals – a fate that is quite typical for women, given the double standard in the sexual realm. Importantly, most of the empirical evidence on hypersexuality is based on men, while empirical research and systematic clinical data on females with Hypersexual Disorder is largely absent from the literature. Although the speculated male: female prevalence ratio of Hypersexual Disorder is estimated at 5:1 (Black, Kehrberg, Flumerfelt, & et al., 1997; Carnes & Delmonico, 1996; Schneider & Schneider, 1996), it is considered to be a male disorder. Thus, the diagnosis of Hypersexual Disorder appears to be unclear in its relevance to and applicability for women. Importantly, the diagnosis of Hypersexuality Disorder was not included in the DSM-5, indicating the potential for harm in pathologizing heightened sexuality.

Kafka’s Hypersexuality Disorder has been the subject of much scrutiny and debate, many arguing against the need and even the existence of this diagnosis. Jason Winters (2010) argues
that currently there is not a distinct boundary between normal and excessive sexual expression. Kafka (1997) previously proposed that hypersexuality could be operationalized as a weekly average of seven or more orgasms; however, academic and clinical communities have not adopted this standard for determining hypersexuality. Although Kafka offered this cut off, because a small proportion of the population would be identified as hypersexual based on this criterion (5-10%), recent data indicate that a larger proportion of the population may reach this criterion (Winters et al., 2010) – with 44% of men and 22% of women meeting this criterion for hypersexuality.

Charles Moser (2011) argues that individuals with a high level of sexual interest and behavior are likely to experience more negative consequences of sex because they have more sex. Winters (2010) also suggests that dysregulated sexuality is associated with increases in all modes of sexual behavior, not only risky ones. He asserts that hypersexuality may be simply a marker of high sexual desire (Winters et al., 2010), which would predict increases in all kinds of sexual behavior – risky and non-risky. Further, studies have found that there is a high level of comorbidity between hypersexuality and other psychopathology, including mood disorders, anxiety disorders, and Attention-Deficit-Hyperactivity Disorder (ADHD) as well as character pathology, including paranoid, histrionic, narcissistic (18%), avoidant, and obsessive-compulsive (Black et al., 1997; Kafka, 1997; Raymond, Coleman, & Miner, 2003), which suggests that hypersexual behavior may be a symptom of another psychological condition rather than its own discrete diagnosis.

Moser (2011) also asserts that the criterion of the Hypersexual Disorder that one’s preoccupation with sexual urges and behaviors may interfere with other non-sexual goals and obligations discounts the possibility that sex can be an essential and life-enhancing activity. For
criteria 2 and 3 of Kafka’s proposal for Hypersexual Disorder, which address the use of sex as a way to manage dysphoric mood states and stress, Moser (2011) and Winters (2010) argue that relying on sex to handle stress and mood disturbances is no different from other non-sexual hobbies and activities, such as meditation, exercise or prayer, in which individuals engage to alleviate distress. In terms of the distress associated with increased frequency and intensity of sexual interests, it would be important to consider the source of that distress. Is the person’s partner who is bringing on the distress because of the incompatibility of their levels of sexual desire? Is the distress due to one’s inability to engage in the type and quality of sexual activity that is desired? Is the distress experienced when one believes that his or her sexual urges, fantasies and behaviors do not meet societal norms? An individual who subscribes to conservative and restrictive views on sexuality may be quite distressed by an increase in sexual fantasies, urges and behaviors, because they deviate from one’s belief system while an individual who holds more liberal attitudes and an openness to a range of sexual practices and engages in sexually satisfying relationships is less likely to experience distress about her heightened sexuality. Feelings of anxiety, guilt and shame coupled with high levels of sexual desire and unfulfilled sexual needs may be sufficient to result in subjective suffering and lead one to seek treatment. These are important questions and problems in the formulation of hypersexuality, especially when the highly sexual, un-researched woman enters the discourse on the significance and implications of heightened sexual desire.

**The highly sexual woman in empirical literature.** Multiple theories and studies on female sexuality have indicated that women are less interested in pursuing sexual pleasure and value sex less so than men (Baumeister & Tice, 2001; Baumeister & Twenge, 2002; McCormick, 1994). Evolutionary psychologists suggest that women are more interested in long-term
commitment because they are looking for male partners who can provide for them and for their offspring (Baumeister & Tice, 2001). Social learning theorists posit that overly sexual women are stigmatized for being sexually permissive and that women receive reinforcement for seeking long-term committed relationships while men are rewarded for desiring multiple sex partners (Milhausen & Herold, 1999; Oliver & Hyde, 1993). Baumeister and Twenge (2002), arguing for female control theory, propose that women inhibit one another’s sexuality in an attempt to compensate for the relative scarcity of available male partners, thereby increasing women’s power. Generally speaking in Western society, men’s sexual pursuits are more readily accepted and approved whereas women repeatedly receive social messages that their sexuality is risky, resulting in unwanted pregnancies and blemished reputations. Recent studies, however, have attempted to identify and examine the characteristics of highly sexual women. Different terms have been applied to describe women with very strong and frequent sexual desire and interest. Blumberg (2003) referred to women who report high levels of sexual desire as “the highly sexual women” whereas other researchers have used the term “women with high sexual interest” in reference to women who greatly value sex in their lives rather than merely basing such label on one’s frequency of sexual activity (Sloggett & Herold, 1996).

Blumberg (2003) conducted a qualitative study of 44 highly sexual women between the ages of 20 and 82 who experience very strong and frequent sexual desire. The author used two definitions to identify potential participants: 1) You typically desire sexual stimulation, usually to the point of orgasm, with yourself or a partner, six to seven times per week or more and act upon that desire; 2) You think of yourself as a highly sexual woman, sex is often on your mind, and it is an aspect of yourself that strongly and frequently affects your behavior, life choices, and quality of life satisfaction. Women had the opportunity to identify with either or both of these
definitions, and thus, highly sexual refers to women who fall into either or both of these
categories. Wentland and colleagues (2009) identified several important characteristics to
distinguish highly sexual women from less sexual women. The authors focused on the following
categories: 1) sex drive; 2) sexual communication; 3) sexual adventurism; 4) sexual fantasies and
thoughts; 5) sexual esteem; 6) sexual body image; 7) reputation concerns; and attitudes toward 8)
casual sex; 9) sexually explicit material; 10) masturbation; and 11) sexy clothing.

Wentland and colleagues (2009) found that highly sexual women scored significantly
higher on all of these constructs compared to less sexual women. Further, these women reported
an earlier age at first intercourse, higher frequency of sexual activity, higher number of lifetime
committed sexual partners as well as casual partners. Specifically, the study found that highly
sexual women express sexual agency with respect to their sexuality, have high levels of
confidence about their sexuality, and are not dependent on their partner for sexual arousal. These
women show significantly higher levels of sexual fantasy, masturbation and sexual self-esteem
than less sexual women, indicating that autonomous sexual desire may be a defining
characteristic of highly sexual women.

Contrary to past studies, which repeatedly have shown women to subscribe to traditional
sexual scripts, which state that permissive sexual behaviors are not as acceptable for women as
they are for men (Milhausen & Herold, 1999; Oliver & Hyde, 1993), Wentland and colleagues
(2009) found that highly sexual women are confident about their sexual ability, think about sex a
lot, and enjoy masturbation. Authors postulate that highly sexual women reap the benefits of
pleasure-focused sex, which outweigh the rewards provided by practicing more traditional sexual
practices, in which women are sexually passive and less interested in sex than men. Further,
these women do not engage in sex with only long-term committed partners, do not need to be in
love to have sex and may engage in sex both in and out of relationships. Finally, one possible explanation for this shift in women’s sexual scripts may be their sense of empowerment due to women’s growing financial independence and scientific advances in birth control, as women no longer need to financially depend on men, may not need to worry about unwanted pregnancy, and are more free to choose the short-term mating strategy of casual sexual relationships (Wentland et al., 2009).

Highly sexual women appear to have higher levels of sexual desire, value sex as a very important aspect of their lives, and have more open attitudes towards and engage more frequently in casual sex and masturbation. Researchers indicate that these women engage in sex because of their strong wish to do so, and in order to experience sexual pleasure. In his qualitative study, Blumberg (2003) found that highly sexual women engage in sexual activities primarily because of the intensity of their desires, which are too strong to be ignored. Weaver and Herold (2000) found that a common reason for women to engage in casual sex was to experience pleasure. Openness to causal sex appears to be a common characteristic for highly sexual women. Slogget and Herold (1996) found that single women with high sexual interest were more likely to have more than ten sexual partners, many of whom were casual sex partners. These women reported that sex was a very important aspect of their lives and that they believed their sex drive to be stronger than that of other women. Mikach and Bailey (1999) compared women with a high number of lifetime sexual partners and women with a low number of partners, finding that women with more partners were more interested in casual sex and exhibited a “masculine” attitude towards their sexuality, but were not emotionally maladjusted. Wentland and colleagues (2009) also proposed that highly sexual women appear to be more liberal in their
choice of sexual activities. The women in Blumberg’s (2003) study, for example, reported being unable to derive sexual satisfaction from only one primary sexual relationship.

Researchers have proposed that women’s masturbation tendencies would be indicative of their level of sexual desire and that highly sexual women would be more likely to engage in masturbation with greater frequency (Gerressu, Mercer, Graham, Wellings, & Johnson, 2008; Pinkerton, Cecil, Bogart, & Abramson, 2003). Pinkerton and colleagues (2003) found that masturbation was predictive of higher levels of sexual interest for women but not for men, concluding that masturbation may be an effective gauge of women’s sexual desire, because it represents one’s sexual feelings independent of one’s partner.

Highly sexual women tend to exhibit more freedom with respect to their sexual practices and fantasies, and communicate their wishes more readily to a partner (Blumberg, 2003; Haavio-Mannila & Kontula, 1997; Morokoff et al., 1997; T. G. Morrison, Harriman, Morrison, Bearden, & Ellis, 2004; Wentland et al., 2009; Yost & Zurbriggen, 2006; Zurbriggen & Yost, 2004). Morokoff and colleagues (1997) found that women with greater sexual experience are more likely to initiate sex. The authors defined sexual assertiveness as one’s ability to obtain sexual fulfillment. Another study found that sexually assertive women engaged in a broad range of sexual practices and behaviors and with higher frequency, and experienced orgasm more frequently during sexual intercourse. These women reported being as sexually satisfied as sexually assertive men (Haavio-Mannila & Kontula, 1997). The highly sexual women in Blumberg’s study reported being very comfortable expressing their sexual likes and dislikes to their partners (Blumberg, 2003). In addition to feeling freer in their actual sexual practices, highly sexual women may experience higher levels of sexual thoughts and fantasies than less sexual women (Wentland et al., 2009). Further, women with more liberal attitudes toward their
sexuality are more likely to experiment within their sexual fantasies (Zurbriggen & Yost, 2004). Another study found that women with heightened sexualities are more likely to experiment with fantasies in which women hold the control and power over their sex partners (Yost & Zurbriggen, 2006). These women also are more likely to use sexually explicit material, such as videos on the Internet and television/DVDs to derive sexual pleasure, indicating their interest in diverse sexual practices (Morokoff et al., 1997; T. G. Morrison et al., 2004).

Highly sexual women appear to have more positive feelings about their sexuality and their bodies (Ackard, Kearney-Cooke, & Peterson, 2000; Blumberg, 2003; Cash, Maikkula, & Yamamiya, 2004; Garcia & Hoskins, 2001; Hurlbert, 1991; Koch, Mansfield, Thurau, & Carey, 2005; Snell & Papini, 1989; Wiederman, 2000; Yamamiya, Cash, & Thompson, 2006). Snell and Papini (1989) defined sexual esteem as one’s capacity to experience positive self-regard and confidence in one’s sexuality such that they derive satisfaction and enjoyment from it. The women in Blumberg’s (2003) study reported that in accepting their heightened sexuality, highly sexual women achieved higher levels of self-confidence, including sexual self-esteem. Garcia and Hoskins (2001) showed that women whose actual and ideal selves were highly consistent on the Index of Sexual Assertiveness (Hurlbert, 1991) had higher sexual esteem scores. Furthermore, body image appears to be a significant predictor of women’s sexual practices such that women who are more comfortable with their bodies are more likely to engage in sexual activity, have orgasm and initiate sex (Ackard et al., 2000). On the other hand, women with negative body image specific to sexual activities exhibited poorer sexual functioning, less sexual assertiveness and more ambivalence about sexual decisions (Yamamiya et al., 2006). Body image in a sexual context appears to be a more significant determinant rather than general body image. Cash and colleagues (2004) also found that women who experience less self-
consciousness and body exposure avoidance during sex are more likely to derive pleasure from
sexual experiences and to self-identify as a sexual person. In a study, considering the impact of
body image on sexual functioning in midlife women between the ages of 35 and 55, body image
was a better predictor of sexual functioning and satisfaction than menopause, such that a woman
who perceived herself as less attractive experienced less sexual desire and engaged in less sexual
activity over the past 10 years (Koch et al., 2005). Further, Wiederman (2000) found that women
who are less self-conscious about their bodies when sexually intimate do not appear to differ in
body size compared to women who are more self-conscious about their bodies in a sexual
context. These findings indicate that highly sexual women may have more positive feelings
about their bodies; however, it also may be that women with more positive body image are more
likely to be highly sexual.

Wentland and colleagues (2009) also postulated that highly sexual women are more
likely to dress in a sexually provocative manner. According to the authors, these women likely
choose to wear revealing clothing in public as well as in private (e.g. sexy lingerie), because it is
arousing both to them and to potential partners and because it provides them with a feeling of
pleasure and confidence. A study found that women who display more skin and wear clothing
that is tighter and more sheer are more likely to self-rate as sexy and bold (Grammer, Renninger,
& Fischer, 2004). Wentland and colleagues (2009) propose that highly sexual women may be
less concerned with the negative impact of their sexuality on their reputation, because of their
self-acceptance and/or because of the significance of sex in their lives. Consistent with such
thinking, the women in Blumberg’s (2003) study who were more accepting of their sexuality and
who valued it as a central component of their lives appeared to be less affected by threats to their
reputation because of their heightened sexuality.
The cluster analysis in the Wentland and colleagues’ (2009) study indicated that there is a
dichotomy of highly sexual versus less sexual women, suggesting that highly sexual women are
distinctly different from less sexual women. While these findings are a valuable contribution to
the field of female sexuality, the distinction between “normal,” “heightened,” and “hypo” levels
of sexual desire remain obfuscated. Further, this study along with other studies on this topic did
not explore the factors that potentially contribute to this dichotomy between highly sexual and
less sexual women. What remains unclear are the underlying mechanisms that render women
more or less sexual women, such as internalized representations of parental relationships, which,
at least in part, shape aspects of women’s sexual self-concept. Understanding what may render
women highly sexual may help researchers and clinicians to understand the forces that inhibit
and/or enhance female sexuality.

**Heightened sexuality in psychoanalytic literature.** Similar to much of the empirical
work on heightened sexuality, psychoanalytic theorists tend to characterize heightened sexuality
in terms of promiscuity or hypersexuality, indicating that high levels of sexual desire are markers
of psychopathology (Kaplan, 1995; Kernberg, 1995). Kernberg does find that promiscuity in
both men and women exists on a continuum; however, nowhere on that continuum does he place
heightened sexuality as a normative, well-adjusted and agentic phenomenon. Stein (2008), on the
other hand, argues that “‘normal’ sexuality is continuous with sexualization of suffering and
trauma and seems to make use of the same mechanisms as the former” (p. 54). I propose that the
phenomenon of heightened sexuality in women may shed light on some of the psychical
processes that facilitate the development of female sexual desire. Applying the work on the
excess of sexuality of Ruth Stein, it is possible that highly sexual women may employ their
sexuality in the service of the ego, thereby traversing the sexual inhibition that they experienced
in their early development with their maternal and paternal figures. Perhaps, these highly sexual women have managed to overcome these conflicts and take ownership of their sexuality and their sexual bodies through different kinds of experiences, providing us with the opportunity to elucidate the mechanisms that underlie the resolution of sexual inhibition in women.

Kernberg (1995) argues that when excitement and orgasm become repetitive, mechanical and dissociated from the deepening of internalized object relations, sexual excitement and orgasm stop functioning in the service of boundary crossing or merger. At this point, sexual excitement diverges from erotic desire and sexual passion and is no longer directed at a particular object, which is essential in Kernberg’s formulation of mature love relations. Kernberg acknowledges that it is not the compulsive gratification of sexual urges that compromises sexual passion in this instance, as masturbation may and often does express an object relationship. The problem occurs when the individual lacks the capacity to engage in object relations, which interferes with “the crucial function of crossing self-object boundaries” (p. 46). For individuals who compulsively seek sexual gratification without investing in the world of object relations, such fusion between self and object is not possible and thus sexual desire and sexual passion deteriorate.

Kernberg asserts that more severely disturbed female patients completely lack sexual desire whereas women with less severe pathology engage in sexual promiscuity, as they frantically search for sexual excitement due to an inability to develop a more stable relationship. He finds that while individuals who have never been sexually or emotionally involved with others are basically unable to engage in object relations, patients who exhibit promiscuous behavior are compulsively struggling to resolve their difficulty in establishing object relations.
According to Kernberg (1995), promiscuity in women may be the result of severe narcissistic character pathology to mild masochistically or hysterically determined pathology. Narcissistic women who engage in sexual promiscuity engage in rapid cycles of idealization and subsequent devaluation of men. While some women with narcissistic pathology may enter into stable, albeit self-destructive, relations with extremely narcissistic men, others simultaneously search for an ideal man just as they intensely devalue each partner, shifting from one man to another. These women devalue the man as soon as he responds to them, remaining fixated on unavailable men, which perpetuates the cycling of idealization and devaluation, and prevents any opportunity for the man to debase the woman.

While patients with severe borderline personality structure exhibit sexual inhibition, less severely disturbed borderline patients manifest greater capacity for erotic desire and sexual excitement. Nonetheless, their disrupted internalized object relations render their relationships sensitive to the mechanisms of splitting. These individuals lack integration of the “all-good” and “all-bad” object and thus split the world into idealized and persecutory figures. Kernberg does not explicitly characterize these individuals as either promiscuous or inhibited but implicit in his thinking is that the fragility of their internalized object relations results in either promiscuous relations or masochistic attachments to sadistic partners. While these patients seem to have integrated, at least in part, aggression with love, showing the ability to “recruit the aggressive, sadomasochistic components of infantile sexuality in the service of the libidinal gratification,” they have not yet integrated sexual desire and sexual excitement, and engage in immature idealization of their partner as a way of defending against the persecutory counterpart of their internalized self-object dyads (p. 67). Intense sexual experiences serve to perpetuate these splitting mechanisms, which Kernberg believes “oedipalize” preoedipal conflicts. As a way to
deny anxiety provoking relations that activate feelings of neediness and dependency, these patients flee into early sexualization of all relationships. They thus appear to be more promiscuous – they are quick to engage in sexual relations with new partners as they defend against aggression that is imbedded in the persecutory counterpart of the idealized object.

Kernberg suggests that patients with masochistic or hysterical tendencies tend to experience profound feelings of unconscious guilt over achieving stable love relations that trigger forbidden oedipal wishes, which propels them from one partner to another as a way to defend against these feelings of guilt. However, these women likely establish strong and stable relations as long as they do not involve a sexual component. A woman with a hysterical personality may develop a deep and meaningful relationship with a man without a sexual component; however, once sexual intimacy is initiated, unconscious guilt over forbidden sexuality may jeopardize the relationship leading the woman to move on to another partner. In this way, both sexual inhibition and promiscuity may be linked to unconscious feelings of oedipal guilt, which either interferes with a woman’s capacity to experience sexual desire or with her ability to direct her desire to only one object, as sexual intimacy evokes the threatening yearnings of the oedipal period.

While Kernberg acknowledges that promiscuity indicates less severe character pathology than sexual inhibition, he designates it as a symptom of psychic conflict and does not consider the possibility that heightened sexuality also may be apparent in healthy, well-adjusted individuals. Further, he does not differentiate between promiscuous behavior and high levels of erotic desire, which may be directed towards multiple partners. As I have repeatedly asserted throughout this proposal, promiscuity may occur without the presence of high levels of sexual desire just as high levels of sexual desire may be possible without its behavioral manifestation. In
fact, a woman who engages in sexual promiscuity without experiencing high levels of sexual desire may be struggling with more complex psychological conflicts as compared to a woman who seeks out multiple sexual partners as a way to fulfill her sexual cravings. Another possibility is a woman who feels intense sexual desire but does not act on those wishes and therefore remains sexually unfulfilled. Much of the theory on inhibited sexuality in women suggests that diminished or absent sexual desire stems from women’s early object relations, which deflate their sexuality and genitality, foster feelings of bodily and sexual inadequacy and fear of loss and rejection, and result in the failure to achieve a sense of sexual subjectivity, to name a few. In this way, women who are able to experience high levels of sexual desire possibly constitute the group of women who are able to overcome the sexual inhibition that originates in childhood.

In contrast to Kernberg (1995), Ruth Stein (2008) suggests that heightened sexual desire may indicate the capacity for more advanced and integrated ego structures – a capacity that is lacking in individuals with character pathology described by Kernberg. In discussing the excess of sexuality, Ruth Stein (2008) argues that the line between normal and pathological is quite blurry and difficult to distinguish. She begins her essay “The Otherness of Sexuality: Excess” by commenting on the contradictory nature of excess, which “denotes both the liberated pleasure beyond bounds and abominable transgression and destructiveness” (Stein, 2008, p. 43). Sexual practices such as sadomasochism or promiscuity can be normal, as the distinction between ““generic” and defensive sexualization, proves, on a closer look, to be less clear” (Stein, 2008, p. 54). Stein refers to the conceptual elaboration of Robert Stoller (1979) whose work on sexual excitement indicated that human beings have the capacity to transform intense emotional experiences through sexuality, thereby converting “vice” into “virtue” and thus engaging in psychical restructuring (Stein, 2008, p. 53). As discussed earlier, Stein argues that the excess of
sexuality can convert pain into pleasure, humiliation into enjoyment, and facilitate more ego advancement and integration.

Stein differentiates between “bad” and “good” excess, which she positions on the same spectrum of sexual desire. She acknowledges that “bad” excess may stem from traumatic experiences of physical and/or psychological abuse or from “relationships so toxic or isolating as to have created perverse, traumatized sexualities” (Stein, 2008, p. 68). These individuals engage the excess of sexuality to cope with the “breach of one’s boundaries” that involved “being flooded and overwhelmed” with intense and horrifying emotions (Stein, 2008, p. 63). Nonetheless, Stein finds that certain individuals have the capacity “to harness the excessive in sexuality in liberating ways” that facilitates the process of healing and reparation.

The excess of sexuality may offer women the opportunity to undo and repair the internalized dynamics that contribute to their inhibited sexuality. Women’s early childhood experiences with their caretakers leave them with complex sexual conflicts that contribute to diminished or even absent sexual desire in adulthood. Benjamin (1988) argues that a woman’s sexual desire is inextricably tied to her sense of sexual subjectivity, such that she can establish a capacity for sexual desire only once she can fluidly shift between the positions of being desired by the other and desiring the other rather than rigidly remaining as the object of another’s desire. Stein, referring to the ideas on shattering and advancing new ego structures through the “excessive other” of Jean Laplanche (1987; 1970) and Leo Bersani (1986, 1995), suggests that sexual excitement results in “the formation of subjecthood” as it offers the “opportunity for undoing existing ego structures in anticipation of more advanced, more integrated ones” (Stein, 2008, p. 53). Women may require the excess of sexual desire in order to develop the subjectivity, which they so often lack and which deprives them of the capacity to experience erotic desire. In
this way, heightened sexual desire in women may represent the process of reparation and resolution of the sexual inhibition that occurred within the context of early object relations.

Steins particularly focuses on shame as one intense emotion that lends itself to transmutation through sexual desire: “Our mind has the uncanny ability to transform feelings through sexuality, and it intensifies them by the specific emotions it overcomes, most particularly shame” (Stein, 2008, p. 62). Echoing Elise’s ideas on the role of shame in sexual inhibition, Stein characterizes sexual shame as “inadequacy, unattractiveness, being inhibited, or being flawed in one’s body” (Stein, 2008, p. 65). Stein also discusses “shame of excess,” which is “about one’s excited, exhibitionistic, flushed states, one’s craven lusts, one’s ludicrous pleasure-dependence.” As discussed earlier, Elise finds that shame significantly contributes to the girl’s deflation of her genitals, her sexuality and her sexual desire and leaves her with feelings of guilt and sexual inferiority. Overcoming sexual shame thus appears to be integral for the girl and woman to “re-inflate” her sexual desire. And Stein proposes that sexuality itself can offer a way to do just that, suggesting that, “overcoming of shame is sexual, since sex very often is an unconscious overcoming of boundaries and their maker, shame” (Stein, 2008, p. 66). She argues that for shame to dissipate, it requires a “desirous other, who validates the excitement and transgresses against the same shame” (Stein, 2008, p. 65). Sexuality can thus provide ways of overcoming sexual conflicts and offers women the space to develop their capacity for erotic desire.

Interestingly, Elise (2000, 2008) writes that boys defend against oedipal conflicts by inflating their sexual desires while women tend to do the opposite and she questions why psychoanalysis has not addressed the concept of healthy inflation of girls’ genitality. I would argue that perhaps due to the circumstances female sexual development, women actually may
need to exaggerate their sexual desires to resolve the multiple barriers that interfere with their sexuality. For Kernberg, object choice stands at the center of mature love and healthy sexuality. Individuals’ inability to develop stable, continuous relations with one object is indicative of underlying pathology. He does not focus on the value of sexual desire in advancing psychic integration as proposed by Stein. Perhaps, whatever propels one into sexual activity and infuses erotic desire – whether pain or pleasure – may either indicate the capacity for psychic advancement or the presence of more integrated personality organization that allows one to experience high levels of sexual desire.

**Conclusion.** Previous studies tended to investigate sexual desire with respect to pathology, studying women complaining of lower desire or of hypersexuality separately, or to focus on highly sexual women while the current study considered an entire spectrum of sexually inhibited to highly sexual women. Such approach offered the possibility of considering certain attributes or experiences of highly sexual women that fostered their sexual desire. Previous studies looking at factors that contributed to low desire or that investigated highly sexual women have not looked at object relations or attachment constructs, which were found to be important in understanding factors that may enhance or inhibit female sexual desire. Further, while body image has been investigated in previous studies on sexual functioning, it has not been considered in the context of sexual desire. Specifically, previous research has not addressed how self-objectification – tendency to monitor their bodies during sex, sexual body esteem – women’s feelings about their sexual attractiveness and desirability, and genital self-image – how women feel about their genitalia, influence women’s experiences of sexual desire. Additionally, previous studies restricted their assessments of sexual desire in order to evaluate pathology while the current study conceptualized sexual desire as the desire for partnered sexual activity, solitary
sexual activity, and cognitive and affective components of sexual desire, generating a more comprehensive definition of sexual desire in women. Further, previous studies have not compared highly sexual and sexually inhibited women’s phenomenological narratives of sexual desire, which elucidated some differences in these women’s bodily, affective, cognitive and relational experiences of their sexuality.

As I have indicated throughout this literature review, one major gap in the understanding of female sexual inhibition is if and how women have the capacity to overcome it. Women’s sexual desires span a wide range with a high prevalence of diminished or absent desire as well as incidence of heightened desire. Although many researchers and theoreticians characterize heightened sexuality as pathological, research shows that highly sexual women appear to have more liberal attitudes toward sex, exhibit more positive regard toward their sexuality and their bodies, and value sex as a central and vital component of their lives. And while Kernberg links hypersexuality to character pathology, albeit conceding that heightened sexuality is less pathological than inhibited sexuality, Stein argues that the excess of sexuality can facilitate the process of restructuring of self to achieve a higher level of ego integration. Given these discrepancies in the literature on diminished and heightened sexual desire, the current study sought to examine how women’s internalized representations of their early parental relations (attachment, separation/individuation, and parental identification) influences aspects of their sexual self-concept (sexual subjectivity, self-objectification, and genital self-image), which, in turn, enhances or inhibits sexual desire in women.

**Objectives and Hypotheses of the Proposed Study**

The current study involved two phases of data collection from healthy heterosexual premenopausal women. In the first phase, women completed self-report questionnaires that
assess internalized representations of parental relationships, sexual self-concept variables, and sexual desire. The resultant quantitative data was then examined to test the hypotheses of the study (described below). Focusing on a smaller subsample of 20 women, the second phase entailed a qualitative and exploratory approach to collecting phenomenological narratives of women's experiences of sexual desire via in-person semi-structured interviews. While the first phase of the study compared variables described above between individuals, the second phase conducted an individual examination of various facets of sexual desire as these are perceived, explained, and linked throughout the individual’s life. The more in-depth and nuanced phenomenological narratives collected in the second phase compliment the quantitative findings of the first phase, as each woman’s story offers unique aspects of women’s intricate, private and intimate feelings and details of their lived experiences of sexual desire.

Based on the previous empirical findings and theories on female sexuality, the study evaluated the proposed model in which sexual self-concept (sexual subjectivity, self-objectification, and genital self-image) mediates the relations between internalized representations of parental relations (attachment, separation/individuation, parental identification) and sexual desire (partnered sexual desire, solitary sexual desire, affective/cognitive sexual desire) in women (Figure 1).

![Figure 1. Proposed Study Model. Sexual self-concept mediates the relationship between early parent-child relations and sexual desire.](image-url)
The hypotheses follow:

1. Lower levels of attachment avoidance and anxiety, of separation/individuation pathology, and more psychological independence from the mother as well as less difference between the parental identification with the father and with the mother (i.e. more equal) will predict greater sexual subjectivity, less self-objectification, and more positive genital self-image.

2. Greater sexual subjectivity, less self-objectification, and more positive genital self-image will predict greater sexual desire for partnered and solitary sexual activity as well as more positive affective and cognitive components of sexual desire.

3. Sexual subjectivity, self-objectification, and genital self-image will explain (mediate) the relations between attachment, separation/individuation, and parental identification with sexual desire, such that the relations between lower attachment avoidance and anxiety, lower separation/individuation pathology, and greater psychological independence from the mother well as less discrepancy between parental identification with the father and with the mother on the one hand and greater sexual desire for partnered and solitary sexual activity and more positive affective and cognitive components of sexual desire on the other hand are explained by greater sexual subjectivity, less self-objectification, and more positive genital self-image.
Methods

Participants

The 562 participants are heterosexual women, 18 to 39 years of age (M=25.50, SD=4.63). The sample comprised 63% White, 12% African-American, 12% Latino, 7% Asian, and about 6% other race/ethnicity. A total of 1,899 female participants were recruited to participate in the study and 53% of these participants (N=1012) were eligible and consented to participate in the study. The pre-study screener (see Appendix I) determined that 882 individuals were ineligible to participate based on the ineligibility criteria (see Table 1).

Table 1

<table>
<thead>
<tr>
<th>Ineligibility Criteria</th>
<th>No.</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gay/Lesbian/Bisexual/Other sexual orientation</td>
<td>228</td>
<td>25.85%</td>
</tr>
<tr>
<td>Medical Condition</td>
<td>229</td>
<td>25.96%</td>
</tr>
<tr>
<td>Incomplete pre-study</td>
<td>221</td>
<td>25.06%</td>
</tr>
<tr>
<td>Age below 18 or above 40</td>
<td>95</td>
<td>10.77%</td>
</tr>
<tr>
<td>Psychiatric Condition</td>
<td>41</td>
<td>4.65%</td>
</tr>
<tr>
<td>Pregnant or Lactating</td>
<td>32</td>
<td>3.63%</td>
</tr>
<tr>
<td>Inadequate knowledge of English</td>
<td>19</td>
<td>2.15%</td>
</tr>
<tr>
<td>Not female biological sex</td>
<td>12</td>
<td>1.36%</td>
</tr>
<tr>
<td>Did not consent</td>
<td>5</td>
<td>.57%</td>
</tr>
<tr>
<td>Total:</td>
<td>882</td>
<td>100%</td>
</tr>
</tbody>
</table>

Of eligible participants, 60% completed the study (N=614) and 56% (N=562) were included in the analyses (See Figure 2). Completers and non-completers were compared on numerous demographics, including age, race/ethnicity, religion and religiosity, level of education, annual household income, employment and school status, relationship status, and having children. Significant differences were found between the groups on race/ethnicity, i.e. $\chi^2 (5, N=1,012) = 19.73, p = .001$, with more completers identifying as White and fewer completers identifying as Latina and African-American.
American, and on religiosity, i.e. $\chi^2 (4, N=1,012) = 9.56$, $p = .05$, with completers being less religious; however, the effect size Cramer’s V were quite small, 0.14 and 0.10, respectively. The groups did not differ on the other variables.

Of the eligible participants, 38 participants were excluded from the study because of missing data. Another 14 participants were excluded because they scored in the high range on a subsample of questions, which were used to identify those women who were pathologically hypersexual, (i.e. they would have scored in the high ranges on the measures of desire but their heightened desire stemmed from certain pathological sexual feelings and behaviors.) Fourteen participants answered, on average, “Always=1” and “Often=2” to such questions as “I can’t feel sexual desire for the person I love” and “I am troubled by my inability to control my sexual thoughts.”

**Figure 2. Recruitment flowchart.**

**Measures**

The *Demographic questionnaire* consisted of basic demographic questions such age, race/ethnicity, education, religion, and income. *Sexual, Medical and Psychiatric History questionnaire* consisted of questions about illnesses that may interfere with sexual functioning. Table 2 shows the list of measures used in the current study and their reliability coefficients for the current sample (See Appendix II for study questionnaires).
**Sexuality screeners.** *Intimate Relations Inventory of Sexuality* (IRIS) is a 157-items self-report questionnaire developed by Foelsch, Bartocetti, Deal, and Clarkin (2003) to assess sexual behavior and sexual relationships. Sixteen of the items were selected from this questionnaire to identify women who may be pathologically hypersexual rather than highly sexual in an adaptive and well-adjusted way (as described in the literature review, Wentland and colleagues, 2009).

Table 2

*List of Measures, Subscales, Constructs, Number of Items, and Cronbach’s Alphas for the current sample for Each Latent Variable.*

<table>
<thead>
<tr>
<th>Measure</th>
<th>Subscales</th>
<th>Construct</th>
<th># of items</th>
<th>Cronbach’s Alpha</th>
</tr>
</thead>
<tbody>
<tr>
<td>Intimate Relations Inventory of Sexuality (IRIS; Foelsch, Bartocetti, Deal, and Clarkin, 2003)</td>
<td>Screener to exclude</td>
<td>16</td>
<td>0.92</td>
<td></td>
</tr>
<tr>
<td>Sexuality Screener (from Wentland et al., 2009; DeRogatis et al., 2008, Blumberg, 2003)</td>
<td>Screener to differentiate</td>
<td>44</td>
<td>0.94</td>
<td></td>
</tr>
<tr>
<td>Experiences in Close Attachment</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Measures</td>
<td>Subscale</td>
<td>Sample Size</td>
<td>Correlation</td>
<td></td>
</tr>
<tr>
<td>----------------------------------------------</td>
<td>---------------------------</td>
<td>-------------</td>
<td>--------------</td>
<td></td>
</tr>
<tr>
<td>ECR-Anxiety</td>
<td>Attachment</td>
<td>18</td>
<td>0.86</td>
<td></td>
</tr>
<tr>
<td>Separation-Individuation</td>
<td>Separation-Individuation</td>
<td>39</td>
<td>0.93</td>
<td></td>
</tr>
<tr>
<td>Psychological Separation Inventory (PSI)</td>
<td>Conflictual</td>
<td>25</td>
<td>0.95</td>
<td></td>
</tr>
<tr>
<td>Emotional Independence</td>
<td>Independence from the Mother</td>
<td>17</td>
<td>0.92</td>
<td></td>
</tr>
<tr>
<td>Semantic Differential</td>
<td>Mother Parental Identification</td>
<td>12</td>
<td>0.70</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Father Parental Identification</td>
<td>12</td>
<td>0.80</td>
<td></td>
</tr>
<tr>
<td>Scale</td>
<td>Score</td>
<td>Cronbach’s α</td>
<td></td>
<td></td>
</tr>
<tr>
<td>----------------------------------------------------------------------</td>
<td>-------</td>
<td>--------------</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Body Image Self-Consciousness Scale (BISC; Wiederman, 2000)</td>
<td>15</td>
<td>0.95</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Female Genital Self-Image Scale (FGSIS; Herbenick &amp; Reece, 2010)</td>
<td>7</td>
<td>0.88</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Female Sexual Subjectivity Inventory (FSSI; Horne &amp; Zimmer-Gembeck, 2006)</td>
<td>5</td>
<td>0.85</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Entitlement to Desire and Pleasure</td>
<td>10</td>
<td>0.81</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sexual Self-Reflection</td>
<td>5</td>
<td>0.80</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sexual Desire Inventory (SDI; Partnered Sexual Desire)</td>
<td>8</td>
<td>0.88</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Selected items included “I feel out of control when it comes to sex,” “Keeping more than one lover protects me from getting hurt,” “I need sex to feel good about myself,” “Offering sex helps me get what I want,” and “I use sex to escape bad feelings.” The response choices ranged from “Always” (1), Often (2), Sometimes (3), Rarely (4), and Never (5).” A mean was computed to obtain a score for pathological hypersexuality, with scores ranging from 1 to 5 (M=4.27, SD=.68). Higher scores indicate lower pathology associated with hypersexuality. Cronbach’s alpha for these items from the IRIS in the current study sample was 0.92. Participants who, on average, replied “Always” or “Often” were excluded from the statistical analyses that tested the hypothesized model; 14 participants who scored 2.5 or below met the exclusion criteria based on their IRIS scores.

*Sexuality Screener* is a 44-item self-report questionnaire based on the measures developed by Wentland and colleagues (2009), the Female Sexual Distress Scale (FSDS-R; (DeRogatis, Clayton, Lewis-D'Agostino, Wunderlich, & Fu, 2008), and 2 screening questions from Blumberg’s (2003) qualitative study about highly sexual women. For their study
distinguishing highly sexual women from less sexual women, Wentland and colleagues adopted questions from Hurlbert’s Index of Sexual Desire (HISD; Apt & Hurlbert, 1992), Relationship Between Mode of Female Masturbation and the Achievement of Orgasm in Coitus (FMOC; Leff & Israel, 1983), Sexual Excitation-Sexual Inhibition Inventory (SESII-W; Graham, Sanders, & Milhausen, 2006), Hurlbert Index of Sexual Assertiveness (HISA; Hurlbert, 1991), Sexual Awareness Questionnaire (SAQ; Snell, Fisher, & Miller, 1991), Sexuality Scale (SS; Snell & Papini, 1989), Inventory of Dyadic Heterosexual Preferences (DHP; Purnine, Carey, & Jorgensen, 1996), and items adapted from Rempel & Baumgartner (2003). The current study used 6 of the original 11 clustering variables including: sex drive, attitudes toward sexually explicit material, sexual adventurism, sexual fantasies and thoughts, masturbatory attitudes, attitudes toward sexy clothing, and attitudes toward casual sex.

Items from the Female Sexual Distress Scale—Revised (FSDS-R) were added to inquire about women’s negative feelings about their sexuality (DeRogatis et al., 2008) (e.g. “I feel distressed about my sex life.”). In addition two questions were added to the screener based on a study on highly sexual women conducted by Blumberg (2003): 1) You typically desire sexual stimulation, usually to the point of orgasm, with yourself or a partner, six to seven times per week or more and act upon that desire; 2) You think of yourself as a highly sexual woman, sex is often on your mind, and it is an aspect of yourself that strongly and frequently affects your behavior, life choices, and quality of life satisfaction. All original scales have acceptable levels of scale score reliability, with alphas of sex drive=.84, attitudes toward sexually explicit material=.88, sexual adventurism=.84, sexual fantasies and thoughts=.88, attitudes toward sexy clothing=.68, attitudes toward casual sex=.86, and correlation coefficient for 2-item cluster variables of .48 for masturbatory attitudes. FSDS-R shows high internal consistency, with
Cronbach’s alpha of .86 and good test-retest reliability, with an intraclass coefficient of .74. Women with sexual dysfunction score higher on the FSDS than healthy controls, indicating discriminant validity.

Response options range from “never (1), almost never (2), rarely (3), sometimes (4), often (5), very often (6), to always (7).” Twelve of the items were reverse scored, and a mean was computed to obtain a score for the sexuality screener with higher scores indicating higher levels of sexuality. Scores ranged from 1.65 to 6.62 (M=4.14, SD=.95).

In the current sample, Cronbach’s Alpha for the Sexuality Screener was 0.94. The Sexuality Screener was used to distinguish between sexually inhibited and highly sexual women for Stage 2 of the study, which entailed an in-depth semi-structured interview, which will be described below.

**Attachment.** *Relationship Structures Questionnaire of the Experiences in Close Relationships-Revised* (ECR-RS; Fraley, Heffernan, Vicary, & Brumbaugh, 2011) is a 36-item scale that assesses attachment dimensions of avoidance and anxiety across four different kinds of intimate relationships, including relationship with mother, father, romantic partner(s), and best friend(s). ECR-RS has been shown to have good reliability, with Cronbach’s alphas ranging from 0.80 to .91 for anxiety and 0.81 to 0.92 for avoidance across all relational contexts and for the composite or global scores (Fraley et al., 2011). Further, the scale has demonstrated good validity when correlated with measures of relationship functioning, such that highly anxious and avoidant people tended to be less committed, less satisfied and less invested in their relationships, while also desiring alternative partners (Fraley et al., 2011). In the current study, only mother, father and romantic partner items were used. The same 9 items are used for each domain, yielding 27 items in total that were used in the current study. The measure yields two
dimensions: 1) the *avoidance* dimension (items 1-6) reflects the degree to which people are uncomfortable opening up to and depending on others (e.g. “I don’t feel comfortable opening up to this person”) and 2) the *anxiety* dimension (items 7-9) indicates the degree of preoccupation with attachment-related worries (e.g. “I am afraid that this person will abandon me”) (Fraley, Waller, & Brennan, 2000). For each item, participants are asked to indicate on a 7-point Likert scale the extent to which they agreed or disagreed with each item, ranging from “Strongly disagree (1) to strongly agree (7).” Four of the 9 items for each domain are reverse scored (#1-4). A mean was taken of all avoidance items across the three relational domains (mother, father, romantic partner) to generate a global score for avoidance, and a mean of all the anxiety items across the three relational domains was computed to generate a global score for anxiety. Higher scores indicate greater levels of attachment avoidance and anxiety. In the current study sample, avoidance scores ranged from 1 to 6.28 (Mean=3.34, SD=1.10) and the anxiety scores ranged from 1 to 7 (Mean=2.52; SD=1.37). In the current sample, Cronbach’s alphas were 0.88 for the global scores of avoidance and 0.86 for the global scores of anxiety.

**Separation/Individuation.** *Separation-Individuation Inventory* (SII; Christenson & Wilson, 1985) is a 39-item self-report measure that assesses adult manifestations of disturbances in the separation-individuation process, i.e. *separation-individuation pathology* (e.g. “When someone gets too emotionally close to another person, they often feel lost.”). The scale has been shown to have good reliability, with Cronbach’s alpha of 0.92 for the overall separation/individuation inventory (Christenson & Wilson, 1985). Christenson and Wilson (1985) established validity by comparing patients diagnosed with borderline personality disorder with a control group of university employees, showing that the former score higher on the SII scale than the latter. Response items were scored on a 6-point scale ranging from “Strongly
disagree (1), Disagree (2), Somewhat disagree (3), Somewhat agree (4), Agree (5), to Strongly
agree (6).” Three of the items (#7, 15, 18) were reverse scored. A mean of all items was
computed to generate score for separation-individuation pathology. Higher scores indicate more
disturbances in separation-individuation process and fragile sense of identity. In the current
sample, scores ranged from 1.18 to 4.92 (M=2.58, SD=0.73). Cronbach’s alpha in the current
sample for the SII was 0.93.

*Psychological Separation Inventory* (PSI; Hoffman, 1984) is a 138-item scale that
assesses psychological separation from one’s mother and father over 4 different subscales
(emotional independence, conflictual independence, attitudinal independence, and functional
independence). PSI has good reliability with Cronbach’s coefficient alphas ranging between 0.84
to 0.92, with 0.88 for emotional independence from the mother and 0.92 for conflictual
independence from the mother (Hoffman, 1984). Construct validity was established by
demonstrating an association between psychological separation and psychological adjustment
variables, including academic adjustment and the absence of interpersonal problems (Hoffman,
1984). The current study included a total of 42 items, with only the conflictual independence (#2,
4, 5, 6, 8, 10, 12, 13, 14, 16, 20, 22, 24, 26, 28, 30, 32, 34, 36, 39, 40, 41, 43) and emotional
independence (#1, 3, 7, 9, 11, 15, 19, 21, 23, 25, 27, 29, 31, 33, 35, 38, 42) subscales and only
for the mother. Conflictual independence refers to the “freedom from excessive guilt, anxiety,
mistrust, responsibility, inhibition, resentment and anger in relation to the mother” (e.g. “I feel
like I am constantly at war with my mother”) and emotional independence refers to the “freedom
from an excessive need for approval, closeness, togetherness, and emotional support in relation
to the mother” (e.g. “Being away from my mother makes me feel lonely”) (Hoffman, 1984, p.
171-172). Participants respond on a 5-point Likert-type scale with responses ranging from “Not
at all true of me” (1) to “very true of me” (5). To compute the emotional independence score, a mean was taken of all the emotional independence items, and to generate the conflictual independence score, a mean was taken of the conflictual independence items. Higher scores indicate more difficulties with emotional or conflictual independence. For conflictual independence, scores ranged from 1 to 6 (M=2.46, SD=1.06) and for emotional independence, scores ranged from 1 to 6 (M=2.54, SD=1.01). The Cronbach’s alpha for the conflictual independence subscale in the current sample was 0.95 and for emotional independence, 0.92.

Parental identification. Semantic Differential (SD; Osgood, Suci, & Tannenbaum, 1957), a 36-item self-report scale that consists of 12 pairs of bipolar adjectives rated on a seven-point scale for oneself, mother and father, was used to assess parental identification. Participants were asked to rate themselves, their father and their mother on each of the 12 dimensions. The 12 pairs are based on the three factors established by Osgood and colleagues(1953): Evaluative (Good-Bad, Cruel-Kind, Fair-Unfair, Honest-Dishonest), Potency (Weak-Strong, Cowardly-Brave, Humorous-Serious, and Violent-Gentle); and Activity (Passive-Active, Tense-Relaxed, Calm-Excitable, Definite-Uncertain). Lazowick (1955) and Ridgeway (1978) applied SD as a measure of parental identification. Emmerson and Neely (1988) found SD to be a “flexible, reliable, and valid data collection” method. A score of perceived similarity to each parent was obtained by summing the squares of the differences between participants’ ratings of themselves and of each parent on each adjective paring and then taking the square root of the sum. Higher scores indicate less identification. Adequate reliability of semantic differential has been established (Bieri, Lobeck, & Galinsky, 1959; Osgood et al., 1957). For paternal identification, the scores ranged from 0 to 19.90 (Mean=6.93, SD=2.94) and for maternal identification, the
scores ranged from 0 to 20.78 (Mean=6.31, SD=2.44). In the current subsample, Cronbach’s Alpha for the Mother subscale was 0.70, and for the Father, 0.80.

Sexual subjectivity. Female Sexual Subjectivity Inventory (FSSI; Horne & Zimmer-Gembeck, 2006) is a 20-item self-report measure that assesses 3 factors of sexual subjectivity: (a) sexual body-esteem, which assesses self-perceptions of sexual desirability and attractiveness (items: 1, 6, 11, 16, 19); (b) sexual desire and pleasure, which assesses one’s sense of entitlement to sexual pleasure during solitary and partnered sexual activity as well as feelings of self-efficacy in achieving sexual pleasure (2, 3, 4, 7, 8, 9, 12, 13, 14, 17) and (c) sexual self-reflection (items: 5, 10 15, 18, 20), which indicates one’s reflection on one’s sexuality, sexual behavior and experiences. All scales and subscales of the FSSI previously have been shown to have high reliability with Cronbach’s alpha ranging from 0.77 to 0.89, with 0.87 for sexual body-esteem, 0.77 to 0.85 for entitlement to desire and pleasure, and 0.79 for sexual self-reflection. Further, validity was established in previous research by demonstrating significant associations between the scales of the FSSI and sexual self-awareness, safe sex self-efficacy, and sexual anxiety (Horne & Zimmer-Gembeck, 2006). Sample items for each factor include “I am confident that others will find me sexually desirable” (Sexual body-esteem); “It is Okay for me to meet my own sexual needs through self-masturbation” (Sense of entitlement to sexual pleasure from self); “I think it is important for a sexual partner to consider my sexual pleasure” (Sense of entitlement to sexual pleasure from partner); “I would not hesitate to ask for what I want sexually from a romantic partner” (Self efficacy in achieving sexual pleasure); “I think about my sexuality” (Sexual self-reflection). Response items ranged from “Not at all true for me (1), a little true for me, moderately true of me, quite a bit true of me, very true of me (5).” Higher scores indicate higher levels of sexual subjectivity, i.e. more positive body esteem, greater sense of
entitlement to desire and pleasure, and higher tendency for sexual self-reflection. Six of the scale items were reverse scored. Means were computed for each subscale, with scores ranging from 1 to 5 for sexual body-esteem ($M=3.27$, $SD=0.97$), 1.30 to 5 for entitlement to desire and pleasure ($M=3.63$, $SD=0.77$), 1 to 5 for sexual self-reflection ($M=3.58$, $SD=0.91$). In the current sample, Cronbach’s alphas were 0.85 for the sexual body-esteem subscale, 0.81 for entitlement to desire and pleasure, and 0.80 for sexual self-reflection.

**Self-objectification.** Body Image Self-Consciousness Scale (BISC; Wiederman, 2000) is a 15-item self-report scale that assesses self-consciousness over one’s bodily appearance during sexual activity. The scale has been shown to have high reliability with Cronbach’s alpha of .95 (Wiederman, 2000). Further, construct validity was established by demonstrating significant associations between the BISC and body esteem, sexual esteem, sexual anxiety, self-rated physical attractiveness, as well as the decreased tendency to engage in vaginal intercourse and to perform and receive oral sex. The items are composed so that women with and without sexual experience involving a partner can respond (e.g., “During sexual activity, I am (would be) concerned with how my body looks to my partner). Participants respond on a 6-point Likert-type scale, ranging from “Never (0), Rarely (1), Sometimes (2), Often (3), Usually (4), Always (5).” A mean of all items was computed to obtain the score for self-objectification, with scores ranging from 1 to 6 ($M=2.37$, $SD=1.12$), with the higher scores indicating a greater level of self-consciousness during sexual activity. In the current sample, Cronbach’s alpha was 0.95. (BISC scores were reversed for analyses to have the same direction as the other measures for the construct of sexual self-concept).

**Genital body image.** Female Genital Self-Image Scale (FGSIS; Herbenick & Reece, 2010) is a 7-item self-report scale that assesses women’s feelings and beliefs about their genitals
(e.g. “I am satisfied with the appearance of my genitals”). The scale has good reliability, with Cronbach’s alpha of 0.88 (Herbenick & Reece, 2010; Herbenick et al., 2011). The scale also has good validity, with strong relationships with women’s experiences of masturbation, gynecological care, and genital self-examination. Women with higher scores on the FGSIS engage in more masturbation and are more likely to seek gynecological care and engage in genital self-examination. Further scores on the FGSIS are positively related to female sexual functioning, with participants who report more positive genital perceptions reporting higher levels of arousal, desire, orgasm, satisfaction, and less pain. Participants respond on a 4-point response scale, ranging from “Strongly agree (1), agree, disagree, strongly disagree (4).” A mean score of all items was computed to obtain a score of female genital self-image, which ranged from 1 to 4 (M=2.97, SD=0.60) with the higher scores indicating more positive genital self-image. Cronbach’s alpha in the current study was 0.88.

**Sexual desire.** Sexual Desire Inventory (SDI; Spector, Carey, & Steinberg, 1996) is 13-item Likert-type self-report questionnaire developed to measure sexual desire. This scale is evidenced to have strong reliability with Cronbach’s alpha of 0.86 and 0.76 for the Partnered and Solitary scale, respectively. Further, the scale has been shown to have strong validity – the solitary sexual desire subscale has a strong association with frequency of solitary sexual behavior while partnered desire subscale is correlated with frequency of partnered sexual behavior in college students. For females, partnered desire is positively correlated with relationship adjustment, sexual satisfaction, sexual daydreams, and sexual arousal (Spector et al., 1996). Respondents were asked to use the last month as a referent for reflecting on their thoughts and feelings about their interest or wish for sexual activity, with or without a partner. Items 1, 2-8, and 11 are summed for the Partnered Sexual Desire score (e.g. “When you have sexual thoughts
how strong is your desire to engage in sexual behavior with a partner?”) and items 3, 9, 10, and 12 are summed to find the Solitary Sexual Desire Score (e.g. “Compared to other people your age and sex, how would you rate your desire to behave sexually by yourself?”); item 13 is not included in either subscale and was therefore omitted from the analyses for the current study. For the 3 frequency items (#1, 2, 10), responses range from “Not at all (1) to More than once a day or Many times a day (7).” For the remaining 8 strength items, respondents rate their level of sexual desire on an 8-point Likert-type scale, “No desire (0) to Strong desire (8).” A mean score of all the partnered sexual desire items and a mean score of all the solitary sexual desire items were computed to obtain respective scores. For the Partnered Sexual Desire subscale, scores ranged from 1 to 8.75 (M=5.84, SD=1.54), and for the Solitary Sexual Desire subscale, scores ranged from 1 to 8.75 (M=4.68, SD=2.21), with higher scores indicating higher levels of sexual desire. In the current sample, Cronbach’s alphas were 0.88 for the Partnered subscale and 0.93 for the Solitary subscale.

Hulbert’s Index of Sexual Desire (HISD; Apt & Hurlbert, 1992) is a 25-item Likert-type self-report measure that assesses overall emotional, behavioral, and cognitive components of sexual desire (e.g. “Just thinking about having sex with my partner excites me,” “I feel I want sex less than most people”). This scale has been shown to have high internal consistency, with Cronbach’s alpha of 0.89, good test-retest reliability of 0.86, and excellent predictive, construct, discriminate and concurrent validity. Response items ranged from “All of the time (0), most of the time (1), some of the time (2), rarely (3), never (4).” Thirteen of the items were reverse scored, and a mean of all items was computed to obtain a score for the affective and cognitive aspects of sexual desire. In the current sample, scores ranged from 1.08 to 4.00 (M=2.89, SD=.66), with higher scores corresponding to greater levels of sexual desire and more positive
affective and cognitive aspects of sexual desire. In the current sample, Cronbach’s alpha was 0.96.

Procedure

Women were recruited over a period of 3 months (01/09/2013-04/10/2013) via advertisement postings asking heterosexual women between the ages of 18 and 40 to participate in a research study on sexual desire in the Volunteer section of Craigslist throughout the United States (e.g. New York City and its tri-state area, Boston, Chicago, Miami, San Francisco, Vermont, Maine, etc.), on Facebook, and on Twitter, with 91% of the participants recruited through Craigslist (See recruitment flyer in the Appendix III). Recruitment continued until the minimum of 600 participants completed the online survey. All measures were administered online through PsychData.com. Prior to beginning the survey, women were asked to register with PsychData.com by using their email and creating a password so that they could complete the survey over multiple sessions. Interested participants completed an anonymous online pre-study screening questionnaire that included demographic items as well as sexual, medical and psychiatric history questions to determine eligibility. Healthy, heterosexual, premenopausal women between the ages of 18 and 40 were deemed eligible to participate and presented with the consent form. Eligible participants completed the online consent form and then proceeded to answer approximately 350 self-report items. Those who met exclusion criteria were automatically directed to the “Thank you” page.

All participants were given the option to enroll in a lottery to win $50-Amazon.com gift certificate (see Appendix IV). Lottery drawings occurred once per every 30 participants who enrolled in the lottery. A total of 429 participants enrolled in the lottery with 15 women winning the gift certificate, which they received after the end of data collection. After participants
completed the online survey, they were presented with the option to be contacted for phase 2 of
the study, which entailed one in-person interview in New York City. Participants were informed
that (1) they would have to attend an in-person session in New York City, (2) the interview
would last about 60-90 minutes, (3) the interview would be audio-recorded, and (3) they would
be compensated a total of $30 for their participation (see flyer in the Appendix IV). Those
women, who were interested in participating in the second phase of the study, provided their
contact information.

Analyses

SPSS was used to generate descriptive statistics for the demographics as well as medical,
psychiatric, and sexual histories of the participants. Chi-square tests of Independence were
conducted to compare participants who completed and who did not complete the online survey.
Descriptive statistics also were examined for each of the primary study variables to evaluate the
assumptions of univariate normality. Further, linear regressions were performed between the
demographic variables including age, race/ethnicity, education, annual household income,
having children, religion, religiosity, taking medications, having a medical or psychiatric
diagnosis and each of the primary study variables to identify potential covariates that need to be
controlled for prior to testing the hypothesized model. Because each of the demographic
variables was significantly related to at least one of the observed variables, the “core” model
variables were residualized by removing the effects of the aforementioned demographic
variables.

Structural Equation Modeling (SEM) was used to test the model of the present study,
which consisted of two components: Confirmatory Factor Analysis (CFA) and the actual
Structural Equation Modeling (SEM). Initially, the structural equation modeling software, Mplus,
Version 7, was used to conduct a Confirmatory Factor Analysis (CFA) in order to establish that the measures used to operationalize each of the latent constructs do, in fact, adequately measure those latent constructs.

The hypothesized study model proposed the following: (1) Attachment Avoidance, Attachment Anxiety, Separation-Individuation Pathology, Conflictual Separation, Emotional Separation, and Parental Identification were used to operationalize Representations of Parental Relations; (2) Sexual Subjectivity (consisting of Sexual Body Esteem, Entitlement to Desire and Pleasure, and Sexual Self-Reflection), Self-Objectification, and Genital Self-Image were used to operationalize Sexual Self-Concept; and (3) Solitary Intensity/Frequency of Sexual Desire, Dyadic Intensity/Frequency of Sexual Desire, Affective/Cognitive Sexual Desire were used to operationalize Sexual Desire. The Confirmatory Factor Analysis indicated that the observed measures did not load onto the latent constructs as was predicted and therefore the model was adjusted as described below. While the model was modified at the level of measures, it remained largely consistent as the level of concept as will be addressed further in the Discussion.

In the adjusted model, the following observed measures (1) Attachment Avoidance, (2) Attachment Anxiety, (3) Separation-Individuation Pathology and (4) Conflictual Separation were used to operationalize the latent construct, Representations of Parental Relations. Two other measures, (1) Parental Identification with the Father and (2) Parental Identification with the Mother were used to operationalize the next latent construct, Parental Identification. Three other observed measures, (1) Sexual Body Esteem, (2) Self-Objectification and (3) Genital Self-Image were used operationalize the third latent construct, Sexual Self-Concept. Finally, (1) Partnered Sexual Desire, (2) Solitary Sexual Desire, (3) Affective/Cognitive Sexual Desire, (4) Entitlement
In order to evaluate the fit of the confirmatory factor model to the data, three goodness-of-fit tests were used. First, the Chi-Square Test of Model Fit is reported along with its associated degrees of freedom and p-value. It should be noted, however, that this particular measure of model fit is particularly sensitive to the size of the sample on which it is based. In large samples the chi-square goodness-of-fit statistic is often found to be statistically significant, which implies that the model does not fit the data. However, given a large enough sample, small, and even trivial, discrepancies between the actual correlations/covariances among the observed measures and the model-implied correlations between those same measures will be found to be statistically significant. For that reason, and although conventionally reported, the chi-square test of model fit is typically supplemented by presenting other goodness-of-fit measures such as the Root Mean Square Error of Approximation (RMSEA) and the Comparative Fit Index (CFI), which are not adversely affected by the size of the sample. For that reason, these additional measures are reported. As recommended in Kline (2011), an RMSEA value \( \leq 0.05 \) is considered to be a “good” fitting model. RMSEA values between 0.05 and 0.08 are considered to indicate a “reasonably fitting” model and RMSEA values larger than this are considered to be poor fitting models. With respect to the Comparative Fit Index, values of this goodness-of-fit measure \( \geq 0.90 \) were once considered to indicate a good fitting model but more current thinking suggests that the cut-off should be \( \geq .95 \) (Kline, 2011).

Assuming that the confirmatory factor analytic model is found to fit the data, or subsequent to any modifications that are required to improve the fit of the model to the data, the second phase of the data analysis estimated the structural equation model. In this phase of the
analysis the goal was to investigate how well parent-child relations (attachment avoidance, attachment anxiety, separation-individuation pathology, and conflictual independence) and parental identification (parental identification with mother, parental identification with father) predicted sexual self-concept (self-objectification, sexual body esteem, genital self-image), which, in turn, predicted sexual desire (partnered sexual desire, solitary sexual desire, affective/cognitive components of sexual desire, sexual self-reflection, and entitlement to desire and pleasure) in women. The aforementioned goodness-of-fit tests were, again, used to evaluate the fit of the model to the data, but in addition, the “strength” or magnitude of the regression coefficients linking the constructs to one another as well as their direction and statistical significance also will be used. The Sobel normal theory test of indirect effects was used to test the indirect effects of parent-child relations and parental identification on sexual desire via sexual self-concept.

Methods for the Qualitative Phase of the Study

Participants

A total of 158 participants consented to be contacted for the interview phase of the study. In order to select a group of 10 women with heightened sexual desire and 10 women with inhibited sexual desire, interested participants with the highest and the lowest scores on the Sexuality Screener were contacted. Some of the initial 20 participants were no longer interested in participating (Low: N=3; High: N=1), did not respond when contacted by the researcher (Low: N=9; High: N=15), or were unable to attend the interview in New York City (Low: N=5; High: N=3); therefore, participants with the next lowest and highest scores were contacted until a group of 10 sexually inhibited and 10 highly sexual women were interviewed, respectively. An independent samples t-test indicated that the two resultant groups significantly differed in their
scores on the sexuality screener: (High: M=5.58, SD=0.34), (Low: M=2.68, SD=0.59), 
t(18)=13.43, p<.01. The average age of the resultant sample was 26.90 years (SD=5.65) in the highly sexual group and 27.22 years (SD=3.99) in the inhibited group. Within the inhibited group, 40% of the women were African American, 40% were White, 10% were Latino and 10% identified as “other”. Within the high group, 50% were White, 10% were African American, Latino, Asian, respectively, and 20% identified as “other.” The two groups did not differ significantly in age or race/ethnicity.

**Procedure**

Participants were interviewed by the researcher at The Graduate Center of the City University of New York in a private room in the Psychology Department. The semi-structured interviews ranged from 39 to 101 minutes in length (M=74.25, SD=14.63) and were audio recorded with two recording devices and subsequently transcribed by a research assistant. Following the informed consent procedure, women were asked a basic history of their sexual experiences (e.g. age of first sexual experience, total number of partners, frequency of masturbation), to describe how they know they are feeling sexual desire, what it means to feel sexual desire or what is sexual desire about, their feelings about their bodies and how they experience sexual desire in their bodies, and 6 stories of experiencing sexual desire: 1) the earliest memory of feeling sexual desire, 2) an exciting memory of sexual desire, 3) a disappointing memory of sexual desire, 4) an experience of sexual desire when by oneself, 5) an experience when sexual desire was absent, and 6) a sexual fantasy (interview prompts in Appendix VI). When prompted for memories, participants were asked to give a detailed description of the experience including when, where and with whom it took place and what kind of emotions and bodily sensations they experienced. If a participant did not spontaneously
generate a detailed narrative, the interviewer asked follow up questions to obtain a more elaborated story.

**Analyses of the Interview Data**

The Listening Guide was used to analyze the interview narratives (Gilligan, Spencer, Weinberg, & Bertsch, 2003). The Listening Guide is based on a feminist approach, which is relational and voice centered, and listens carefully to the subtleties of human voices and stories. This method requires several readings or “listenings” of the interview transcript, each time listening for a particular voice. Each listening was underlined with different colored pens and then documented through notes and interpretive summaries. The first two readings are required regardless of the interview question. (I) The first reading listened for the plot (Who? Where? When? With whom? Why? What is happening) and the listener’s response to what is being said (thoughts, feelings, associations, countertransference responses). (II) The second reading entailed listening for the voice of “I,” following the first person pronoun in order to listen to the first person voice and to hear how this person spoke about herself. During this reading, “I-Poems” were constructed by underlining every 1st person “I” within the passages along with the verb and other important words. The “I” phrases were pulled out in the order that they appeared in the text and placed on a separate line to generate free-fall association. The third, fourth and fifth readings listened for the voices specific to the present study. Three research voices were examined in the present study: the voice of sexual desire, the voice of bodily desire, and the voice of relational desire. (III) The *voice of sexual desire* was identified by any references to desiring, wanting, craving, needing, wishing for a sexual experience (partnered or solitary), sexual fantasies, and experiences of sexual arousal and attraction to real or fantasied partner(s). (IV) The *voice of bodily desire* was identified by any references to physical arousal and sexual bodily sensations
(e.g. lubrication, tingling, heat), wish for physical closeness/contact, tactile stimulation, touch, and bodily pleasure (e.g. orgasm, pressure). (V) The *voice of relational desire* was identified by any references to wish for emotional closeness, intimacy, affection, love, the experience of mutuality and connection, and the wish for merger. The following segments of the interview were selected to listen for the four voices (self and 3 research voices): women’s responses to 1) how they know that they are feeling sexual desire and what they are desiring, 2) what happens in the body when they feel sexual desire, 2) an exciting memory, 3) a disappointing memory, and 4) a memory when feeling desire by oneself.
Results

Descriptive Statistics

Tables 3 and 4 contain descriptive statistics with respect to participants’ demographics, as well as medical and psychiatric histories, respectively. The participants in the current study were relatively young (M=25.50, SD=4.63). They were largely secular or slightly religious. Further, well over half of the participants reported being in an exclusive relationship while approximately 80% of the sample was unmarried and 84% did not have children. In terms of medical history, the current study sample was relatively healthy as most of the women in the study denied major health conditions and about two-thirds of the participants denied any psychiatric condition and use of antidepressants, antihypertensives, or other medications.

Table 3

Participant Demographics (N=598)

<table>
<thead>
<tr>
<th>Demographic</th>
<th>Statistic/Participant Response</th>
<th>Statistic/%Participants</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age (years)</td>
<td>Mean</td>
<td>25.50</td>
</tr>
<tr>
<td></td>
<td>SD</td>
<td>4.63</td>
</tr>
<tr>
<td></td>
<td>Median</td>
<td>25</td>
</tr>
<tr>
<td></td>
<td>Range</td>
<td>18-39</td>
</tr>
<tr>
<td>Race/Ethnicity</td>
<td>African-American/Black</td>
<td>11.9%</td>
</tr>
<tr>
<td></td>
<td>Asian</td>
<td>7%</td>
</tr>
<tr>
<td></td>
<td>Caucasian/White</td>
<td>62.6%</td>
</tr>
<tr>
<td></td>
<td>Latino</td>
<td>11.9%</td>
</tr>
<tr>
<td></td>
<td>Other</td>
<td>6.4%</td>
</tr>
<tr>
<td>Education</td>
<td>High School/GED</td>
<td>30.3%</td>
</tr>
<tr>
<td></td>
<td>Associate’s Degree</td>
<td>14%</td>
</tr>
<tr>
<td></td>
<td>Bachelor’s Degree</td>
<td>34.9%</td>
</tr>
<tr>
<td></td>
<td>Master’s Degree</td>
<td>15.3%</td>
</tr>
<tr>
<td></td>
<td>Doctoral Degree</td>
<td>4.9%</td>
</tr>
<tr>
<td>Annual Household Income</td>
<td>$0-25,000</td>
<td>36.1%</td>
</tr>
<tr>
<td></td>
<td>$25,001-50,000</td>
<td>28.7%</td>
</tr>
</tbody>
</table>
$50,001-75,000 17.1%
$75,001-100,000 10%
More than $100,000 7.7%

Relationship Status
- Uninvolved 24.5%
- Seeing more than one person, not living together 8.0%
- Seeing more than one person, living with one or more of them 2.3%
- Seeing someone exclusively, not living together 30.2%
- Seeing someone exclusively, living together 34.9%

Marital Status
- Married 16.8%
- Divorced 2.0%
- Separated 1.0%
- Single 80.2%

Having Children
- No 84.2%
- Yes 15.7%

Religion
- Atheist/Agnostic 33.6%
- Christian 42.3%
- Jewish 7.2%
- Other 16.7%

Religiosity
- Not at all 39.6%
- A little Bit 30.4%
- Moderately 20.4%
- Quite a bit 7.8%
- Extremely 1.5%

<table>
<thead>
<tr>
<th>Medication/Condition</th>
<th>Participant Response</th>
<th>% Participants</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medications</td>
<td>None</td>
<td>63.6%</td>
</tr>
<tr>
<td></td>
<td>Antidepressants</td>
<td>15.3%</td>
</tr>
<tr>
<td></td>
<td>Other</td>
<td>20.6%</td>
</tr>
<tr>
<td>Medical Conditions (Diabetes, Thyroid, Cardiovascular, Neurological, Stroke, Cancer, Amenorrhea, Polycystic Ovarian Syndrome (PCOS),</td>
<td>None</td>
<td>90%</td>
</tr>
</tbody>
</table>

Table 4
Participants’ Medical and Psychiatric Histories (N=598)
Hyperprolactinaemia or hyperprolactinemia (HP), 
*Congenital adrenal hyperplasia* (CAH), Turner Syndrome

<table>
<thead>
<tr>
<th>Health Condition</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>One or more medical condition</td>
<td>9.8%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Psychiatric Conditions (Current or history)</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>None</td>
<td>67%</td>
</tr>
<tr>
<td>Depressive Disorder</td>
<td>20.2%</td>
</tr>
<tr>
<td>Anxiety Disorder</td>
<td>17.9%</td>
</tr>
<tr>
<td>Panic Disorder</td>
<td>3.8%</td>
</tr>
<tr>
<td>Posttraumatic Stress Disorder</td>
<td>3.4%</td>
</tr>
<tr>
<td>Eating Disorder</td>
<td>4.4%</td>
</tr>
<tr>
<td>Other Psychiatric Diagnosis</td>
<td>4.4%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Birth History</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Never given birth</td>
<td>83.8%</td>
</tr>
<tr>
<td>Yes, vaginally</td>
<td>10.8%</td>
</tr>
<tr>
<td>Yes, by Cesarean section</td>
<td>3.6%</td>
</tr>
<tr>
<td>Both, vaginally and cesarean section</td>
<td>1.3%</td>
</tr>
</tbody>
</table>

Table 5 includes information about participants’ sexual history. Most of the study sample was sexually active; however, about one tenth of the women reported never having had sexual intercourse and about one tenth reported a very high frequency of sexual intercourse. Most of the participants reported that they had masturbated at some point in their lives and about two thirds continue to masturbate on a regular basis. Most of the sample denied a history of or current diagnosis of sexual dysfunction. In sum, the women who participated in the current study were quite sexually active in both partnered and solitary sexual activity; however, there was quite a range in terms of age of first intercourse and total number of partners.
Table 5

*Participants’ Sexual History*

<table>
<thead>
<tr>
<th>Sexual History</th>
<th>Statistic/Participant</th>
<th>Statistic/%Participants</th>
</tr>
</thead>
<tbody>
<tr>
<td>History of sexual intercourse</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Never</td>
<td></td>
<td>5.3%</td>
</tr>
<tr>
<td>With men only</td>
<td></td>
<td>83.5%</td>
</tr>
<tr>
<td>With both women and men</td>
<td></td>
<td>10.4%</td>
</tr>
<tr>
<td>Penile-vaginal intercourse</td>
<td></td>
<td></td>
</tr>
<tr>
<td>No</td>
<td></td>
<td>10.9%</td>
</tr>
<tr>
<td>Yes</td>
<td></td>
<td>88.9%</td>
</tr>
<tr>
<td>Age at first penile-vaginal intercourse (in years)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>N</td>
<td>Mean</td>
<td>17.54</td>
</tr>
<tr>
<td></td>
<td>SD</td>
<td>2.81</td>
</tr>
<tr>
<td></td>
<td>Median</td>
<td>17</td>
</tr>
<tr>
<td></td>
<td>Range</td>
<td>12-31</td>
</tr>
<tr>
<td>Lifetime number of sexual (penile-vaginal intercourse)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>partners</td>
<td>N</td>
<td>534</td>
</tr>
<tr>
<td></td>
<td>Mean</td>
<td>10.54</td>
</tr>
<tr>
<td></td>
<td>SD</td>
<td>15.44</td>
</tr>
<tr>
<td></td>
<td>Range</td>
<td>0-200</td>
</tr>
<tr>
<td>Frequency of sexual intercourse per month</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Never</td>
<td></td>
<td>5.2%</td>
</tr>
<tr>
<td>1-5 times</td>
<td></td>
<td>34.1%</td>
</tr>
<tr>
<td>6-10 times</td>
<td></td>
<td>19.4%</td>
</tr>
<tr>
<td>11-15 times</td>
<td></td>
<td>11.9%</td>
</tr>
<tr>
<td>16-20 times</td>
<td></td>
<td>7.7%</td>
</tr>
<tr>
<td>More than 20 times</td>
<td></td>
<td>7.7%</td>
</tr>
<tr>
<td>Frequency of orgasm during sex</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Never</td>
<td></td>
<td>14%</td>
</tr>
<tr>
<td>Rarely</td>
<td></td>
<td>17.5%</td>
</tr>
<tr>
<td>Some of the time</td>
<td></td>
<td>24%</td>
</tr>
<tr>
<td>Most of the time</td>
<td></td>
<td>23.5%</td>
</tr>
<tr>
<td>All of the time</td>
<td></td>
<td>9.3%</td>
</tr>
<tr>
<td>Lifetime history of masturbation</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Never</td>
<td></td>
<td>9.0%</td>
</tr>
<tr>
<td>At some point</td>
<td></td>
<td>90.9%</td>
</tr>
<tr>
<td>Frequency of masturbation/week</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Never</td>
<td></td>
<td>11.4%</td>
</tr>
<tr>
<td>1-5 times</td>
<td></td>
<td>64.8%</td>
</tr>
</tbody>
</table>
6-10 times         10%
11-15 times        2.1%
16-20 times        0.8%
More than 20 times 1.1%

Sexual Disorders
None            96.1%
One or more disorders 3.9%

Descriptive Statistics: The Observed Measures

Table 6 lists the descriptive statistics for the observed measures, including the means, standard deviations, and the correlations between the measures.

Table 6

Correlation Matrix of the Observed Variables

<table>
<thead>
<tr>
<th>Construct</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
<th>9</th>
<th>10</th>
<th>11</th>
<th>12</th>
<th>13</th>
<th>14</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.Attachment avoidance</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2.Attachment anxiety</td>
<td>.55**</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3.Separation-Individuation pathology</td>
<td>.32**</td>
<td>.51**</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4.Conflictual Independence from Mother</td>
<td>.37**</td>
<td>.45**</td>
<td>.37**</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5.Paternal Identification</td>
<td>.32**</td>
<td>.29**</td>
<td>.12**</td>
<td>.11**</td>
<td>1</td>
<td></td>
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<td></td>
</tr>
<tr>
<td>6.Maternal Identification</td>
<td>.28**</td>
<td>.26**</td>
<td>.13**</td>
<td>.27**</td>
<td>.47**</td>
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<td></td>
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<td></td>
</tr>
<tr>
<td>7.Self-Objectification</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8.Sexual Body</td>
<td>.28**</td>
<td>.37**</td>
<td>.37**</td>
<td>.29**</td>
<td>.18**</td>
<td>.22**</td>
<td>.62**</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>9.Genital Self-Image</td>
<td>.19**</td>
<td>.28**</td>
<td>.33**</td>
<td>.19**</td>
<td>.13**</td>
<td>.17**</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>10.Partnered Sexual Desire</td>
<td>.25**</td>
<td>.21**</td>
<td>.29**</td>
<td>.14**</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>11.Solitary Sexual Desire</td>
<td>.14**</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>12.Affective/Cognitive</td>
<td>.03</td>
<td>.08</td>
<td>.02</td>
<td>.07</td>
<td>-003</td>
<td>-02</td>
<td>.003</td>
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<tr>
<td></td>
<td>-</td>
<td>.05</td>
<td>-10*</td>
<td>-05</td>
<td>-01</td>
<td>.01</td>
<td>.26**</td>
<td>.25**</td>
<td>.36**</td>
<td>.80**</td>
<td>.39**</td>
<td>1</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Confirmatory Factory Analysis (CFA)

Confirmatory Factor Analysis, which hypothesized 4 factors, including (1) Internalized Representations of Parental Relations, (2) Parental Identification, (3) Sexual Self-Concept, and (4) Sexual Desire, was computed. The goodness-of-fit statistics for the CFA indicated that the model did not adequately “fit” the data using the model fit chi-square statistic, i.e., $\chi^2 = 279.20$ (71) $p < .001$. However, it is well known that this particular fit statistic is sensitive to size of the sample. Given that the current study sample has (n=) 562 cases, this result is not particularly surprising. That is to say, large samples like the one available in this investigation confer substantial statistical power to reject the null hypothesis ($H_0$) of “perfect fit” even though the discrepancy between the actual and model-implied covariances is minor and possibly even trivial. For this reason, the root mean square error of approximation (RMSEA) and the Comparative Fit Index (CFI) are also reported. These two goodness-of-fit statistics indicate that the model does provide a reasonably good fit to the data: RMSEA = .072, with the .90 confidence interval of the RMSEA = (.063, .081), and the Comparative Fit Index = .903 (Kline, 2011).

Table 7 presents the factor loadings for each of the fourteen measures used to operationalize the four latent constructs in this confirmatory factor model. As seen in this table, all of the loadings are $\geq .50$ indicating that all of the observed measures are strong indicators of the constructs on which they load. The internal consistency reliability coefficients for these four
factors are 0.95 for Representations of Parental Relations, 0.81 for Parental Identification, 0.95 for Sexual Self-Concept, and .96 for Sexual Desire.

Table 8 presents the correlation matrix of the 4 latent variables of Representations of Parental Relations, Parental Identification, Sexual Self-Concept, and Sexual Desire. As seen in this table, as expected, the Representations of Parental Relations and Parental Identification constructs are positively, moderately and significantly associated with each other ($r = .42$, $p < .001$) as are the Sexual Self-Concept and Sexual Desire constructs ($r = .43$, $p < .001$). Also as expected, both Representations of Parental Relations and Parental Identification are negatively but significantly associated with Sexual Self Concept ($r=-0.54$, $p<.001$) and ($r=-0.29$, $p<.001$), respectively. Representations of Parental Relations also is significantly and negatively, albeit weakly, correlated to Sexual Desire while Parental Identification does not have a significant correlation with Sexual Desire.

Table 7

*Standardized Coefficients ($\beta$) for Confirmatory Factor Analysis*

<table>
<thead>
<tr>
<th>Construct</th>
<th>Representations of Parental Relations</th>
<th>Parental Identification</th>
<th>Sexual Self-Concept</th>
<th>Sexual Desire</th>
</tr>
</thead>
<tbody>
<tr>
<td>Attachment Avoidance</td>
<td>0.63*</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Attachment Anxiety</td>
<td>0.80*</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Separation-Individuation</td>
<td>0.59*</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pathology</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Conflictual Independence</td>
<td>0.54*</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>from Mother</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Maternal Identification</td>
<td>0.67*</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Paternal Identification</td>
<td>0.67*</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Self-Objectification \hspace{1cm} 0.78*
Sexual Body Esteem \hspace{1cm} 0.77*
Genital Self-Image \hspace{1cm} 0.54*
Partnered Sexual Desire \hspace{1cm} 0.87*
Solitary Sexual Desire \hspace{1cm} 0.53*
Cognitive/Affective Sexual Desire \hspace{1cm} 0.90*
Sexual Self-Reflection \hspace{1cm} 0.66*
Entitlement to Desire and Pleasure \hspace{1cm} 0.62*

\*p<.001

Table 8

*Pearson Correlations of the 4 latent factors*

<table>
<thead>
<tr>
<th>Factor</th>
<th>Representations of Parental Relations</th>
<th>Parental Identification</th>
<th>Sexual Self Concept</th>
<th>Sexual Desire</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Representations of</td>
<td>1</td>
<td>-</td>
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</tr>
<tr>
<td>Parental Relations</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Parental</td>
<td>0.42**</td>
<td>1</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Identification</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sexual Self</td>
<td>-0.54**</td>
<td>-0.29**</td>
<td>1</td>
<td>-</td>
</tr>
<tr>
<td>Concept</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sexual Desire</td>
<td>-0.11*</td>
<td>-0.03</td>
<td>0.43**</td>
<td>1</td>
</tr>
</tbody>
</table>

*p<.05, **p<.001
Structural Equation Model

The findings from the confirmatory factor analysis support the claim that the four latent constructs used in testing the structural equation model are well measured. Given that, the second phase of the model-building process, i.e., the estimation and testing of the structural equation model, was undertaken. The goodness-of-fit statistics for the hypothesized model indicated that the model did not adequately “fit” the data using the model fit chi-square statistic, i.e., $\chi^2 = 285.30$ (73) $p < .001$. Again, because this particular fit statistic is sensitive to the size of the sample, other goodness-of-fit statistics were examined, i.e., the RMSEA and the CFI. The RMSEA=0.072 with a 0.90 confidence interval of the RMSEA = (.060, .081). The CFI = 0.901. Both of these goodness-of-fit statistics indicate that the hypothesized model appears to provide a reasonably good fit to the data.

The Structural Submodel:

Figure 3 present the standardized regression coefficients, i.e., the direct effects, in this model. As seen in this figure, and as hypothesized, positive Representations of Parental Relations predicted more positive Sexual Self-Concept ($\beta = -.50$, $p < .001$) such that women who are more securely attached, who have less separation-individuation pathology, and who are more individuated from their mothers are more likely to have more positive sexual body esteem and genital self-image and are less likely to self-objectify in a sexual context. Contrary to expectation Parental Identification was not significantly related to Sexual Self Concept ($\beta = -.07$, $p > .34$). Further, more positive Sexual Self-Concept predicted higher levels of Sexual Desire ($\beta = .41$, $p < .001$), such that women who had more positive sexual body esteem and genital self-image were more likely to have higher levels of sexual desire in partnered and solitary contexts. Of note, as shown in Table 8, Representations of Parental Relations is significantly but weakly related to
Sexual Desire ($r = -0.11$) while the SEM indicates that Sexual Self-Concept mediates the relationship between Representations of Parent Relations and Sexual Desire. Further, while Parental Identification is significantly related to Sexual Self-Concept ($r = -0.29$), it does not have a significant association in the path analysis, indicating that the relationship between Parental Identification and Sexual Self-Concept is subsumed by the Representations of Parental Relations.

*Figure 3.* Results for the structural equation model. Comparative Fit Index = .90; root mean square error of approximation = 0.72; chi-square = 285.30; degrees of freedom = 73. SE for each latent factor: Parent-Child Relations=.06, Parental Identification=.07, Sexual Self-Concept=.05, Sexual Desire=.04 (*p<.001*).
The Sobel test indicated that there are two indirect effects: (1) the indirect effect of Representations of Parental Relations via Sexual Self-Concept on Sexual Desire and (2) the indirect effect of Parental Identification via Sexual Self-Concept on Sexual Desire. Results indicated that more positive Representations of Parental Relations were related to higher levels of Sexual Desire via more positive Sexual Self Concept ($z' = -0.20, p < .001$), i.e. Sexual Self Concept significantly mediated the relationship between Representations of Parental Relations and Sexual Desire. On the other hand, results indicated that Parental Identification was not significantly related to Sexual Desire via Sexual Self-Concept ($z' = -0.03, p > .34$); Sexual Self Concept was not a significant mediator between Parental Identification and Sexual Desire. Further, the $R^2$ statistic indicates that the Representations of Parental Relations construct explains 28% of the variance in sexual self-concept and that sexual self-concept explains 17% of the variance in sexual desire. These results support the hypothesis that low levels of attachment avoidance and anxiety and of separation-individuation pathology as well as adequate separation from mother predict more positive sexual self-concept, i.e. less self-objectification in a sexual context, higher sexual body esteem, and better genital self-image, which in turn predicts higher levels of sexual desire, including higher desire for partnered sexual activity and for solitary sexual activity (i.e. masturbation), more positive affective and cognitive components of sexual desire, more sexual self-reflection, and more feelings of entitlement to sexual desire and pleasure. On the other hand, these results did not support the hypothesis that parental identification with the mother and the father is related to women’s experiences of their bodies in a sexual context and in turn to sexual desire.
Results from the Qualitative Interview Portion of the Study

Demographics

Tables 9, 10, and 11 contain information for each participant, including her demographics, medical and psychiatric histories, as well as information about participants’ sexual history. Independent samples t-test and Chi-square Tests of Independence were conducted to compare the highly sexual women group and the sexually inhibited women groups on demographics as well as medical, psychiatric, and sexual histories. Differences between the groups were found in the highest level of education and relationship status. In the high group, 10% of women had finished high school, 60% had a Bachelor’s Degree, 20% had a Master’s Degree, and 10% had a Juris Doctor Degree while in the inhibited group, 40% of women had a high school degree, 40% had an Associate’s Degree, 10% had a Bachelor’s Degree, and 10% had a Master’s Degree, $\chi^2(4, N = 20) = 10.71, p = 0.03$. For relationship status in the high group, 10% were uninvolved, 50% were seeing more than 1 person, 40% were seeing someone exclusively whereas in the inhibited group, 40% were uninvolved, 30% were seeing someone exclusively, and 30% were seeing someone exclusively and living together, $\chi^2(3, N = 20) = 9.94, p = 0.02$.

In terms of medical and psychiatric history, 30% of the women in each group had a lifetime history of psychiatric diagnosis, such as depressive disorder, anxiety disorder or eating disorder, and 20% of the women in each group reported taking a psychotropic medication, such as an antidepressant. Only one participant in the entire sample reported an oncological history.

In terms of sexual history, the average age of first penile-vaginal sexual intercourse was 17.13 years (SD=2.70) in the highly sexual group and 16.20 years (SD=2.39) in the sexually inhibited group. An Independent Samples T-test indicated that the two groups varied significantly in terms of the total number of sexual partners, (Low group: M=6.5, SD=9.32; High
Group: M=28, SD=31.27), t(18)=2.11, p=.049. Women also varied significantly in terms of frequency of monthly sexual activity, χ²(4, N = 18) = 9.36, p = 0.05. In the sexually inhibited group, 25% reported that they never have sex, 50% reported that they tend to have sexual intercourse 1-5 times per month, and 25% reported that they tend to have sexual intercourse 6-10 times per month. On the other hand, 10% of the highly sexual women have sexual intercourse 1-5 times per month, 40% 6-10 times per month, 20%, 11-15 times per month, and 30% of women have sexual intercourse more than 20 times per month. Only one woman (from the low group) indicated that she never masturbates and only one woman indicated that she has a sexual dysfunction diagnosis (low group; vaginismus).

Table 9

Participants’ Demographics

<table>
<thead>
<tr>
<th>Name</th>
<th>Group</th>
<th>Age</th>
<th>Race</th>
<th>Relationship Status</th>
<th>Education</th>
<th>Household Income</th>
<th>Religion</th>
<th>Religiosity</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cecilia</td>
<td>High</td>
<td>27</td>
<td>White</td>
<td>Single</td>
<td>BA/BS</td>
<td>$75,001-100,000</td>
<td>Agnostic</td>
<td>A little bit</td>
</tr>
<tr>
<td>Chloe</td>
<td>High</td>
<td>28</td>
<td>White</td>
<td>Single</td>
<td>MA/MS</td>
<td>$0-25,000</td>
<td>Jewish</td>
<td>Moderately</td>
</tr>
<tr>
<td>Elisa</td>
<td>High</td>
<td>34</td>
<td>Asian</td>
<td>Single</td>
<td>BA/BS</td>
<td>$50,000-75,000</td>
<td>Agnostic</td>
<td>Not all</td>
</tr>
<tr>
<td>Ellie</td>
<td>High</td>
<td>29</td>
<td>White</td>
<td>Nonexclusive</td>
<td>MA/MS</td>
<td>$25,000-50,000</td>
<td>Protestant</td>
<td>Moderately</td>
</tr>
<tr>
<td>Gabriella</td>
<td>High</td>
<td>23</td>
<td>Other</td>
<td>Exclusive</td>
<td>HS/GED</td>
<td>$0-25,000</td>
<td>Atheist/</td>
<td>Not all</td>
</tr>
<tr>
<td>Gwen</td>
<td>High</td>
<td>30</td>
<td>White</td>
<td>Exclusive</td>
<td>BA/BS</td>
<td>$50,000-</td>
<td>Other</td>
<td>Quite a bit</td>
</tr>
<tr>
<td>Name</td>
<td>Education</td>
<td>Relationship</td>
<td>Level</td>
<td>Income Range</td>
<td>Religion/Belief</td>
<td>Intimacy</td>
<td></td>
<td></td>
</tr>
<tr>
<td>-------</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Kendra High 24 Other Exclusive BA/BS More than $100,000</td>
<td>Other</td>
<td>A little bit</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Maggie High 29 White Single JD $0-25,000</td>
<td>Atheist/ None</td>
<td>Not at all</td>
<td></td>
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</tr>
<tr>
<td>Nicky High 21 African-American Exclusive BA/BS $50,000-75,000</td>
<td>Agnostic</td>
<td>Not at all</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Vivienne High 24 Latina Exclusive MA $50,000-75,000</td>
<td>Christian</td>
<td>Moderately</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Alexa Low 23 Latina Married HS/GED $0-25,000</td>
<td>Roman</td>
<td>Quite a bit Catholic</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Caroline Low 19 White/ Ethnic Exclusive HS/GED $75,001-100,000</td>
<td>Atheist</td>
<td>Not at all</td>
<td></td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Lola Low 35 African-American Divorced Associate’s Degree $25,000-50,000</td>
<td>Christian</td>
<td>Not at all</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Maria Low 22 White Married HS/GED $50,000-75,000</td>
<td>Atheist/</td>
<td>Not at all None</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Marina Low 39 Middle-Eastern Married BA/BS $75,001-100,000</td>
<td>Muslim</td>
<td>Moderately</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Micaela Low 30 White Single MA/MS $0-25,000</td>
<td>Other</td>
<td>A little bit</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nina Low 27 African-American Single Associate’s Degree $0-25,000</td>
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<td>Lifetime number of sexual intercourse</td>
<td>Frequency of sexual intercourse per month</td>
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Table 11

Participants’ Sexual History
Independent samples t-tests were conducted to compare all study variables (attachment avoidance, attachment anxiety, separation-individuation pathology, conflictual independence from mother, emotional independence from mother, parental identification with mother, parental identification with father, self-objectification, sexual body esteem, genital self-image, partnered sexual desire, solitary sexual desire, affective/cognitive sexual desire, sexual self-reflection, entitlement to desire and pleasure) for the highly sexually group and the sexually inhibited group (Table 12).
Table 12

*T-tests between study variable means for Sexually Inhibited (N=10) and Highly Sexual Groups (N=10).*

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<tr>
<th>Construct</th>
<th>Sexually Inhibited</th>
<th>Highly Sexual</th>
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<tr>
<td></td>
<td>Women</td>
<td>Women</td>
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<tr>
<td>M</td>
<td>SD</td>
<td>M</td>
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<tr>
<td>Sexual body esteem</td>
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<td>.76</td>
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<tr>
<td>Genital self-image</td>
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<tr>
<td>Partnered sexual desire</td>
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<td>Affective/cognitive sexual desire</td>
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<tr>
<td>Sexual self-reflection</td>
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<td>Entitlement to desire and pleasure</td>
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<td>.95</td>
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<tr>
<td>Self-objectification</td>
<td>2.90</td>
<td>1.39</td>
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*p<.05, **p<.01, †p=.10

These results indicate that highly sexual women show significantly more positive sexual body esteem and genital self-image, experience higher levels of partnered and solitary sexual desire as well as affective/cognitive aspects of sexual desire, engage in more sexual self-reflection, and exhibit more entitlement to sexual desire and pleasure than sexually inhibited women. Further, sexually inhibited women are more likely to experience self-objectification in a sexual context than highly sexual women. No statistically significant differences between the groups were
found with respect to the other study variables (e.g. attachment avoidance/anxiety, separation/individuation pathology).

Results of the Narrative Analyses

The following analyses examine 1) how women tend to experience sexual desire, 2) the objective of sexual desire in women, and 3) what tends to excite and 4) inhibit sexual desire in women in the highly sexual group and in the sexually inhibited group, respectively.

How do women tend to experience their sexual desire? In the highly sexual group, all women experience sexual desire as bodily sensations that elicit thoughts and feelings and as thoughts and feelings that pass through their minds and trigger their bodies; however, for some the emotion-cognitive aspects of desire dominate whereas for others the bodily response serves as the prominent marker or gauge of the woman’s sexual desire. Further, most of these women describe sensations that are not sequestered to the genital region but rather incorporate the totality of their body in the experience of desire. The women in the sexually inhibited group are much more heterogeneous in their experience of sexual desire, such that some women have strong physical sensations of which they may or may not be aware while others report an absence of a bodily response. These sensations tend to be focused in the erogenous zones (e.g. genitals, breasts) rather than an all body sensation that is described by the highly sexual women. Further, the bodily experience of the sexually inhibited women seems to be split off from the thoughts and feelings of their desire or is accompanied by feelings of anxiety, loneliness, sadness, or detachment.

Bodily markers of sexual desire.

Highly sexual women. Women in the highly sexual group describe an intense awareness of physical sensations of tingling, throbbing, aching, and heat that signals the presence of their
desire. Kendra explains that her body becomes extremely hot, her body hair stands up, and she feels “an electrifying effect…of energy coursing through my body.” Cecilia, for whom sexual desire starts in her mind and travels to her body, tends to feel tingly and warm, and “like I want to have a penis inside of me.” Maggie does not elaborate on her bodily sensations unless prompted by the interviewer but spontaneously responds that she knows she is feeling sexual desire “when my brain or my body is telling me that this is something that I want to do soon….I’m craving it, my body is craving it…there’s the physiological reaction such as wetness and those kinds of things that tell me that I’m craving that at the moment. I think that’s just my body creating a happy atmosphere for a sexual encounter.” Nicky indicates that she feels “a tingling, you know there [in the genital area]” and gets “in a very lusty mindset.” She tends to feel sexual desire “in the genitals and then I feel it in my feet. Sometimes I can feel it in my fingers. This one time I felt it in my scalp. I don’t know what that was about…it’s like tingling, kind of a wave of sensations…” Elisa describes her desire as “a physical sensation, like sometimes like a tingling, it’s kind of general and all over…” and when prompted she describes experiencing “a flush of heat may be like in the chest area sometimes. I can feel like hot and tingling… a deep like almost aching pain in like the mid-section and the groin like a tingling and an aching”. Gabriella states, “I feel it [desire] as in my body tingles. I start having a lot of fantasies in my head.” Gwen states, “I can physically feel it in I suppose the center of what would be my clitoris…when I’m in the physical vicinity of someone who I’m attracted to or want to have sex with, it’s more of a kind of full body feeling.” Ellie’s sexual desire is “primarily like thinking about it and then also the physical sensation in my vaginal region that communicates that I’m feeling sexual desire.” When prompted, she elaborates,

*My heart rate probably increases a little bit. There’s like upward movement of energy. There is definitely like pulsations in my vaginal region. Like there’s like a warmth,*
sometimes a wetness. I feel it in my stomach, sometimes, just kind of like tingly sensation. Sometimes in my, in like the crown of my head, just kind of like this like subtle positive tingly positive excitement kind of sensation.....it kind of goes all over the place.

The women in the highly sexual group indicate that they are highly aware of these physical sensations. Vivienne experiences her sexual desire as intense sensations in her body that are palpable and very much part of her awareness:

Sometimes it [sexual desire] almost feels like an ache, like in between my legs that needs to be like...like when you’re thirsty and you need water...like an ache...you can only remove it... from having sex...your body just goes into like...it’s kind of like...a waterfall. The kind of feeling, it’s very overwhelming, it kind of takes over your whole body, it feels very tingly, literally like a waterfall because it also affects my wetness and how wet I get....you know I’m extremely wet because I’m so turned on and I have so much desire...

Chloe largely relies on her body to let her know that she is feeling desirous. Although she finds that mental desire is more powerful, she continuously comes back to her body as a marker for her desire. At times, she will not be certain how she feels about a potential partner and will check in with her body’s arousal to ascertain whether or not her desire is present: “Like sometimes I’ll be with someone and I don’t know how I’m feeling about them and then like, I’ll touch myself and I’ll be like, oh, I’m wet. I guess, I’m liking this. And then my mind will kind of go along.” Chloe feels that her body will not mislead her as she cannot force her arousal. The intensity of her mental preoccupation with her desire is mirrored in her bodily sensation that her vagina is missing something and she yearns to be penetrated: “I’ll feel like I need to. My body is compelling me to just be on them. I’ll feel like I really need that. I’ll feel like I usually need their penis inside of me. I really need it. Sometimes it feels like my vagina is being like something needs to be here.”

Sexually inhibited women. For some of the women in the sexually inhibited group, physical sensations of sexual desire are analogous to those of the women in the highly sexual
group. Raya starts “to feel warm and tingly and then, like I start to get moist and that type of thing physically…” Nina senses “a lot of heat, like I feel hot, like I feel kind of flushed almost, like my face gets really hot and I just feel, that’s usually how I know.” Peyton finds that “….I usually get wet. I usually get a little more excited….something happens in my brain. Sometimes my boyfriend will kiss my neck or bite my neck and that will turn me on. Like “it’s go time.” Tanya, with much prompting, indicates that she feels “a little tingling in the genital region.” Maria’s “breathing becomes more frequent,” “breasts become harder, and in the genitals I become wetter.” Lola feels “pulsating, um warmth in my lower extremities not anything up here [breasts] or anything…” While the descriptions of these bodily sensations are present, they are not as elaborated or palpable as in the narratives of the highly sexual group. Furthermore, for these women, these physical sensations do not necessarily designate a clear indication of their sexual desire. For Nina, the arousal does not mean that she needs to have sex right now and for Raya, cuddling is preferable to having sexual intercourse. Peyton is not always aware of her physical arousal or what triggered the sensations. Tanya is terse and cannot elaborate on her bodily experience. When Maria talks about her bodily sensations in the context of sexual desire, she seems quite clinical and distanced from her emotional or relational experience. She explains desire in terms of chemicals in the brain and sexual pain during a disappointing sexual experience in terms of elongation of the vaginal canal. Lola attributes her arousal to her biological clock and detaches from her bodily sexual desire: “I think yeah, I’m 35 and I think now my body is just like ‘you need to be doing it [having sex].’ I’m like, ‘Really?’ and it’s like ‘Ok.’ Like emotionally, no, I could read a book. But the way my body is sounding the alarm, it wants to have sex.” When she talks about feeling sexual desire in a solitary context, she describes it as stemming from a need to urinate, grounding it in a purely physiological need that
is devoid of actual sexual desire: “[I’m] having to go to the bathroom, and not feeling like getting up and then I begin to feel aroused and like oh my god no, because a lot of times if I do that [masturbate], it will stop the sensation of having to urinate. So it will go to another level and it’s like okay oh my god okay I just sat here….most of the time it’s the bathroom.”

Many of the women in the sexually inhibited group cannot describe physical sensations because they are lacking sexual desire. Alexa and Marina, both married, immediately state that they do not experience sexual desire. When asked about her bodily sensations, Alexa describes what she believes her body should do in very clinical terms: “I feel like it’s something the body would naturally work with. I feel like I’ve never experienced it personally…the body would go through the motions of what you experience during sex if something arouses you….the body I feel would naturally lubricate itself to prepare for intercourse or whatever else would work with that…” Her friend once described to her a genital tingling sensation of arousal, which Alexa keeps waiting for but the only time she remembers experiencing it is when she was playing with her stuffed animals when she was 3 years old. Marina does not wish to engage in sexual activity much of the time, but her husband forces her to have sex with him. She describes sex as “nasty” elaborating, “I don’t like this liquid (of arousal)…I have to wash many times.” At the same time, when her husband is nice to her, she is able to access some sensations of her desire: “I feel like my heart is pulsing….I feel something in [my genitals…].” When her husband does not show concern for her needs, which happens more frequently, Marina’s desire is absent and her body feels “Cold! Nothing at all. And I feel pain sometimes.”

Micaela and Caroline are both virgins who experience some physical sensations that elicit feelings of distress. Micaela distinguishes between arousal and desire: “…desire has more of an emotional connotation to me….whereas arousal would be more of a physical thing…” She
remembers only one instance of feeling such arousal when kissing a male partner: “I felt like my heart sort of increased, my heart rate, and I felt warmer and I felt I guess kind of like I don’t know if this is the right word or not but like a tingling sensation sort of…” The physical sensations produce a mix of hopefulness that she has the capacity to feel sexual feelings and anxiety about what her partner may desire from her: “I was freaked out about what he like [wanted…]…looking back I feel a little bit better that I can at least remember having some sexual feelings because that makes me feel like may be I’m not broken, like there’s not necessarily something wrong with me….” Micaela also experiences physical sensations in response to sadomasochistic fantasies of being spanked in a sexual context: “I’ll feel more aware of um different parts of my body…I guess some sort of like tingly kind of sensation or warm. Once I felt sort of like a muscle or tendon or I don’t know what it was, sort of like having little contractions or like spasms or something… in my like genital region…” These sensations of arousal elicit feelings of shame and disgust in her, as she struggles with the experience of feeling sexual desire in response to fantasies that she describes as perverted and disgusting. Caroline, who has a boyfriend, with whom she engages in sexual activity other than intercourse, explains that she is “waiting for my body to tell me it’s okay” to have sexual intercourse for the first time. Her narrative has few descriptions of her bodily experience of sexual desire, which she characterizes as “kind of like when you’re feeling like you want to masturbate, except there’s someone else there so it’s just like, okay, I want to release something in that way…” yet she cannot elaborate what that actually feels like in her body. The only physical sensation of desire that she describes is “butterflies in the stomach,” which she associates with a disappointing memory of sharing a first kiss with a boy: “…it’s [the butterflies] almost synonymous with like doom….I know that something romantic is about to happen to me but…it also makes me feel
sick.” Caroline makes sure to clarify that “the butterflies” were not a sign of “horniness” and that this first kiss moment is separate from “lust and sex”.

**Affective and cognitive markers of sexual desire.**

*Highly sexual women.* Most of the women in the highly sexual group also describe the affects and cognitions that emerge when they are feeling desirous. Further, many indicate that sexual thoughts and feelings frequently dominate their consciousness. Chloe indicates that sexual desire is “something I feel like I experience a lot” and while her bodily response is an important way to gauge her desire, “a lot of the times, it will be a mental thing. I literally can’t sit still. I can’t concentrate on something. And I’ll be looking out the window. I’ll be looking up. My mind is somewhere else. I’ll be fidgeting or something. I’m like, I need to have sex.” Nicky, who suggests that her desire is “mostly mental” also frequently finds herself in “a lusty mindset” and “it’s like kind of hard, you can’t really shake it, because once you are in there, I feel like I’m kind of stuck there until I at least relieve myself.” Similarly, Cecilia, who “definitely pretty much would always want to have sex if it was available to me,” knows that she is “horny” because she is “thinking about it [sex] a lot” and it makes her “feel a little bit crazy but crazy like not like unstable crazy but like I just want to go and get it. It usually makes me more sociable. I feel happy, excited.” Vivienne not only experiences powerful physical sensations when she feels sexual desire (as described above) but also feels intensely mentally stimulated: “I’m thinking about what I want, so what I want next whether it be sex or something else…Like whether I want some kind of touch or something, that’s where my mind is going, it’s kind of racing into like this feels really good, what do I want next…”

Some of the women convey a sense of fluidity between their bodies and their minds such that their bodies elicit sexual thoughts and feelings, which trigger physical sensations that
mutually enhance one another. When Elisa is not in the presence of a potential partner, sexual images “start in my head and then like it’s really more like a localized tingling in the groin…” while Ellie experiences desire primarily as “thinking about it and then also the physical sensation in my vaginal region that communicates that I’m feeling sexual desire…” Gabriella characterizes her sexual desire as a “high” that permeates throughout her mind and body:

What my body does first is the fantasy thing. Secondly when I feel like that scene keeps playing over and over again, my vagina starts tingling and it’s telling me you need to start doing something about it now. Then my, I’m going to have say it, my nipples get hard. They get hard and then everything starts feeling tight like it starts, it feels tighter than usual. And then once I have it [sex], I feel a little loose, and I just feel free….before I have sex, I have so much energy to do anything.

Sexually inhibited women. The affects and cognitions associated with sexual desire that the sexually inhibited women describe further indicate a sense of ambivalence or distress about sexual desire. Raya states that she experiences sexual desire if “I don’t really have anything else to think about,” which tends to happen when she knows that she is going to have sex. Peyton, who suffers from vaginismus, knows “it’s go time,” because her mind is “…blank…it’s like white noise, static,” however, oftentimes there is “little voice in the back of my head: ‘be careful, you don’t want it to hurt. You don’t want to feel pain. Make sure everything is ok’. ” Nina associates feelings of loneliness with her experience of sexual desire: “… if I feel lonely or something then that’s when I desire to be with somebody in that [sexual] way.” Tanya knows she is feeling sexual desire “when it’s been long periods of time where I would go, you know, without having sex and you know that’s when I consider it be that [sexual desire]…” Maria gauges her desire by how blank her mind feels, because when feeling desirous, “My focus goes on my partner and I don’t have any outside thoughts. But if I get this thought then I understand that I’m getting out of the desire so it’s all about being in the moment.” Maria needs her husband
to identify her arousal and sometimes feels “worried…that something is wrong I guess…because I don’t have this desire…” Lola, who reports a history of rape, states, “it’s not an emotional thing for me, it’s just like a physical…” For Lola, her bodily and emotional/cognitive experiences of sexual desire are very much split.

For the women who tend to not experience sexual desire, such as Marina, Alexa, Micaela and Caroline, their narratives reflect their distress, anxiety, pain, and trepidation as well as a sense of confusion about the nature of sexual desire. Alexa feels that she lacks the capacity to feel sexual desire: “A desire, a personal mental desire to want sex isn’t something that I think is in me….I feel like all of that ['oh you’re hot, I want you inside me] seems logical and clinical in a way. It doesn’t even feel like something I feel would genuinely come from me.” Micaela imagines that sexual desire would feel like being “sexually attracted to someone, to want to kiss them or …have one form or the other of sex, to have like a physical response…” She describes feeling fearful and overwhelmed during her only experience of making out with a boy when he started to touch her under her shirt:

“I started to feel, well I don’t know if that was desire or if it was more I guess like arousal…I felt like I was sort like okay I’ve had enough I need my own space now….I wanted him to leave…I was just so freaked out by the whole thing…and freaked out that I wouldn’t have any control…not like he would like forcibly do anything but just that I would be too embarrassed or too like I wouldn’t say no if I didn’t want to do something, like I wouldn’t stand up for myself. And so then it was like well I don’t even want to be in the situation…I feel like he definitely wanted more physical intimacy than I did…”

Caroline’s narrative conveys a sense of self-monitoring and a detached, cerebral processing of her sexual desire. She acknowledges that sexual desire originates in “my brain…because I think like a lot about everything…before I even feel it anywhere else, I kind of think about it first.” Further, the thoughts that she characterizes as sexual desire are generally not sexual in nature: “Like my thoughts about people don’t go immediately to the bedroom. It’s
always like okay what the first kiss is going to be like? What would it be like…what’s the moment before the first kiss going to be like….what would it be like after, after that, after the first kiss, like once you’re, what would the first time be like but I always think about the first kiss first.” Further, emphasizing the romantic or relational aspect of sexual desire, she states, “sexual desire it’s kind of about me feeling liked and loved and respected,” placing herself in the role of the love object.

**What is the objective of female sexual desire?** While the highly sexual women experience powerful sensations of sexual desire, the objective of their desire is not only the physical pleasure of touch, stimulation, penetration and orgasm, but more often the feeling of closeness, connectedness, and intimacy that is experienced in the context of sexual activity. Furthermore, some of these women seek to achieve a sense of ownership over their bodies, empowerment of their sexuality, and an integration of their sexual self-concept. This group of women describes problematic sexual experiences earlier in their histories, which they intentionally set out to transform with success. The objective of sexual desire in the Low Group is often split in terms of bodily pleasure and relational needs. Some engage in sexual activity not because they actually want to have sex but because it provides them with a way to feel close and connected with another person while others enjoy the physical release of orgasm but only in a solitary context. Further, sexually inhibited women tend to engage in sexual activity in order to please their partners rather than themselves while others tend to avoid sexual activity all together because of absent desire or the negative feelings that sexual desire evokes in them.

**Bodily desire**

*Highly sexual women.* Many of the highly sexual women maintain that their sexual desire is relational in nature; however, physical pleasure, including orgasm, is also an important aim of
sexual activity. Orgasm is not the only bodily sensation that they seek, as some women describe enjoying the experience of penetration, pressure, and the tactile sensations of skin-to-skin contact.

Chloe encapsulates her physical need in her statement, “I’ll feel like I usually need their penis inside of me” while Cecilia fantasizes about men ejaculating inside of her and desires the release of an orgasm. Maggie craves not only the orgasm but physical touch: “I really enjoy having somebody’s body touching mine, like their body, and I enjoy the act of sex. I enjoy the release. I enjoy pleasuring somebody else. I find that to be very sexy….The orgasm…but also other parts of it…foreplay is pleasurable, kissing is pleasurable, hands touching….all the sensations…it’s not just about the orgasm. It’s also about all the other parts of it.” Vivienne craves relief for the “ache between my legs” that “you can only remove it or like get rid of it from having sex or some kind of sexual encounter.” She craves an orgasm, which is not always easy for her to achieve. Gwen’s sexual desire also is about experiencing the release of orgasm but also the sensation “that comes from getting like hit in the right spot has always been my favorite part of sex.” Kendra yearns for skin-to-skin contact that she experiences during sex and “the feeling when you first get penetrated…the very beginning of penetration is my favorite part…the very first moment of penetration is my favorite part…” When masturbating, Ellie experiences a sense of freedom in her capacity to pleasure herself through multiple orgasms, which allows her to feel connected to her body, her desire, and her pleasure.

*Sexually inhibited women.* While some women desire the physical pleasure of sexual contact, such as orgasm or touch, half of the women in the Low Group do not derive bodily pleasure in either solitary or partnered sexual activity. The women, who are able to experience sexual pleasure in their bodies, suggest that it is something that they do not necessarily need. Raya enjoys the “feeling of fullness of sex” and “the skin-to-skin contact that intercourse brings;”
however, she adds, “I can do without it.” Peyton desires an orgasm and to feel her boyfriend “on top of me, feel the pressure, I like the whole pressure feeling, the weight on top of me…feel him holding me.” Yet, she also worries about feeling sexual pain, which sometimes inhibits her desire for sexual pleasure – a fear that does not plague her when she is by herself: “I don’t have to worry about feeling any pain….I can take my time. I can do whatever I want. I know what I want more than my partner knows what I want because I’m in my own body.” Nina indicates that she tends to have very pleasurable sexual experiences but does not perceive herself to be a very sexual person, describing her masturbatory activities as satisfying the need to relieve tension or stress, which she distinguishes from her sexual desire to be with another person, which is about closeness and connection rather than the physical orgasm or gratification. Nina values her body’s capacity for sexual responsiveness and feels distraught when her orgasmic ability is compromised by antidepressants: “So even though I felt something sexual, physically I couldn’t really do anything. Like I just felt like….my body was failing me.”

**Relational desire.**

*Highly sexual women.* The majority of the women in the High Group describe their sexual desire as a wish for closeness, intimacy, attachment, and merger. Importantly, many of these women maintain that sexual contact creates fertile ground for such connection, which is uniquely powerful. Gabriella desires the multifaceted nature of sexual engagement: “I want rough sex, the sensual part of sex, I want the emotional attachment, the merge that we, I like having with him…” Vivienne craves the deep connection of a sexual union, “that connection and….really deep higher level, like something that it’s more even so than sex that you connect with a person…when you lock eyes with someone and, and you get really deep into this other person that it’s like, it doesn’t compare to anything else.”
For Cecilia, sexual desire seems to be primarily a desire to experience a feeling of closeness and connectedness. Although she desires to “feel a penis inside of me,” this physical yearning seems to embody her craving for a merger with another. She finds that being naked with someone automatically creates a sense of closeness and connection that is hard to achieve in other ways. Cecilia longs for the sense of companionship and emotional closeness that she derives from the sensuality of skin-to-skin contact with another person, which she likens to a motherly instinct, suggesting that her sexual desire embodies a sense of nurturance, affection, and warmth. In her desire for sex that is simultaneously rough and sensual, she wants to experience a sense of “melting together,” conveying her desire to transcend the boundaries between self and other:

[I want] the companionship and the sensuality of being naked with someone and having that close contact…..it feels warm and good and to be close to someone when you’re naked with somebody even when you don’t know them very well, you automatically feel closer to them….so having, feeling that closeness with somebody is something that I enjoy, I look for, I live for….roughness that’s also like sensual and loving, like our bodies kind of melt together as opposed to just kind of like awkward and hard and cold...

Elisa describes her sexual desire in terms of a wish to be close and connected to another, and similarly to Cecilia, perceives sexual activity as a unique route to achieving a deep and intense, albeit, temporary bond with another that is not only sexual but spiritual. Even when she is by herself, she replays past sexual experiences that embodied intense connectedness in order to stimulate her desire and enjoys the physical sensations that those memories elicit. For Elisa who has had sexual intercourse with over 100 partners, sexual desire is inextricably linked to her yearning for connection and intimacy.

I want that feeling of like real closeness and intimacy with a person….at certain moments during sex you feel really, really connected to that person on multiple levels like not just sexually but spiritually and it’s a really intense thing. And like sometimes like with guys who I’m not in a relationship with but I do experience that when we have sex it’s, it’s a, it’s like a temporary….you feel that bond like temporarily but you know like you know it
was real and you don’t talk about it afterwards but um but I find myself still like drawn to those people.

Kendra describes sexual desire as an intense yearning to be close, to connect and unite with someone – to experience a merger with another. She enjoys the synchronicity of sex that reflects a sense of mutual attunement that she experiences in her sexual encounters.

...I just feel like an overwhelming burning desire to....feel the warmth of someone else’s skin and like just like that sort of electricity that you get between two people that are genuinely attracted to each other...a simultaneous orgasm with someone else is a sort of like spiritual union with another person that you can’t really get usually outside of sex....when you’re having sex and it’s like perfectly coordinated and like you move together and....you’re not just feeling yourself, you’re feeling someone else and like you’re reacting to their reactions....uniting like becoming something entirely different than just him or her...

Sexually inhibited women. While many of the women in the sexually inhibited group also desire closeness and intimacy, sex seems to be the toll that they have to pay in order to enjoy the sense of connectedness that it provides. Their desire is therefore largely relational and is devoid of the sexual component that is endorsed by the women in the highly sexual group. Rather than seeing sexual activity as a unique opportunity to experience an intense bond (as described by highly sexual women), they submit to their partner’s desires in exchange for connection, thereby surrendering their subjectivity and experiencing objectification. For some of these women, their desire is to satisfy or please their partners by engaging in sexual activity. Nonetheless, they do have the capacity to experience the relational pleasure of a sexual encounter, which does not happen for all of the women in this group, as some lack any type of sexual desire and derive no satisfaction from sexual activity.

Maria characterizes her sexual desire as a yearning for “something romantic...love...feeling it together, amplifying it together.” When she is feeling desirous, she feels a sense of connectedness with her husband; however, she also experiences anxiety about
her appearance, her low desire and her incapacity to orgasm. Peyton expresses conflict about partnered sexual activity, from which she derives “that feeling that I like of being loved and having somebody who cares for me and all that,” but also runs the risk of feeling excruciating pain while the experience of sexual desire in a solitary context is safe and pain free. Marina, who feels distressed by her low sexual desire, expresses feelings of love and a wish for closeness for her husband, but perceives sex as her wifely duty to please not only him but her whole family: “I feel that I will be happy if I have pleased him….a few days of happiness, no complaining, no high voice, no stuff like this. And when he is happy, all kids are happy. Yea, I try to please the whole family…just pleasing him, not myself.” While Raya indicates that she tends to experience sexual desire in both her body and mind, she acknowledges that she engages in intercourse in order to please her partner in exchange for intimacy: “…I’m more into the intimacy of touching, holding, kissing type thing. Like that does it for me more than actual intercourse…I like the skin-to-skin contact that intercourse brings…intimacy is a two way street so you have to give to get, and vice versa so if that’s [sexual intercourse] what they want then that’s what I do, but I’m still being fulfilled because I like the skin-to-skin. I like to feel connected…” As opposed to the women in the High Group, who view sex as a unique channel to intense connection, Raya believes that she can fulfill her wish for intimacy in other ways: “I could sit next to him and watch TV or be able to you know have dinner or you know talk or whatever so that kind of fulfills me a little bit more now because it’s more of a mental thing than you know a physical but when you do have sex you know, it’s fine but I desire just the closeness of it.”

Lola repeatedly asserts that her sexual desire is a purely physical need and that once she is sexually aroused, her emotional connection to her partner dissipates. On the other hand, when she masturbates, she longs for “someone else to pleasure me,” wishing to “give myself to that
person.” She talks about the mental as “up there/here” and the physical as “down there.”

Interestingly, masturbation fulfills her “mentally/up” while dyadic sexual encounters are all about the physical, “down there” gratification that leaves her feeling empty and alone, which she attributes to engaging in sexual activity outside the covenant of marriage. For Nina, sexual arousal and desire are largely split into solitary and relational domains, respectively. She sometimes feels the physical need for a sexual release, which she achieves through masturbation while other times she feels lonely and craves physical touch: “I’m not the most sexual person so I actually prefer just the physical contact with somebody, just cuddling with them.” Similarly to Raya, Nina will engage in sexual activity in order to experience closeness: “… I want physical contact with them but if they are not like the cuddly type then whatever I’m comfortable doing with them, if it’s something sexual then that’s usually what happens.”

Alexa, Micaela, and Caroline do not derive a sense of connectedness from sexual activity but crave romance and love that is free of sexual contact. They describe romantic fantasies that are completely disconnected from the sexual realm. Despondent about her absent desire, Alexa affirms her love for her husband: “It’s not that I don’t like my husband, I love him. Not a single doubt is there. I just don’t want sex.” Micaela yearns for an intimate romantic relationship, which she disentangles from sexual desire. When she describes feeling aroused while making out with a boy, she disowns her desire but acknowledges the presence of romantic feelings: “I didn’t really feel any desire to kiss him…I liked him and I felt, I think I did have feelings for him.” Micaela’s sexual feelings are sequestered to her sadomasochistic fantasies while her wish for an intimate bond is stripped of her sexual desire: “I’ve met men who I would want to like may be I’m like interested in them and like interested in the idea of having a relationship but I’ve never met anyone and felt like just like sexually attracted to them.” While Caroline believes that sex is a
“good way to express intimacy,” she too divorces love from sex: “I believe that lust and love, sex and love are kind of separate, like you can, yes you can be making love but the fact that you can do that without having sex kind of leads me to believe that like okay sex is kind of something extra, something not quite connected to it you know….” She feels guilty about her low desire, because she senses that her boyfriend is ready to engage in sexual intercourse; however, her needs are primarily relational and can be satisfied by “other smaller things, like just taking a nap with my boyfriend or just holding his hand or just you know kissing him in the like non crazy make out sense.”

**Desire for Transformation and Self-Empowerment**

*Highly sexual women.* The narratives of some of the women indicate that their sexual desire is not only about achieving bodily and relational gratification but also about expressing a sense of empowerment and ownership over their sexuality and their bodies. Further, they describe transformative experiences in which they set out to attain mastery and agency within a sexual context and to enhance their sexual self-concept, including their feelings about their bodies, sexual pleasure, and desire as well as to repair the wounds of past negative experiences.

Gabriella fantasizes about being able to express her desire to her partner, which makes her feel liberated thereby enhancing her desire. Having struggled with feelings of shame about her high desire in the past, Nicky’s sexual desire makes her feel like woman and “now that I, I myself know that it’s normal, it’s like comforting to me…I feel proud of it, and…I’ve accepted it, and I feel, feel happy…” Maggie’s sexual desire is about her self-expression and her battle against the sanctions and restrictions that are imposed on female sexuality by society and her Christian family: “…it’s also empowering for me to have control over my sexuality especially because that’s such a taboo area for women and to not care about what society thinks or what I
was told growing up…and now I own it…it’s my sexuality to express however I want so I find that a very empowering part of it.”

Elisa and Ellie describe a desire to repair past negative experiences that marred their sexuality. Elisa, who has had an extensive sexual history of over 100 partners which started when she was 13 years old, sought out to reframe her early sexual experiences as a teenager, in which she felt “dirty,” “like a whore,” and “a toy.” By re-experiencing the same sexual acts (e.g. “multiple guys at the same time”) in the context of safe relationships with her boyfriends, she wished to overcome “these like mental barriers” and rid herself of “that feeling of sex being like dirty.” And “It worked!” Having grown up in a Christian family, who conveyed the message that sex was reserved solely for marriage, Ellie struggled to reconcile her sexual desire and pleasure with her family values. She describes two negative sexual relationships in which she felt disconnected from her body and unable to experience sexual pleasure: “it was really difficult to be present and be connected to my body and experience pleasure….it was difficult to even think it was possible…to feel sexual desire and be able to have pleasure in that moment with that person. It’s like it’s almost like my body would almost involuntarily clench up and I couldn’t like, I wanted to but then my body was doing something else and I couldn’t control it.” Ellie thus set out to achieve a sense of agency, to connect to her body, to take ownership over her sexual desire and to gain mastery over her sexual pleasure. She describes an exciting sexual experience, in which the focus of her sexual desire was to gain insight into her body in a sexual context and to overcome past painful and dissatisfying sexual experiences:

*I’m most interested in figuring out how my body works, and how I can feel pleasure when having sex….trying to figure out where is it that, like in what position do I need to be in for like things to be lining up right to be able to feel an orgasm, and I figured it out….the desire was to experience this kind of pleasure, the sexual desire was directly linked to the end result of the full orgasm pleasure and so the satisfaction was in finishing that train of thought or desire, or coming to a, coming to a close...*
Sexually inhibited women. With the exception of Nina, the women in the sexually inhibited group do not disclose such experiences of transformation and self-empowerment in the context of their sexual desire. Nina, who interestingly characterizes herself as “not a very sexual person,” divulges that feeling sexual desire makes her feel like an adult woman. She reflects on an exciting memory of sexual desire in which she experienced a mutual sexual desire without feeling the impulse to conceal it:

*It was the first time I felt like...a woman sexually...[I felt like] I can deal with the sex thing...that was the first time I felt comfortable and just it was like an extreme attraction and I wasn’t, for the first time I wasn’t trying to hide that attraction...I associated being sexual with being...an adult....when I feel sexually awkward and even that sometimes happens now, I feel like a teenager almost...I feel like a lot of people who are my age and way younger than me, kind of own their sexuality and I haven’t yet exactly....for me to feel this mutual attraction and not try to hide it all, that I feel like I felt like a complete adult.*

What excites women’s sexual desires? Women were asked to describe their most exciting experiences of sexual desire to gain insight what factors tend to enhance their sexual desire. Most of the narratives in both groups contain themes of novelty as well as intense emotional and physical attraction as essential factors in fueling sexual desire. In the high group, women talked about the anticipation of encounters with new sexual partners as well as fleeting connections with strangers. The narratives of the highly sexual women reflected a sense of mutuality and an integration of the physical and emotional factors in enhancing sexual desire while sexually inhibited women emphasized the relational aspect of their experiences.

Highly sexual women. In describing their exciting experiences of sexual desire, the majority of the highly sexual women reflect on their memories of beginning a new relationship and anticipating either engaging in sexual activity for the first time or early in the relationship while feeling an intense sexual and emotional connection. Two of the women recount
experiences in which they experienced and fulfilled powerful sexual desire for a stranger. Although only one woman recounts have a vaginal orgasm for the first time in her life as the main catalyst for her desire, multiple women describe experiences that resulted in a satisfying sexual experience, usually involving an orgasm. Although having an orgasm may not have originally excited their desire, the memory of a gratifying sexual experience appears to be an important factor that would enhance desire.

Anticipation and novelty. When pondering an exciting experience of desire, Chloe states, “Exciting desire would be something where I have to wait,” as the desire builds and intensifies over time. She recounts experiencing a mutual attraction with a man who showed potential as a long-term romantic partner: “the period of when he asked me out until we actually had sex was probably the most exciting time of desire because I really, really liked him. I found him attractive and I thought he was really smart. And I knew I got along with him already.” Similarly, Vivienne describes intentionally waiting two months to have sex with her current boyfriend, which intensified their mutual desire:

...there was a lot desire and a lot of want whereas we both wanted each other but we waited and waited for a while...having that desire so many nights and not doing anything about it because we had both kind of had a mutual understanding....it was very intense...it was very thick...it was very palpable.....it’s just like excited and...ecstatic....I really wanted this...this is what I’ve been waiting for...it was just like an intense want and desire....when you can’t even think straight.

The novelty and intensity of her emotional connection with her boyfriend fueled Nicky’s desire when she had sex with her boyfriend for the first time. She remembers experiencing powerful bodily sensations and feeling a strong attachment to her partner: “It [tingling sensation] was all over my body but it was way more than previous times so I knew it was different. May be it was because it was like genuine love....looking back on it, I’ve never been in love with any other guy. I was deep in love with him, so in love with him.” Nicky links her bodily response to
her relational experience in this encounter: “…before that, I guess I was kind of holding back emotionally and which caused me to kind of hold back sexually….You just felt free…I can really open myself, open my body, it’s like yours.”

*Intensity of a sexual and emotional connection.* Gwen, Elisa, Maggie, and Cecilia talk about powerful emotional and sexual connections with previous partners that fueled their sexual desires. Gwen recounts the beginning of a relationship in which she experienced mutual sexual satisfaction and sense of connectedness: “…we were both just like enjoying it [having sex for hours] and also just that feeling of just kind of being like swept in each other…that mutual feeling of like you both can’t get enough of the other…” Cecilia describes a difficult relationship in which she experienced an intense sexual attraction, which she attributed to both the physical compatibility (pheromones, “we danced well together”) and the emotional bond: “I had never had such a strong physical, such a strong physical attraction to somebody in my life. And I just wanted to have sex with him all the time... and I like longed for his body to be close to mine.” Admitting that she has never felt a desire so intense, Cecilia does not have insight into what made it so powerful. She mentions that she and her partner came from very different backgrounds that ultimately ended their relationship; however, it seems that the sense of separateness that those differences engendered, coupled with their emotional closeness and physical attraction allowed Cecilia to retain her autonomy while merging with another. Elisa replays a past experience of having very connected sex with a male friend to fuel her sexual desire when she fantasizes: “we felt a bond like really, really intensely...And I replay that a lot….I guess through sex we were able to become closer because we don’t talk a lot but we do feel a really intense loyalty for each other…” Echoing Nicky’s experience, Elisa’s sense of connectedness and trust with her partner fostered her sexual desire: “When I feel safe and secure
like that than I feel that I can be more responsive during sex and I can, I’m more active during sex.” She explains that “there’s no obligation, no pressure, no restrictions” in their relationship, which possibly creates sufficient space to enhance the wish for merger with another. Maggie describes feeling excited and overwhelmed by an intense sexual and relational desire for a man: “the times I think of him, I immediately feel turned on, I immediately feel desirous…he just sort of like I guess just encompasses everything that I sort of want from somebody in terms of a partner and in terms of a life partner but also as a sexual partner.”

*Desire for a stranger.* Gabriella and Kendra’s most exciting narratives of desire involve having fleeting sexual encounters with a stranger. They both emphasize the importance of mutual attraction and a sense of freedom to act on their desires. Gabriella attended a sex party where she immediately became drawn to and pursued a man: “It was just something about him, his physical features, his personality. It just made me want him, it just made me want to take him.” Gabriella’s desire was enhanced not only by the object of her desire but also by the circumstances of the party (“everybody was walking around the house butt naked“) and her own wish to liberate her desire: “I just wanted to just be wild….I think that was the only time I expressed myself, like sexually I expressed myself to him….and I told him, I want you. I want you now. It’s not going to work if I don’t get you right now….“ Gabriella’s sense of agency enhanced her desire: “for me that was the most exciting moment….that’s when I feel it the most, if I initiate it. It would feel like I did something sexual that I wasn’t really embarrassed about……I felt all my body just came free…” Kendra had a brief fling with a fellow hotel guest while on vacation with her family, which she describes as “one of the most like intense sexual desire experiences that I’ve had…” Similar to Gabriella’s experience, Kendra felt sexually liberated: “the idea of meeting a stranger and just like barely talking to them and just like having
sex with them and like having really good sex with them and never seeing them again is a really attractive one to me for some reason…I feel like you’re the most uninhibited.” Kendra and Gabriella reflect on the importance of mutual attraction in their encounters. Gabriella explains that her desire would be turned off if she did not sense reciprocity in her partner’s desire. She states, “I told him about my desire, and that’s when his desire was the same as mine.” Kendra elaborates on this experience of mutuality: “I think that’s like what made me attracted to him was just like I could tell that he was attracted to me, which I noticed that’s another thing that happens a lot…I’m only attracted to people that I can tell are already attracted to me….I also feel it’s the basis of attraction is like when someone’s attracted to you, like mutual attraction is really nice to have.”

**Sexually inhibited women.** Since some of the women, as in the case of Alexa and Micaela, do not experience sexual desire, they could not generate narratives about exciting desire or suggest factors that may enhance their sexual desire. The rest of the women in this group did divulge memories of exciting experiences of desire, in which similarly to the high group, the novelty of the relationship, the intensity of the connection, and the experience of mutuality fueled their desires.

Marina remembered feeling very desirous when she was first married and wishing to be pregnant. She felt attractive and was not bogged down with house chores, child-rearing, and a job. Now a period of separation from her husband also enhances her desire as well as an opportunity to care for herself and her body. Raya describes her first sexual experience with her now estranged husband, in which she felt a deep connection and mutual desire. Peyton remembers the first time she and her boyfriend made out – it was a three-hour make-out session in which she was aware of their mutual desire that did not entail other activity and therefore did
not pose the risk of vaginal pain that tends to inhibit her desire. Maria describes a public sexual encounter with her husband before they were married and attributes the excitement to their shared desire, carefree feelings, and playfulness. Nina recounts her first experience of mutual attraction in which she did not feel the need to conceal her feelings. Lola discloses a “wild” sexual experience with a previous partner after a brief separation, which enhanced her desire.

**What inhibits women’s sexual desires?** In order to elucidate factors that tend to inhibit sexual desire in women, participants were asked to describe a disappointing experience of sexual desire. Women in the highly sexual group tended to focus on both relational and bodily facets of their encounters, including an absence of mutuality, lacking chemistry or connection with the partner, the partner’s misattunement to their needs and the resultant physical dissatisfaction. The sexually inhibited women, who often experience low or absent desire, expressed very different reasons, including sexual trauma and experiences of objectification by self or other. Expectedly, while the highly sexual women described isolated incidents of inhibited desire, women in the Low Group described pervasive problems in their sexual functioning. Further, women in the High Group appeared to be more aware of contributing factors to their low desire in a given context whereas sexually inhibited women seemed to have less insight into the forces that undermine their desire, as the latter perceive their low/absent desire as a personal defect or flaw while the former identify as highly desirous women who tend to be surprised when their desire plummets.

**Highly sexual women.** With some variation, most women in the highly sexual group attribute the inhibition of their sexual desire to their partner’s incapacity to tune into, understand, and respond to their needs. Further, several women identify problems in the relationship or in the connection with their partners as factors that undermine their desire while others locate the
problem to their internal experience of desire. They all respond to such experiences with suspension of both bodily and relational desire.

*Lacking attunement.* Maggie describes feeling objectified by a partner who seemed oblivious to her needs: “I was just sort of a means to an end…it was very clear to me that it was more about him getting off than a mutual experience…it was more about his own body rather than two people.” Cecilia reflects on her first experience of sexual intercourse in which she felt angry and disappointed with her “supposedly” more experienced boyfriend of two years for not being attentive to her arousal and pleasure, resulting in the loss of her desire to be sexual with him in the future: “I was just disappointed because like he, probably mad at him, for like not knowing, for like being older and like not knowing that I should have been wet, or like trying too hard and it being painful and like him continuing to try, and then I remember he like, he had passed out like in the middle of it or right after it, and I was just kind of like like ‘that’s it?’ Like you asked me for two years to have sex with you and then that and nothing?” Ellie describes her partner’s tendency to pull out after ejaculation, which “left me feeling really bad” and his refusal to respond to her needs once she expressed them. Ellie indicates that this sexual relationship made her realize “that I had some stuff to deal with around sex and my body and desire and my relationship to the past and how I wanted to embrace myself,” and her wish to undergo healing and reparation of the pain and disappointment of her first sexual experience.

*Problematic dynamic and lacking mutuality.* Chloe describes engaging in sexual intercourse with a partner, whom she had been desiring for a period of 4 years. She explains that their desire was mutual but timing would interfere with an opportunity to be together as one of them would be in a monogamous relationship. Chloe discloses that once in the midst of a sexual encounter with him, her desire was absent: “…I really wanted to be with him…but the chemistry
wasn’t there…” Chloe admits that she initially ascribed fault to a lack of sexual prowess in her partner but later acknowledged that likely the problem stemmed from some unknown aspect in their dynamic. Gabriella talks about not feeling a connection to her partner when she lost her virginity: “I don’t like having sex with certain people, certain personalities. So when I do have sex with them, it’s just a fake thing….I just don’t feel it anymore, it will just lay it out in my mind…it didn’t feel fun, it didn’t feel good. I just felt…like I didn’t have that attachment to them. And once I don’t have attachment, it doesn’t feel good.” Elisa recounts lacking her desire for a male friend with whom she previously had had a mutually satisfying and connected sexual relationship. She explains that the ambiguity of his relationship status made her feel conflicted about their relationship, and therefore interfered with a sense of connectedness and her sexual desire: “….we didn’t feel connected, like, it just felt wrong…it wasn’t physically satisfying. I couldn’t get myself there….I was aroused while we were hanging out… but then when it actually started to get like really going…like okay now we’re going to have sex then it felt wrong…” Gwen discloses feeling frustrated by her sexual dissatisfaction in a previous relationship, which would inhibit her desire to be sexual. While she initially blamed her partner for his inability to satisfy her sexual needs, she came to attribute her low desire to their problematic dynamic: “….we couldn’t we didn’t communicate very well….we didn’t understand each other well. We couldn’t, didn’t communicate well….” Kendra contrasts her experience of intense sexual desire (described above) with deeply emotional relationships that she had had with people before this encounter, which seemed to inhibit her desire: “I had like a lot of sort of emotional relationships with people that were like more intimate than they should have been, and I think may be that killed it [sexual desire] a little bit.” Kendra suggests that an intense emotional closeness may undermine sexual desire, which requires a certain level of separateness and distance.
Vivienne’s describes an encounter with her partner, in which she did not have spontaneous desire but rather developed responsive desire as he stimulated her:

*I didn’t particularly want to have sex and then once we started, I got excited and I was like okay, but it wasn’t like a desire that came from me where I was like prepping for it and I really wanted it…I didn’t initially have that desire…it’s more responsive….it wasn’t like something I was coerced into, but kind of like persuaded into doing it….it might not have been what I wanted to do initially but he knows my body at this point and he knows kind of like what spots to touch and what I like. So it’s like if he starts to do those things then I’m more willing….I do have desire. it’s not like there isn’t desire there, it’s kind of a desire that’s different….it’s not the kind of like a desire, a fire that was already there, it was already lit, I came in with it, it’s kind of something he kind of starts to work on within me, you know, like a stick and a rock….there is desire that he brought on but it’s not something that was already there and then I fueled off of him so that it’s a very large desire.*

Although Vivienne’s account does not betray any element of coercion, it suggests a missing sense of mutuality in her desire with her partner. She seems to lack ownership over her own desire but rather borrows her partner’s desire, which results in a disappointing sexual experience.

**Sexually inhibited women.** The narratives of women in the sexually inhibited group reflect two important factors that undermine their sexual desire: 1) a history of sexual trauma, which includes not only sexual assault but other painful experiences in a sexual context and 2) objectification by their partners, such that their partners’ sexual desires tend to displace their own desire.

**Sexual trauma.** Several women describe traumatic sexual experiences. Notably, these women do not necessarily link these traumas to their lacking desire, which they perceive as a personal defect. Alexa begins the narrative by stating that she does not have sexual desire: “a personal mental desire to want sex isn’t something that I think is in me.” As the interview continues, she alludes to multiple nonconsensual sexual experiences, which she does not describe in detail or cite as reasons for her absent desire. At the same time, she describes a previous experience in which she decided to take charge over her sexuality: “I’d been tired of being forced
to not consent to sex and being forced to consent and being forced to do things I didn’t want to do….I thought that if I initiate things, it will be great, it will be good.” In this instance, Alexa tries to exercise agency over her sexuality and to be the subject rather than object of her desire. Unfortunately, when she engages in this experiment, her desire is lacking and rather than being forced by another, she forces herself to have sex with someone she does not desire, repeating her past nonconsensual experiences and reinforcing the experience of objectification and force in a sexual context. In her relationship with her husband, Alexa describes herself as an object of his desire – an object that is lifeless and replaceable, like a “blowup doll.”

Lola also indicates that she has had multiple experiences of being raped; however, unlike Alexa, Lola shows an awareness that her sexual trauma history is related to her “emotionless” sexual desire: “even the young man I had sex with, I have no feelings at all…I think it has to do with being raped…I don’t have any feelings…” As opposed to Alexa, Lola does have sexual desire, which she locates solely in her body rather than in the wish to connect with another. Lola harbors the fantasy that the bodily and the relational would be integrated within her sexual desire once she is married, repeatedly, asserting that she should not be feeling desire outside the covenant of marriage. Yet, when she talks about her first marriage, she states that she never experienced sexual desire for her husband and rarely engaged in sexual activity with him. For Lola, her history of rape does not necessarily result in inhibited sexual desire but in fragmentation, such that it detaches from her relational needs. Once sex is imminent, she feels emotional deadness and once she orgasms, she needs to disengage from her partner.

Peyton denies a history of trauma but indicates that she feels tremendous anxiety about feeling “stabbing pain and tearing” during intercourse, which inhibits her sexual desire in a partnered context. She states that she will feel pain “if I’m not like 100% ready and it has to be
the perfect time in between my period just ending and just starting.” Peyton states that she even cannot use tampons, which result in similar pain and vomiting. Interestingly, Peyton indicates that prior to losing her virginity, she was able to use tampons pain-free. Peyton’s first experience of having sexual intercourse was extremely traumatic because she felt tremendous pain: “…he started…the worst pain…like he couldn’t go all the way in, just pain. And that was, that was pretty bad…” This experience of excruciating pain was quite traumatic and inhibited Peyton’s sexual desire: “after a certain amount of days had passed [after having sex] I would feel desire again…until I was with him and he wanted to, and then at first desire and then pain, pain, pain, no [desire].”

*Objectification by self and other.* Although other women in the sexually inhibited group do not endorse a history of trauma, they describe experiences of feeling forced, out of control, objectified, and overwhelmed by the desire of the other. While for some of these women, such feelings are pervasive, others seem to describe isolated incidents of powerlessness and loss of agency that turned off their desire.

Feeling coerced to engage in sexual activity with her husband and to submit to his needs as a wifely duty, Marina is not the subject of her own desire but assumes the role of an object of his desire: “…he wants anybody, yes…just to fill his desire…” When she does wish to be sexual with her husband, he rejects her, making her feel punished for the times when she refuses to have sex with him, which leaves her feeling ashamed, unloved, and undesirable, perpetuating her sense of objectification and low desire. Raya describes an episode with her now estranged husband when he tried to have anal sex with her without her consent, which made her feel “violated” and “abused” and immediately turned off her desire. Her feelings of powerlessness and violation inhibit her sexual desire: “Once I feel like I’m losing that control then all acts stop,
I don’t respond to that…” Maria recounts an instance in which her husband became very aggressive during sex and similarly to Raya, her desire deflated: “I was feeling desire in the beginning but then he became more like aggressive in a sense so I started to feel pain because he was too pushy…I felt very like offended in a sense and started crying.” Maria becomes tearful at this point in the interview, expressing feelings of guilt for upsetting her husband. At the same time, she acknowledges the experience of coercion: “I didn’t want to participate.” Maria worries about her low desire and her incapacity to orgasm, feeling guilty and defective. She exhibits a sense of self objectification in her monitoring of her sexual functioning as well as her body in her sexual encounters with her partner. Blaming herself for her sexual inadequacy, it is difficult for her to acknowledge that perhaps part of the reason for her low desire is her husband’s misattunement to her needs.

Micaela and Caroline worry about feeling overwhelmed by their partners’ desire. In her only experience of sexual activity with a man, Micaela monitors her partner’s desire while lacking her own: “I was thinking about what he expected or wanted and what I was going to do if that’s what he wanted….I mean I didn’t really feel any desire to kiss him…” She feels fearful and worries about feeling overpowered by the other’s desire and lacks a sense of agency and control with respect to her own sexuality: “I was just so…freaked out that I wouldn’t have any control in that I wouldn’t have a say in what we were doing…not like he would like forcibly do anything but just that I would be too embarrassed…I wouldn’t say no if I didn’t want to do something, like I wouldn’t stand up for myself.” While Caroline does not explicitly exhibit anxiety about being forced to have sex or an inability to express her wishes to her boyfriend, she demonstrates a similar sense of powerlessness and an expectation of being overwhelmed by her partner’s desire: “Once we would do it, I really don’t know how often we would…even though
we’re not having sexual intercourse now...I can get really exhausted.” In wondering how
frequently she and her partner would have sex, she disavows a sense of agency in making the
decision to have sex as though it does not depend on her desire. Further, Caroline worries about
losing a sense of self if she engages in sexual intercourse with her boyfriend: “I still feel very
connected to myself. I still feel after all of these months that I’m still my own best friend….I get
the feeling that if I have sex now, I would kind of lose an aspect of myself…” Caroline
anticipates that engaging in sex would impinge on her autonomy rather than constitute an
expression of her subjectivity. Of note, Caroline discloses her concern that the birth control pill,
which she takes to manage severe menstrual cramps, may be responsible for her low libido. At
the same time, she does not consider switching to a different type of pill or trying to address her
menstrual pain in another way, suggesting that perhaps Caroline is, in part, invested in her low
libido, which safeguards her from the dangers of sexual intercourse.
Discussion

The present study investigated the relations between women’s internalized working models of relationships with their parents (i.e., attachment styles and level of separation-individuation as well as parental identification), their sexual self-concept (i.e., level sexual subjectivity, self-objectification, genital self-image), and their level of sexual desire (partnered, solitary, and affective/cognitive components of desire). Participants in this study were healthy, premenopausal, heterosexual women between the ages of 18 and 40 years who ranged from sexually inhibited to highly sexual in their level of desire. It was hypothesized that women who were low on attachment avoidance and anxiety as well as on separation-individuation disturbance, who were more individuated from the mothers without feelings of guilt, anger, resentment or conflict, and who approached equal identification with their mothers and their fathers were more likely to endorse a positive sexual self-concept and, in turn, would be more likely to endorse higher levels of sexual desire.

A structural equation model partially supported the hypotheses of the current study. As expected, internalized working models of parental relations significantly predicted sexual self-concept, such that women who reported lower levels of attachment anxiety and avoidance and of separation-individuation pathology, and who were more individuated from their mothers without feelings of guilt, anger or resentment were lower in their tendency towards self-objectification and had more positive sexual body esteem and genital self-image. On the other hand, contrary to the study hypothesis, parental identification did not have a significant relationship with the construct of sexual self-concept, and thus parental identification did not mediate the relationship between representations of sexual self-concept and sexual desire. Multiple factors may have contributed to this finding, which will be discussed below. Furthermore, as hypothesized, sexual
self-concept was significantly related to sexual desire, such that lower levels of self-objectification, more positive sexual body esteem, and more positive genital self-image predicted higher levels of sexual desire, including desire for partnered sexual activity, solitary sexual activity (e.g. masturbation), more positive affective and cognitive self-assessments of sexual desire, higher tendency for sexual self-reflection and a greater sense of entitlement to sexual desire and pleasure. The structural equation model fit to the data showed a reasonably good fit specifying only indirect effects, i.e. no direct relationship between internalized working models of parental relations and sexual desire. In this way, the present study yielded results that supported a fully mediated model, in which the relations between internalized representations of parental relations and sexual desire were explained by sexual self-concept.

**Internalized Working Models of Parent-Child Relations and Sexual Self-Concept**

The results of the present study emphasize women’s experience of their bodies as central to understanding the link between internalized working models of parental relationships that originate in childhood and sexual desire that is experienced in adulthood. Importantly, the sexual self-concept construct resolved to be a physical sexual self-concept, such that it was comprised of sexual body esteem, genital self-image and self-objectification. Further, self-objectification was assessed by a scale that measured body-image self-consciousness in a sexual context rather than a global self-objectification measure.

The results indicate that insecurely attached and poorly individuated women are more likely to self-objectify their bodies in a sexual context and show poor sexual body esteem and genital self-image. These findings resonate with the attachment and object relations theories, which suggest that people’s templates for relationships and internalized representations of self and other stem from their early experiences with their parental figures. Importantly, an infant’s
and young child’s relationship with her parents is largely physical, with the mother breastfeeding the baby and the parents bathing, dressing, caressing, kissing, rocking, and cradling the child to nourish, soothe, protect, and respond to the child’s needs, as well as to bond and to express affection towards the child. Parental love, care, responsivity, and attunement as well as intrusiveness, rejection, maltreatment, and abandonment are largely communicated through the body during the child’s early years. As the child grows, the physicality of the parent-child relationship begins to recede as the child becomes more verbal but remains an important mode of connecting until adolescence when the developing child requires more privacy, firmer boundaries, and ownership over their maturing bodies. The physical body therefore serves as the earliest register for relational experiences. It follows that disturbances in the parent-child relations such as intrusive, mis-attuned, unresponsive, or neglectful parenting, would not only result in insecure attachment and inadequate resolution of the separation/individuation phase of development but also interfere with the development of the capacity to embody one’s body and a sense of bodily competence and integrity, as demonstrated by the results of the present study.

Attachment and object relations theories postulate that the child internalizes the representations of self and other in the context of early parent-child interactions, which generate templates for adult romantic relationships, and that these early bonds are mediated through the body. At the same time, these writings often neglect to address that the sensuality of the mother-child relationship not only forms the basis for intimacy and relatedness but also sparks the development of adult sexuality and desire. Such link likely has been neglected in many previous writings due to the prohibitions against infantile sexuality in fear of sexualizing the parent-child relationship. Nonetheless, psychoanalytic theorists suggest that early mother-daughter relationships affect women’s internalized representations of their sexual bodies while attachment
research indicates a link between sexual body esteem and competence, and attachment style. For example, research demonstrated that insecure attachment is related to lower self-perceptions of sexual attractiveness and sexual prowess, such that insecure individuals tend to express less abilities to satisfy their own sexual needs as well as lower sexual self-esteem and physical attractiveness and sensuality (Bogaert & Sadava, 2002; Deborah Davis & Vernon, 2002; Shafer, 2001; Tracy et al., 2003).

Kernberg (1995) and others (Chassegue - Smirgel, 1970; Elise, 2000, 2008) discuss how the mother’s ministrations of the infant’s body result in early sexual excitement, stimulating the child’s body surface eroticism, which is the predecessor to sexual desire that develops in adulthood. Echoing Freud’s (1923) claim that the ego “is first and foremost a bodily ego,” Margaret Mahler (Mahler & McDevitt, 1982) suggests that the infant’s earliest representation of herself is derived “through sensations from within [her] own body…” (p. 829). She argues that the self-boundary formation and delimitation of the body self from the parental figure constitute the first step in the process of differentiation from the mother-child symbiosis. Most importantly, Mahler indicates that the mother’s libidinization of the baby’s body through physical ministrations facilitate differentiation and eventual separation-individuation as well as generate the “earliest sense of the body self as entity” (p. 833). She suggests that this experience of bodily differentiation appears “to be the condition on which the feeling of “being alive” rests” (p. 833). The child therefore develops a sense of herself as a “separate self” through both the pleasurable and unpleasurable body experiences in the context of her relationship with her mother, as the infant comes to perceive the mother as the one who provides the pleasurable and relieves the unpleasurable bodily feelings: “In short the mother, in addition to being a check
point for differentiation, has become indispensable for the infant’s sense of wellbeing” through the experiences of the infant’s body (p. 839).

The findings of the current study, which indicate a link between bodily representations and internal working models of parent-child relations, resonate with attachment research as well as with Mahler’s and other object relations theories that implicate the child’s bodily experiences in the context of mother-child relations in identity development and the process of separation-individuation.

Sexual Desire and the Bodily Self-Representations

The current findings also indicate that women’s tendency to self-objectify their bodies in a sexual context, their self-appraisals of their sexual attractiveness and desirability, as well as their perceptions of their genitals are related to their feelings of sexual desire. In the current study, sexual desire was assessed by measuring women’s wish to participate in both partnered and solitary sexual activity as well as the affective and cognitive aspects of their sexual desire.

The current findings resonate with psychoanalytic theory (Elise, 2000, 2008; Kernberg, 1995), which suggests that the deflation of female genitality, which stems from the mother’s unconscious rejection of her daughter’s sexuality and is perpetuated by the physical anatomy of female genitals, results in sexual inhibition. As discussed in the literature review, Kernberg (1995), Elise (2008), and others suggest that the mother’s handling of the boy bodies and the girl bodies differs as they develop, such that the mother engages in an unconscious rejection of her daughter’s genitality thereby inhibiting the girl’s sexuality. In response to the mother’s rejection, the girl experiences shame and inadequacy, and thus internalizes these repressed and inhibited self-representations of her sexuality (Elise, 2008; Kernberg, 1995). Elise (2000) further proposes that the female anatomy – the retracting clitoris and contracting vagina – perpetuates the
deflation of female genitality, confirming women’s self-perceptions of their sexuality as hidden, absent, and diffuse.

The findings of the current study also are in line with previous research that has shown that self-objectification, poor sexual body esteem as well as poor genital body image interferes with women’s sexual functioning (Berman et al., 2003; Buzwell & Rosenthal, 1996; Herbenick & Reece, 2010; Herbenick et al., 2011; Sanchez & Kiefer, 2007; Steer & Tiggemann, 2008). Steer and Tiggemann (2008) found that women who tend to monitor their bodies in general, also tend to do so in sexual situations and that higher levels of body shame and appearance anxiety predict higher self-consciousness during sexual activity. Further, they found that more self-consciousness during sexual activity is related to poorer current and general sexual functioning. These findings suggest that women, who engage in self-surveillance during sexual activity, tend to dissociate during sex and therefore disconnect from their sexual desire and experience little or no pleasure and more aversive feelings during sex.

Further, studies have indicated that a sense of one’s sexual desirability is connected to one’s confidence in one’s sexual competence. A study of Australian adolescents showed that sexual attractiveness and desirability (i.e. sexual body esteem) was associated with sexual competence, such that individuals who felt highly competent and in control in the sexual domain also were confident about their sexual appeal and behavior (Buzwell & Rosenthal, 1996). Multiple studies also investigated the link between female genital self-image and sexual functioning, finding a link between how women perceive their genitals and sexual functioning in all domains (Berman et al., 2003; Herbenick & Reece, 2010; Herbenick et al., 2011). While these studies did not specifically focus on the link between these bodily constructs and sexual desire in women, they did demonstrate that women’s perceptions and feelings about their bodies in a
sexual context influence their overall sexual functioning (assessed by Female Sexual Function Index). In this way, women’s capacity to embody their bodies during sexual activity (rather than engaging in self-objectification) as well as positive sexual body esteem and genital self-image is predictive of better sexual functioning, which is consistent with the findings of the current study.

Re-conceptualizing Sexual Subjectivity and Sexual Desire

One unexpected finding in this study was that 2 of the 3 sexual subjectivity variables loaded on the desire factor rather than the sexual self-concept factor. Specifically, the 3 subscales of the Female Sexual Subjectivity Inventory, including Sexual Body Esteem, Sexual Self-Reflection and Entitlement to Sexual Desire and Pleasure, did not load on the same factor of Sexual Self-Concept; the latter two subscales (i.e. Sexual Self-Reflection and Entitlement to Sexual Desire and Pleasure) loaded on the desire factor. Thus, these variables were better indicators of women’s sexual desires than of their sexual self-concept. The sexual self-concept construct, on the other hand, consisted of self-objectification, sexual body esteem, and genital self-image, thereby emphasizing the bodily aspect of one’s sexual self-concept. While the components of the model changed at the level of measures, it did not change at the level of theory or conceptualization. Nonetheless, these alterations to the model require a closer look at both the measures of sexual subjectivity and desire as well as at the definitions of sexual subjectivity and sexual desire.

The empirical literature on the definition of sexual desire captures the behavioral and motivational components of sexual desire – the yearning or urge to behave sexually, which may be accompanied by sexual fantasies or actual partnered or solitary sexual activity; yet, this definition of sexual desire is incomplete as it leaves out the significance of the wish for sexual activity – real, fantasied, partnered or solitary. The psychoanalytic literature conceptualizes
sexual desire as the wish for a temporary merger with another and the obliteration of boundaries of self, which allow for further ego integration but also require the autonomy and the integrity of self (Chodorow, 1978; Kernberg, 1995; Stein, 2008). Benjamin (1988) indicates that the desirous woman craves a space in which she can be known. Further, she suggests that women can experience sexual desire only if they are able to be the subject of that desire — to feel agency and ownership over their own desire. She suggests that in their desire, women yearn for a sense of mutuality and recognition.

Researchers and theoreticians investigating and exploring the concept of sexual subjectivity consider it to be the woman’s capacity to embody her body, her sense of entitlement to the pleasure she may derive from her body, and her sense of ownership and agency with respect to her body (Benjamin, 1988; Horne & Zimmer-Gembeck, 2006; Martin, 1996; Tolman, 2002). Horne and Zimmer-Gembeck (2006) include sexual body esteem, entitlement to sexual desire and pleasure and capacity for sexual self-reflection in their conceptualization and assessment of female sexual subjectivity. The studies on sexual subjectivity in adolescent girls have demonstrated that sexual subjectivity is related to a greater level of sexual experience, more diverse sexual experience, and that sexual subjectivity tends to rise as a function of an increase in sexual experience (Zimmer-Gembeck et al., 2011). These findings can be interpreted to suggest that sexual subjectivity is an aspect of sexual desire, such that greater sexual desire would likely result in greater sexual activity and that as one gains experience in sexual activity, provided that it is positive, her sexual desire also would likely increase.

The findings of the current study suggest that sexual desire is not merely the wish to behave sexually – in fantasy or reality, with partner or with oneself – but entails other essential components of the phenomenology of sexual desire. It is my argument that sexual desire and
sexual subjectivity are part and parcel of the same phenomenon and that they cannot exist without one another – i.e., one cannot feel sexual desire unless one has the capacity to be the subject of her sexual desire and to feel entitled to experience desire and pleasure in both partnered and solitary sexual situations as well as to be able to reflect on and therefore acknowledge one’s own sexuality. In feeling sexually desirous, the woman feels the wish or yearning to be sexual, she feels she has the right to have this wish, she feels ownership over this wish, she possesses agency with respect to this wish and she can reflect on and recognize this wish within her psyche and her body. Further, the current findings indicate that to experience these components of sexual desire, the woman needs to have the capacity to embody her body – the capacity, which she tends to develop in the context of her early relational experiences.

**Purely Mediated Model**

As expected, another important finding in the current study was that the relationship between internalized working model of parental relations and sexual desire was completely mediated by sexual self-concept, defined by women’s bodily experiences. There was no direct relationship between attachment, separation-individuation, and parental identification with the construct of sexual desire, suggesting that women’s capacity to embody their bodies, their sense of sexual bodily esteem, and genital self-image serve as one of the mechanisms underlying the impact of women’s early parental experiences on their sexuality, more specifically their sexual desire. This important and novel finding lends support to the psychoanalytic theories reviewed in this manuscript in that it demonstrates that women’s representations of their early relational experiences are implicated in their capacity to experience sexual desire in adulthood through women’s physical sexual self-concept. In other words, the ways in which early relational experiences influence sexual desire are based very much in how women experience their bodies,
specifically in a sexual context. The body thus serves as the conduit between early relational experiences and adult sexual desire.

The results of the present study are consistent with previous findings, which have found that individuals with insecure attachment tend to experience negative feelings in response to sexual activity (Birnbaum et al., 2005; Gentzler & Kerns, 2004; Tracy et al., 2003). Specifically, previous studies indicate that individuals with attachment anxiety tend to show ambivalence about sex, utilizing their sexuality as a way to elicit caretaking behaviors in their partners, whereas individuals with attachment avoidance are more likely to either abstain from sexual activity or pursue casual sex to attain prestige and power over others rather than to fulfill their sexual desire (Mikulincer & Shaver, 2003, 2007).

While there is not much empirical research into the link between separation-individuation and sexual desire, psychoanalytic theorists, such as Kernberg (1995), Benjamin (1988), Chodorow (1978), and Holtzman and Kulish (2000, 2003), implicate the separation-individuation process between mothers and daughters in women’s sexual inhibition. They argue that women struggle in their separation from their mothers, which may remain conflicted and unresolved, and that inadequate differentiation between mothers and daughters greatly contributes to women’s lack of autonomy and agency with respect to sexual desire (Benjamin, 1988; Holtzman & Kulish, 2000, 2003). Based on the conceptualization of sexual desire as the wish for merger with the other, the sexual act may be threatening to those who do not feel fully individuated and separate – threatening to their relationship with the mother and threatening to their integrity of self.

Current findings do not refute previous research or theory but further explain and refine the link between sexual inhibition and internalized working models of early relations in
identifying one of the mechanisms that explains the link between early childhood experiences and adult sexuality – the capacity to embody one’s body during sexual activity, sexual body esteem and positive feelings about one’s genitals. For example, women who are insecurely attached and/or poorly individuated from their mothers and who managed to develop a sense of bodily integrity, esteem and competence, particularly in a sexual context, are more likely to have greater sexual desire than women who have impoverished object relations as well as poor internalized representations of their sexual bodies.

**Parental Identification, No link to Sexual Self-Concept or Sexual Desire**

Contrary to study hypotheses, parental identification with the mother and the father was not significantly related to either the mediator of sexual self-concept or to sexual desire within the structural equation model. However, parental identification was significantly, albeit, weakly correlated to the sexual self-concept construct while showing no significant correlation with sexual desire. Further, parental identification was significantly associated with the construct of internalized representations of parental relationships. These results suggest that the construct of internalized representations of parental relationships subsumed the contribution of parental identification to sexual self-concept. In other words, whatever role parental identification plays in sexual self-concept, it may be better explained by attachment and separation-individuation, which comprise the internalized representations of parental relationships construct.

Nonetheless, some additional factors may have contributed to this finding. One issue may be the inadequacy of the measure in assessing parental identification. Unfortunately, few measures of parental identification exist and Semantic Differential, which was used in the current study, has not been widely utilized, tested or validated in recent decades. This measure is an indirect assessment of parental identification, which relies on how similarly participants would
characterize themselves to their parents on three factors, including Evaluative (Good-Bad, Cruel-Kind, Fair-Unfair, Honest-Dishonest), Potency (Weak-Strong, Cowardly-Brave, Humorous-Serious, and Violent-Gentle), and Activity (Passive-Active, Tense-Relaxed, Calm-Excitable, Definite-Uncertain). Possibly, such measure did not adequately assess participants’ level of identification with either of their parents – or at least, the element of identification that was specifically relevant for the current study. Benjamin (1988) argues that the girl derives the capacity for autonomy, separateness, agency and subjectivity through her identification with her father while her identification with her mother gives her access to attachment, merging, holding, containment, and sameness. Semantic Differential likely did not tap into these aspects of the parental relationships or identifications. Additionally, some participants may not have had a mother or a father and therefore could not identify with a maternal or paternal figure.

Unfortunately, participants’ family of origin structure was not assessed in the current study, which is one of its limitations.

Another explanation for the finding regarding parental identification may be at the level of theory, such that women’s identifications with their parents do not play a role as suggested by Jessica Benjamin (1988). Rather, it is the internalized representations of self and other and the development of agency and autonomy through the separation-individuation process that supersede any role, which women’s parental identifications may play in their psychosexual development. Further, as discussed above, Benjamin argues that the father represents autonomy, agency and subjectivity while the mother represents merging, attachment, and sameness, which are based on the gender divisions of a patriarchal culture. While the Western world remains largely patriarchal, the past 50 years has seen a major shift in gender dynamics and considering
that the average age of the sample was approximately 25 years old, such characterization of maternal and paternal figures may not apply to the participants of the current study.

**Internalized representations of parental relationships: Attachment, separation/individuation and parental identification**

The current research study also yielded findings that are quite relevant to the field of attachment and object relations in demonstrating that attachment anxiety, attachment avoidance, separation-individuation pathology, and conflictual independence (freedom from guilt, anger, a sense of responsibility, resentment) were significantly related and represented one construct of internalized working models of parent-child relations. Specifically, the findings indicate that participants with secure attachment are less likely to exhibit separation-individuation pathology and show greater freedom from guilt, anger, resentment and a sense of responsibility towards their mothers. While attachment has been heavily researched, separation-individuation has not received much empirical attention and there has been a scarcity of research into the relationship between attachment styles and separation-individuation. In this way, the current finding lends support to the link between these two important aspects of inter- and intrapsychic organization. An example of the implication of the link between people’s attachment security and their separation-individuation difficulties would be that anxiously attached individuals, fearing abandonment, neglect and/or rejection by the other, struggle with being separate and seek to be in a constant state of merger with the other while avoidantly attached individuals, harboring a fragile sense of autonomy, worry about being impinged upon and perceive the other as a threat to their integrity of self. These findings indicate that attachment and separation-individuation form one meta-construct that reflects individuals’ internalized object relations that stem from their early experiences with their primary caretakers.
Furthermore while parental identification was not significantly related to sexual self-concept or sexual desire in the structural equation model (although it had a significant bivariate correlation with sexual self-concept), it was significantly associated with the internalized working models of parental relationships (attachment and separation-individuation). Previous research has not addressed the relationships between parental identification and separation-individuation or attachment styles. As discussed previously, Freud suggested that parental identification is based on “an emotional tie with an object” and develops in the context of a dependency relationship (anaclitic identification) or as function of the fear of the aggressor (aggressive identification). Parental identification occurs as the child models herself on the parents’ overt behaviors, their motives, and their aspirations for the child and thus how the child identifies with both maternal and paternal figures partly contributes to the development of one’s autonomous identity. The findings of the current study indicate that maternal and paternal identification is related to the constructs of attachment and separation-individuation; however, the significance of these associations requires further investigation into these developmental processes and their sequelae in adulthood.

Furthermore, contrary to expectation, the Emotional Independence subscale of the Psychological Separation Inventory did not load on the internalized working model of parental relations factor – i.e. for participants of the current study, emotional independence, or the freedom from need for approval, closeness, togetherness, and emotional support from the mother did not join conflictual independence, attachment, or separation-individuation pathology in characterizing women’s internalized representations of relationships and was not related to the self-representations of their sexual bodies or to their sexual desires. This finding is consistent with previous research that conflictual independence and not emotional independence was
related to adjustment in love relations while emotional adjustment was related to academic adjustment (Hoffman, 1984). Further, in a Belgian study of emerging adult women and men, ages 18-22, Geuzaine, Debruyne, and Liesns (2000) found that young women were less likely to be emotionally independent from their mothers compared to their male counterparts. The authors interpreted these findings through the developmental models proposed by Gilligan (1982), Surrey (1993) and Josselson (1987) who argue that relatedness and emotional dependence, rather than detachment, are essential for women’s development throughout their lives. Furthermore, conflictual independence subscale seems to capture more negative aspects of inadequate separation from the mother, including guilt, resentment, anger, and anxiety whereas emotional independence taps into women’s reliance on their mother’s support, advice, encouragement, and sense of togetherness, which appears to tap into a different aspect of object relations and possibly influence their capacity for love relations in a different way, which requires further investigation in future research.

**Phenomenology of Sexual Desire in Highly Sexual Women and Sexually Inhibited Women**

The qualitative semi-structured interviews with ten highly sexual women and ten sexually inhibited women focused on the phenomenology of sexual desire in women, capturing how women tend to experience their sexual desire, the objectives of their desires, as well as the factors that tend to excite and to inhibit female sexual desire. The aim of this portion of the study entailed gaining insight into how women in both groups conceptualize their sexual desires and elucidating differences in the personal narratives of desire between the two groups. The analysis of the interview narratives listened for the voice of sexual desire, the voice of relational desire, and the voice of bodily desire. While the voice of sexual desire focused on the presence, level, and quality of desire on a global level, the voice of bodily desire addressed women’s experiences
of bodily sensations and physical arousal (e.g. lubrication, tingling) as well as the wish for touch, skin-to-skin contact, and other stimulation while the voice of relational desire concerned women’s needs and wants for connection, intimacy, closeness and merger. Such distinctions in the listenings of these three voices allowed for a nuanced and multidimensional inspection of women’s experiences of desire such that some women endorsed the presence of sexual desire but denied its relational and/or bodily manifestation while others weaved in all three voices in their accounts of desire, demonstrating a certain degree of fragmentation or integration, respectively, in their phenomenology of sexual desire.

Overall, the narratives of highly sexual women seemed more homogenous than those of the sexually inhibited group – the former felt a sense of ownership and agency with respect to their desires, they perceived it as an important aspect of their identities as competent, adult women, and they derived tremendous satisfaction from being able to experience sexual desire, which is consistent with previous research on heightened female sexuality (Blumberg, 2003; Wentland et al., 2009). Further, the stories of the highly sexual women reflected a confluence of the bodily and relational aspects of their sexual desire, such that they largely tended to experience desire as both affective and physical sensations to fulfill their yearning for connection and physical gratification. For these women, their bodies are essential markers of their sexual desire and as such, physical sensations of arousal are not only enjoyable but also cherished experiences that are linked to their self-concept as competent, sexual, adult women. While the objective of their sexual desire is not necessarily merely physical, as will be discussed below, the highly sexual woman’s aroused body creates fertile ground for a relational and bodily expression of burgeoning desire.
The narratives of sexually inhibited women reflected a greater heterogeneity in the experience of sexual desire as some women completely lacked the capacity to experience sexual desire on both relational and bodily levels while others expressed a more fragmented sense of sexual desire such that they were unable to integrate the bodily, affective/cognitive, and relational components of their desires. While some of the sexually inhibited women also described bodily sensations as markers of their sexual desire, they often lacked awareness of these sensations or responded to them with feelings of distress, loneliness, anxiety or ambivalence. Several of the women in this group described feeling defective about their absent or low desires. Others characterized their desires as purely physical experiences devoid of relational needs or affects.

The narratives that emerged from the interviews are consistent with the findings from the quantitative portion of the study, which found a significant link between women’s appraisals of their sexual bodies and their sexual desire. The quantitative findings suggest that less desirous women have less positive sexual body esteem and genital self-image, and tend to self-objectify in a sexual context, which in turn inhibit their desire for partnered and solitary sexual activity, the affective and cognitive components of their sexual desire, and undermine their capacity for sexual self-reflection. While analyses of the interviews did not directly address how women’s feelings about their bodies related to their desire, the qualitative finding did indicate that highly sexual women tend to have powerful and pleasurable physical sensations that are integrated with their relational and affective experience of desire while sexually inhibited women are more distressed or less aware of their bodies in the context of desire. Addressing the inhibition of female sexual desire, Elise (2000, 2008) suggests that the deflation of female genitality, which stems from phallocentric, patriarchal gender dynamics, is inextricably linked to women’s
inhibited desires while empirical research on sexual subjectivity, self-objectification, sexual body
esteem, and genital self-image suggests that negative self-appraisal as well as monitoring of
one’s body may undermine women’s desires (Calogero & Thompson, 2009b; Fredrickson &
Roberts, 1997; Wiederman, 2000). Such distressing feelings about one’s sexual body as well as
the proclivity to observe rather than embody one’s body are likely to result in fragmentation of
one’s experience of desire, which is evident in the narratives of the sexually inhibited group. The
bodily experience of highly sexual women, on the other hand, plays a prominent, powerful, and
palpable counterpart to the relational, affective, and cognitive facets of their sexual wants, needs,
and yearnings.

The narratives that emerged from the interviews also delineated how both highly sexual
and sexually inhibited women characterize the objective, aim or motivation behind their sexual
desires. Notably, the two groups did not differ in the content of their responses, citing the
physical pleasure of orgasm, skin-to-skin contact, and penetration, as well as the relational
gratification of intimacy, closeness, and connectedness as the foremost needs and wants
epitomized by their sexual desires. However, while these two themes permeated the narratives of
the women in the highly sexual group, the sexually inhibited women again tended to show a split
in their capacity to derive physical and relational gratification through sexual activity. Some of
these women described incapacity to experience sexual pleasure while others sensed the physical
need for a sexual release but did not necessarily rely on sex as a conduit for connection and
intimacy. While highly sexual women perceived sexual activity as a unique way to establish an
intense connection with another, however fleeting it may be, the women in the inhibited group
acquiesced to sexual activity as a way to experience intimacy and closeness because that is what
their partners desired. Although they acknowledged that sexual engagement did offer an
opportunity to forge an intimate bond with another and to express love and affection, they indicated their preference for nonsexual ways of connecting.

Notably, the narratives of the highly sexual women portrayed sexual desire as a powerful wish for a temporary merger with another – a theme that did not emerge from the accounts of the inhibited group. They described the experience of “melting together”, “spiritual union,” “uniting” and “becoming something completely different” in elaborating on the objective of their desire. The theme of merger and transcendence of the boundaries of self through a sexual union echoes the conceptualization of sexual desire by psychoanalytic object relations theorists, such as Kernberg (1995), Stein (2008), and Benjamin (1988), among others, which was described in detail in the first chapter of this manuscript. In articulating the requisites for mature object relations, Kernberg (1995) defines erotic desire as the wish to fuse with a love object, transcending one’s boundaries while retaining the autonomy of self, which the highly sexual women articulate in their narratives of desire. It is interesting to consider these qualitative findings in the context of the quantitative results of the present study, which indicated that women who are more individuated from their mothers and who have a secure attachment style, indicating a capacity to balance autonomy and relatedness, are more likely to have positive bodily sexual self-concept and, in turn, have higher levels of sexual desire. It follows that an internalized sense of personal autonomy and positive working models of self and other would be essential characteristics of a highly sexual woman who would have the capacity to embody her sexual desire for a powerful, albeit, temporary merger with her love object.

Kernberg (1995) further maintains that sexual passion provides an opportunity for a restructuring of early object relations as the sexual union facilitates a resolution of oedipal conflicts through a new relational experience. Benjamin (1988) suggests that sexual desire
encapsulates the woman’s need for recognition in the intersubjective realm through the experience of merger with the other; Stein (2008) contends that overcoming separateness through a sexual union generates a restructuring of self and thus the sexual merger carries the transformative potential for the self as the old self shatters in its union with a love object. Several of the highly sexual women and one woman from the inhibited group similarly convey that sexual desire not only reflects their bodily and relational needs but also endows them with an opportunity to feel a sense of empowerment and ownership over their sexuality and their bodies. These women describe desiring the transformative potential of a sexual merger to imbue them with mastery, agency, and an integrated sense of self, and to repair the wounds of previous traumas in a sexual context. I would argue that, based on these findings and the theories of Kernberg (1995), Stein (2008) and Benjamin (1988), the highly sexual woman’s desire allows her to undergo a constant process of transformation towards greater integration of her object relations and her sense of self while the sexually inhibited woman, impeded by her absent or low desire, continues to struggle with deflated genitality and fragmented representations of self and other.

The interview narratives also revealed certain factors that tend to incite and inhibit women’s sexual desires, specifically in their accounts of exciting and disappointing sexual experiences. The highly sexual group indicated that the anticipation and novelty of new sexual experiences, a sense of mutuality of desire, as well as intense physical and emotional connection tended to enhance their desire while the lack of attunement and mutuality as well as a problematic relational dynamic with the partner diminished their desire. Research demonstrates that women are more likely to feel higher levels of sexual desire early in the relationship and that desire dwindles in long-term relationships (e.g. Perel, 2010). Esther Perel (2006), in *Mating in*
Captivity, suggests that the familiarity, safety, and closeness of long-term relationships squelch desire, which is fueled by novelty, danger, the unknown and the uncertain. Sexual desire as the wish for merger is predicated on the individual’s sense of autonomy within her relationship, as one cannot wish to merge with someone who is not already separate from her – desire requires distance. Novelty likely enhances such sense of separateness, which renders the potential for merger ever more desirable and exhilarating. Jessica Benjamin (1988) suggests that women’s need for mutuality and recognition underlie women’s desire to merge with another, in which the blurring of boundaries between self and other provide an opportunity to be truly known. Benjamin suggests that being recognized by the other allows the woman to experience herself as a separate and autonomous individual. The highly sexual women’s capacity for separateness and autonomy allows them to experience a sense of mutuality and connectedness, which ignites an immense yearning to temporarily transcend the boundaries between self and other, to fuse with her partner, and to feel recognized and known by him.

While some of the women in the inhibited group also referred to novel or mutually connected sexual experiences that incited higher desire, many reported absent or deflated desire to be sexual. The themes of inhibition that emerged from the narratives included traumatic sexual experiences, including nonconsensual sex and physically painful first sexual encounters, as well as the feeling of objectification by self and other in a sexual context. Previous research has indicated that inhibited sexual desire is multidetermined and that trauma, especially sexual trauma, is likely to result in low or absent desire (Clayton, 2003; Kinzl, Traweger, & Biebl, 1995). Other previously illustrated correlates of diminished desire includes sexual difficulties, such as an incapacity to experience physiological arousal, orgasmic difficulties, and sexual pain, which also were evident in the narratives of the inhibited group (Cherner & Reissing, 2013;
Multiple women expressed anxiety about being overpowered by the desire of the other, suggesting their lacking sexual subjectivity and the internalized objectifying gaze. As mentioned earlier in this section and argued by multiple theorists and researchers in the field of sexuality, including Tolman (2002), Benjamin (1988), Horne and Zimmer-Gembeck (2006), sexual subjectivity is part and parcel of sexual desire – one needs to be able to not only feel herself to be the object of another’s desire but to be the subject of her own desire. The absence of subjectivity is pervasive in the narratives of sexually inhibited women. They do not feel agentic. They are powerless. They monitor the desire of the other and cannot embody their own. Without access to their own desires, in their position as object rather than subject, these women do not have the opportunity to experience mutuality or a sense of attunement and recognition that is described by the highly sexual group. This finding is consistent with the quantitative results of the present study as well as with the theory of objectification posited by Frederickson and Roberts’ (1997), which indicates that (self-) objectification undermines multiple aspects of women’s wellbeing, including that of sexual functioning and desire. As demonstrated by the current quantitative findings, women’s early relational experiences are implicated in women’s physical sexual self-concept through which they also play an important role in adult sexual desire. Women who are struggling with insecure attachment and separation-individuation difficulties are more likely to harbor negative sexual body esteem and to self-objectify in a sexual context, resulting in a compromised capacity to embody one’s body and therefore diminished or absent desire.

While sexually inhibited women struggle with integrating the physical and the emotional, their bodily needs for touch and physical pleasure and their relational wants for intimacy and closeness, as well as romantic love and eroticism, highly sexual women articulate sexual desire
as both an expression of bodily cravings and of relational yearnings. For highly sexual women, connectedness is the impetus, the spark and the outcome of their desires. At the same time, the relational is not divorced from the bodily, as it is for the sexually inhibited women, for the physical experience of sexual desire appears to be inextricably linked to the wish for closeness, connectedness, and intimacy in the highly desirous narratives, which integrate the cognitive-emotional and the bodily aspects of sexual desire. Finally, the narratives of women’s sexual desires demonstrate that sexual desire is as much about the capacity for mutuality as it is about possessing a sense of agency. Sexually inhibited women feel objectified, victimized and disempowered while highly sexual women experience a sense of agency and ownership with respect to their sexuality and sexual desire. Craving pleasure, intimacy, connection, transformation, and aliveness on both bodily and psychic levels, highly sexual women feel entitled to pursue the object of their desires – they are the subjects of their own desires.

**Implications of the Current Study Findings for the Field of Female Sexuality**

The purpose and findings of the current study are relevant to the study of female sexuality and sexual disorders and treatments. Previous epidemiological studies have shown that low or absent sexual desire is the most common and often most distressing sexual disorder in women (Bancroft et al., 2003; Laumann et al., 1999; Shifren et al., 2008; West et al., 2008). Population studies of the two primary symptoms of hypoactive sexual desire – decreased desire for sexual activity and sexually related distress – demonstrated that up to 15% of U.S. women endorse this combination of symptoms (Bancroft et al., 2003; Leiblum et al., 2006; Lindau et al., 2007; Rosen et al., 2009; Shifren et al., 2008). A recent study of the prevalence of hypoactive sexual desire disorder (according to DSM-IV-R), using self-report and a structured in-person diagnostic interview in clinic-based samples of 701 U.S. women found that almost 30% of
women endorsed the presence of decreased or low desire with accompanying distress (Rosen et al., 2012). However, half of these women did not meet criteria for the HSDD diagnosis, because their low desire or distress was better accounted for by another medical or psychiatric condition, side effects of prescription or non-prescription drugs, or stress and relationship factors. The authors found that the overall prevalence of generalized, acquired HSDD is 7.4%.

Although epidemiological research on sexual desire problems retains certain methodological problems that may overestimate the prevalence of desire disorders in women (as described in the introduction), it clearly remains a major sexual difficulty for women, such that women with decreased desire and sexually related distress tend to exhibit higher rates of depression, lower quality of life, and less sexual and relationship satisfaction (Dennerstein et al., 2006; Leiblum et al., 2006). Further, over 40% of women with symptoms of low desire and associated distress seek treatment for their sexual problems. In this way, investigations into the factors that may contribute to lower sexual desire in women are essential to inform and improve the quality of treatment of female sexual disorders, which is necessary to enhance women’s mental health, relationship satisfaction, and their overall quality of life.

The current study has two important clinical implications for the treatment of desire difficulties in women. First, the findings indicate that women’s internalized working models of early parent-child relations, specifically their attachment styles and the level of separation-individuation pathology and sense of nonconflictual independence from their mothers, are fundamental to understanding the origins of female sexual inhibition. In this way, attachment-and/or object relations-based psychotherapy would benefit women struggling with sexual problems, specifically those related to desire.
Further, sexuality does not exist merely in the realm of the mind but also in the body. The ways, in which women embody, experience, and perceive their bodies are inextricably linked to their experience of their sexuality, and specifically, to their sexual desires. Current findings emphasize the importance of focusing on women’s bodies in the treatment of sexual desire difficulties – not merely on their body image but on the sexual aspects of their bodies, on their capacity to embody their bodies, on their sexual body esteem, and on their tendency to monitor their bodies during sexual activity, which interferes with sexual functioning and may result in dissociative experiences. Further, the qualitative findings suggest that highly sexual women tend to integrate the bodily, affective, cognitive and relational facets in their experiences of sexual desire while sexually inhibited women’s narratives of desire are more fragmented and disjointed, splitting off the physical from the relational.

Psychotherapy has historically focused on patient’s verbal narratives while largely pushing the bodily manifestations of psychopathology or of personal experience to the margins of the therapeutic focus. Although sexology has historically integrated bodily-based approaches (e.g. sensate focus techniques) into the treatment of sexual disorders, clinical approaches to female sexual dysfunctions require further consideration of the mind-body link. For example, Brotto and colleagues (Brotto, Krychman, & Jacobson, 2008) propose yoga and mentalization treatments that can enhance the mind-body connection and foster spirituality in enhancing women’s sex lives. Although there is a dearth of empirical studies on the impact of yoga on women’s sexual functioning or sexual satisfaction, the authors indicate that the techniques of fostering body-mind connection have existed in the field of sexology since the 1960s (Tiefer, 2006). The findings of the current study support the reintegration of bodily-based interventions
into clinical practice and demonstrate the need for further development of theory and controlled studies of such treatments for improving women’s sexual functioning.

Suzanne Iasenza, a psychoanalyst, a couples therapist, and a sex therapist, proposes an integrative approach to addressing sexual problems that resonates with the findings of the current study (Iasenza, 2010). She suggests that working with complex sexual issues necessitates the integration of multiple theoretical perspectives, including psychoanalytic, systemic, and cognitive behavioral schools, and the incorporation of clinical interventions that operate on multiple levels of patients’ experience including “the cognitive, affective, behavioral, somatic and discursive realms” (p. 292). To this end, the therapist takes on multiple roles of “co-creator of safety, interviewer, sex educator, sexual detective, empathic listener, co-meaning-maker, hypothesis generator, coach, witness, sex-affirmative parent, and assignment-giving teacher” (p. 306). In proposing an integrative therapy to address sexual problems, Iasenza suggests utilizing therapeutic sexual history-taking, mindfulness sensate focus, as well as deconstructing the meaning of sex with patients. The sexual history-taking facilitates the exploration of childhood dynamics, such as the internalized parental couple, attachment patterns, erotic templates developed in early life, as well as how the sexual problem may represent a repetition of a painful past in the service of reparation and mastery. In deconstructing sex, Iasenza instructs her patients on different types of sexual response cycles (e.g. Basson) to expand their framework of acceptable sexuality that may not always start with desire but ignite desire in the course of a sexual engagement, and asks them to generate lists of desired sexual acts, which she normalizes in the course of the therapy. Iasenza also adapts the technique of sensate focus, which is a progressive touching exercise that was developed by Masters and Johnson who believed that a fundamental source for sexual dysfunction was spectatoring (observing what one is doing instead
of experiencing it). She adapts sensate focus as a sexual meditation practice with the aim of enhancing sexual presence, comfort and connection by asking patients to tune into their thoughts, feelings, and bodily sensations while touching in order to bring mindful presence and thus foster desire for expansive sexual experiences.

While Iasenza applies her integrative sex therapy in her work with couples, her approach can be adapted to working with individuals who are struggling with sexual difficulties, such as disorders of desire. The sexual history-taking that she describes involves the exploration of the conscious and unconscious dynamics that address issues around attachment, separation-individuation and internalized erotic templates laid down in childhood in the context of early relational experiences. Further, her mindfulness-based sensate focus indicates the importance of gradually exploring one’s body, learning its desires, pleasures, and displeasures, and developing the capacity to embody one’s body in a sexual context by fostering one’s ability to remain present and tuned into both mind and body. Importantly, Iasenza calls for therapists to aid patients in expanding their definitions, frameworks, and practices in the realm of sexuality as a way to account for the fluidity and multidimensionality of sex and gender. The current study findings implicate both early relational experiences as well as physical sexual self-concept in inhibiting and enhancing sexual desire and underscore the importance of helping women to not only be the object of another’s desire but to be the subject of their own desire. Further, the findings suggest that the physical sexual self-concept is one of the mechanisms through which early relational experiences transmit certain erotic templates, both inhibiting and enhancing, into adult sexuality. Just as the etiology of female sexual dysfunction is multidetermined, its treatment too requires a multifaceted approach and thus intervening at the level of psyche and soma is integral to the treatment of disorders of desire in women.
Limitations of the Study

The current study contains several limitations in its methodology and findings. This study was in certain ways an exploratory study because the constructs and measures incorporated into the model have not been configured in such relationships in previous research. As a result, the factor loadings did not resolve in a predicted pattern as discussed above.

Although the current study had a large sample of close to 600 participants who completed the study, recruitment involved a self-selection bias, which may have drawn women who are more comfortable in or even derive pleasure from disclosing issues about their sexuality. As discussed in the results, the sample was relatively young, not very religious, relatively sexually active, and unmarried. As such, this sample may not be representative of the general population of U.S. women. Nonetheless, the exclusion criteria did eliminate women who suffered from certain medical conditions that are known to affect sexual functioning so as not to confound the results of this study. Further, the quantitative analyses controlled for multiple confounding variables including socioeconomic status, education, religion, medical problems and psychopathology, and excluded participants who were high on the hypersexuality (pathological heightened sexuality) measure.

Another limitation of this study in terms of extending our understanding of female sexuality and generalizability of findings is that the sample excluded women who identified as lesbian or bisexual. While the purpose of the exclusion criteria was to reduce variability and eliminate confounding variables associated with sexual orientation, it is important to study women in their totality to properly address female sexuality and sexual desire. The elimination of non-heterosexual women from the study sample points to a larger issue in the literature, for the psychoanalytic theory that forms the basis of this study is based on heterosexual women and
specifically addresses women’s desires for a man. In her research on female sexual fluidity in approximately 100 young women (acknowledged by author as not a fully representative sample), Lisa Diamond (2009) demonstrates that women may experience sexual desire in response to the person rather than a specific gender and that women’s sexual gender preferences may shift throughout their lifetime, indicating that for women the heterosexual/homosexual divide is not always fixed as has been posited for men. While I would argue that the factors that inhibit and/or enhance sexual desire in women would differ in certain ways as a function of women’s gender preferences (which is beyond the scope of the current study), much of the psychoanalytic theories on female sexual inhibition address specifically women’s sexual desires for a man and thus a large gap in the literature that remains concerns not only women who desire men, but also women who desire women, and women who desire both men and women.

Another limitation concerns the length of the survey, which contained over 350 items and required 30-60 minutes to complete. As a result, there was a moderate attrition rate of about 40% and the final sample that was included in the analyses was slightly over 50% of the consented and eligible participants due to missing data. Although the completers and non-completers did not differ significantly on most of the demographics, they may have varied on other variables that were not considered in this study. For example, although a high percentage of the participants reported being in a committed relationship, the length of these relationships was not assessed, which could have confounded the results since relationship length has been found to be negatively correlated with the level of sexual desire in women (Rosen et al., 2012).

Since a major finding of the current study concerned women’s perceptions of their sexual bodies, future studies should focus on refining the measures that would assess this aspect of women’s sexual functioning. For example, future studies should include measures of self-
appraisal of sexual competence/prowess, ability to satisfy one’s own and partner’s sexual needs, and awareness/knowledge of one’s sexual body (e.g. erogenous zones) to assess the mediator between internalized working models of relationships and sexual desire. Further, in addition to assessing self-objectification as body image self-consciousness in a sexual context as was done in the current study, future research should incorporate a global measure of self-objectification to address the role of the social context in female sexuality, which would round out the dynamic and relational perspectives that are addressed in the present study.

The interview portion of the study contained a relatively small sample. Further, the interview portion of the study, which is an intimate and exposing endeavor, likely, attracted a very specific group of women who feel comfortable in talking about their sexuality. Of note, some of the women indicated that they do not usually have the opportunity to talk about their sexuality and sexual desire, and that they chose to participate in the study, because they were interested in understanding themselves and/or wanted to contribute to the field of female sexuality. An important demographic difference between the two groups is that African American women accounted for a proportionally larger portion of the sample in the inhibited group (40%) than in the highly sexual group (10%). Although the sample is quite small and therefore the current results cannot be generalized, this finding is consistent with the research of Laumann and colleagues (1999) who found that African-American women tend to experience less sexual desire and less sexual pleasure than White women.

Additionally, 30% of the participants (three in each group) endorsed a psychiatric condition, including depression, an eating disorder, and anxiety and four women (two in each group) reported taking psychiatric medications, such as an antidepressant. Importantly, these diagnoses were not assessed in the study and are based solely on the self-report of the
participants. Sexual problems have been linked to both psychiatric conditions as well as psychiatric medications, such as SSRIs, (Meston & Bradford, 2007) and therefore, it is important to consider the interplay between these women’s experiences of their desire and the diagnoses that they carry and the medications that they take. Interestingly, three of the women in the highly sexual group reported taking SSRIs, which challenges previous research findings that have shown that SSRIs result in diminished libido. In the sexually inhibited group, all of the women who endorsed taking psychiatric medications indicated that their low desire preceded the initiation of the medication. Further, it is possible that the psychological disturbance contributed to either increased or decreased desire in both groups; however, this was not adequately examined in the current study. The symptomatology of the diagnoses was not assessed by the researcher or verified by collaterals, such as medical records; the diagnoses are based solely on self-report and thus it is not possible to know whether or not the participants were symptomatic at the time of the interviews. Further, the interview prompts did not address women’s experiences of their desire in the context of their psychological difficulties. Although the interviews did address participants’ history, it did not obtain a comprehensive developmental history, including a trauma history and object relations history, which would have shed more light on their current sexual functioning.

Additionally, the interview did not aim to provide an exhaustive list of the objectives of sexual desire or the factors that tend to inhibit or excite sexual desire but to highlight some recurring themes in women’s narratives of heightened and inhibited sexual desire. Another limitation concerned the analysis of the interviews, which was conducted by only one reader and thus inter-rater reliability was impossible to establish.
Conclusion and Future Directions

The present study aimed to add to the literature on female sexuality, specifically in the realm of desire, and to continue to answer and expand upon Freud’s “great question that has never been answered and which I have not yet been able to answer, despite my thirty years of research into the feminine soul, is ‘What does a woman want?’” (Freud & Strachey, 1925). Although we have elaborate theory about female sexual inhibition, which suggests that low or absent sexual desire is the default position for women, and abundant empirical investigations into the prevalence, diagnostics, etiology and treatment of disorders of sexual desire, scholarship is scarce on why some women experience sexual desire, at times, at heightened levels, while others report decreased or lacking desire. While decreased desire is quite prevalent among women, many women experience healthy levels of sexual desire. The findings of the present study indicate that these women exhibit agency and ownership with respect to their sexuality, place great value on their sexual lives, and are able to embody their bodies as sexual beings. While research into low desire is quite important for both empirical and clinical purposes, the study of healthy and vibrant sexuality in women constitutes an important, albeit, neglected domain of the study of female sexuality.

The present findings highlight the importance of investigating the problems of sexual desire in the context of early relational experiences. Further, sexual desire does not merely exist in the realm of the psyche but also in the body and thus explorations of the nature of sexual desire should take into account women’s experiences of their bodies, especially in a sexual context. Finally, the qualitative approach to the study of sexual desire is a valuable tool to examine the phenomenology of desire and future research also should assess and examine attachment styles (e.g. Adult Attachment Interview (AAI); (George, Kaplan, & Main, 1996) and
the level of object relations (e.g. Object Relations Interview (ORI); (D. Diamond, Blatt, Stayner, & Kaslow, 2011) as they relate to women’s narratives of their experiences of sexual desire.

The clinical implications of the current study emphasize the importance of exploring internalized representations of parental relations in women who are struggling in the sexual domain of their lives. Specifically, therapeutic assessments and interventions for women with inhibited sexuality should focus on resolving conflicts with respect to internalized object relations and repairing attachment related traumas. In other words, enhancing patients’ attachment security and a sense of individuated and autonomous identity may help women to develop the capacity for sexual subjectivity so that they can take ownership and exercise agency with respect to their sexual desires and embody their bodies in a sexual context. Further, clinical modalities that foster mind-body integration also are essential addressing issues of low or absent sexual desire in women.

The findings of current study thus indicate that women are diverse in their sexual wants, needs, and longings – they want to feel connected and attuned to, they want to transcend the boundaries of self through the fleeting merger of a sexual union, they want to experience bodily pleasure and satisfaction, they want to feel empowered and recognized. Importantly, in order for women to have access to and embody their desires, they require the capacity to be agents of their sexuality and their sexual bodies, which is contingent on one’s sense of autonomy and integrity of self and positive representations of self and other.
APPENDIX I

PRE-STUDY SCREENING QUESTIONNAIRE

PLEASE COMPLETE THE FOLLOWING ANONYMOUS QUESTIONNAIRE TO DETERMINE IF YOU ARE ELIGIBLE TO PARTICIPATE IN THIS STUDY.

1. Your biological sex is?
   Male
   Female
   Other

2. Your age is ______________________

3. What is your sexual orientation?
   Heterosexual/Straight
   Homosexual/Gay/Lesbian
   Bisexual
   Other

4. Are you pregnant?
   No
   Yes

5. Are you nursing?
   No
   Yes

6. Have you ever been diagnosed with any of the following medical conditions? (check all that apply)
   None
   Diabetes
   Thyroid disorder
   Cardiovascular disease
   Neurological disease
   Stroke
   Cancer
   Amenorrhea
   Polycystic Ovarian Syndrome (PCOS)
   Hyperprolactinaemia or hyperprolactinemia (HP)
   Congenital adrenal hyperplasia (CAH)
   Turner Syndrome

7. Have you ever been diagnosed with any of the following psychological or psychiatric conditions? (check all that apply)
None
Depressive disorder
Anxiety disorder
Panic disorder
Posttraumatic stress disorder
Eating Disorder
Sleep Disorder
Substance abuse/dependence disorder
Bipolar disorder
Personality disorder
Schizophrenia
Psychosis

8. Can you speak, understand, and read in English?
No
Yes
APPENDIX II

DEMOGRAPHICS QUESTIONNAIRE

THE FOLLOWING QUESTIONS WILL ASK YOU TO PROVIDE SOME BACKGROUND INFORMATION ABOUT YOU.

1. What is your date of birth?

2. What is your race or ethnicity?
   African-American, Non-Latino
   Hispanic/Latino
   Asian
   Native American
   White/Caucasian, None-Latino
   Other

3. What is your annual household income?
   $0-25,000
   $25,001-50,000
   $50,001-75,000
   $75,001-100,000
   More than $100,000

4. Are you?
   In School – part-time
   In School – full-time
   Not in school

5. Are you?
   Employed – part-time
   Employed – full-time
   Unemployed
   Disabled

6. What is your highest level of education?
   High School/GED
   Associate’s Degree/2-year college degree
   BA/BS
   MA/MS/MBA or any other Master’s level degree
   JD/MD/PhD/Other PhD program

7. Which of the following best describes your religion?
   Roman Catholic
   Protestant
   Other Christian
   Hindu
   Jewish
   Buddhist
Muslim
Atheist/None
Agnostic
Other

8. How religious are you?
Not at all
A little bit
Moderately
Quite a bit
Extremely

9. What best describes your present relationship status: (Please select one)
Uninvolved
Seeing more than one person, not living together
Seeing more than one person and living with one or more of them
Seeing someone exclusively, not living together
Seeing someone exclusively, living together

10. Are you legally?
Married
Divorced
Separated
Single

11. Do you have children?
No
Yes

MEDICAL, PSYCHIATRIC, AND SEXUAL HISTORY QUESTIONNAIRE

THE FOLLOWING QUESTIONS WILL ASK YOU TO PROVIDE SOME INFORMATION ABOUT YOUR MEDICAL, PSYCHIATRIC AND SEXUAL HISTORY.

1. Your height is______________________

2. Your weight is_______________________

3. Are you taking any medications?
None
Antidepressant (for example, Cefexa, Effexor, Cymbalta, Wellbutrin, Zoloft, Prozac, Paxil, Lexapro, Abilify, Seroquel)
Antihypertensives (medications for high blood pressure)
Other

4. Have you ever given birth?
No
Yes, vaginally
Yes, by Cesarean section
Yes, both vaginally and by cesarean section

5. Have you ever had genital surgery?
   No
   Yes (please specify) __________________________

6. Have you ever had sexual intercourse with
   Man
   Woman
   Neither
   Both

7. Have you ever had penile-vaginal sexual intercourse?
   No
   Yes

8. How old were you the first time you had penile-vaginal sexual intercourse?
   _________

9. With approximately how many people have you had penile-vaginal sexual intercourse in your lifetime?
   ______________

10. When was the last time you had sex?
    Today
    within the last week
    within the last month
    within the last 6 months
    within the last year
    more than a year ago

11. If you have sex monthly, how many times per month do you have sexual intercourse?
    Never
    1-5 times
    6-10 times
    11-15 times
    16-20 times
    More than 20 times

12. How often do you have an orgasm during sex?
    Never
    Rarely
    Some of the time
    Most of the time
    All of the time

13. Have you ever masturbated?
No
Yes

14. If yes to #13, How many times per week do you masturbate?
Never
1-5 times
6-10 times
11-15 times
16-20 times
More than 20 times

15. Have you ever been diagnosed with the following? (check all that apply)
None
Hypoactive Sexual Desire Disorder
Female Sexual Aversion Disorder
Female Sexual Arousal Disorder
Female Orgasmic Disorder
Vaginismus
Dyspareunia

16. How old are you?

SEXUALITY SCREEENER

THE FOLLOWING QUESTIONS WILL ASK YOU ABOUT YOUR FEELINGS AND ATTITUDES ABOUT YOUR SEXUALITY. PLEASE READ EACH QUESTION CAREFULLY AND RESPOND AS TRUTHFULLY AS POSSIBLE.

1. I have a huge appetite for sex
2. I feel distressed about my sex life
3. It is not easy for me to go weeks without having sex with another person
4. I feel I want sex more than most people
5. I enjoy reading erotic or sexually explicit stories that turn me on, and/or looking at erotic or sexually explicit images that turn me on, and/or watching erotic or sexually explicit videos that turn me on
6. I feel worried about sex
7. I feel inferior because of sexual problems
8. I would find it exciting to engage in sex with more than one person at the same time (e.g., a threesome)
9. I don't daydream about sexual situations.
10. I feel guilty about sexual difficulties
11. When it comes to sex, I am willing to try almost anything
12. Having sex in different settings than usual (e.g., outside the bedroom) and/or having sex in public is a real turn on for me
13. I hardly ever fantasize about having sex.
14. I feel embarrassed about sexual problems
15. I feel regrets about my sexuality
16. I enjoy being tied up during sex
17. I enjoy tying up a partner during sex
18. I don't think about sex very often.
19. I like using vibrators and/or other sexual toys by myself
20. I like using vibrators and/or other sexual toys with a partner
21. I feel stressed about sex
22. I feel comfortable having sex while I have my period
23. I enjoy fantasizing about sex
24. Fantasizing about sex can quickly get me sexually aroused
25. I fantasize about having sex often
26. I think about sex (a lot)
27. I feel that I think about sex more than other women do
28. My sexual fantasies become sexually explicit very quickly
29. I really enjoy masturbating to orgasm
30. I feel sexually inadequate
31. I enjoy touching myself during sex
32. I am comfortable engaging in sexual activities on a 1st date with a new partner
33. I enjoy sex even when I am not in love with a partner
34. I consider having different sex partners to be sexually enjoyable
35. If I am sexually attracted to someone, I don’t need to be in a relationship with that person to enjoy having sex
36. I am comfortable approaching a new partner for sex
37. I feel frustrated by my sexual problems
38. I think of myself as a highly sexual woman, sex is often on my mind, and it is an aspect of myself that strongly and frequently affects my behavior, life choices, and quality of life satisfaction.
39. I typically desire sexual stimulation, usually to the point of orgasm, with myself or a partner, six to seven times per week or more and act upon that desire

Never
Almost Never
Rarely
Sometimes
Often
Very Often
Always

RELATIONSHIP STRUCTURES (ECR-RS) QUESTIONNAIRE

THIS QUESTIONNAIRE IS DESIGNED TO ASSESS THE WAY IN WHICH YOU MENTALLY REPRESENT IMPORTANT PEOPLE IN YOUR LIFE. YOU’LL BE ASKED TO ANSWER QUESTIONS ABOUT YOUR PARENTS, YOUR ROMATNIC PARTNERS, AND YOUR BEST FRIEND. PLEASE INDICATE THE EXTENT TO WHICH YOU AGREE OR DISAGREE WITH EACH STATEMENT BY CHOOSING A NUMBER FOR EACH ITEM.

---------------------------------------------------------------------------------
PLEASE ANSWER THE FOLLOWING QUESTIONS ABOUT YOUR MOTHER OR A MOTHER-LIKE FIGURE.
---------------------------------------------------------------------------------

1. It helps to turn to this person in times of need.
2. I usually discuss my problems and concerns with this person.
3. I talk things over with this person.
4. I find it easy to depend on this person
5. I don't feel comfortable opening up to this person.
6. I prefer not to show this person how I feel deep down.
7. I often worry that this person doesn't really care for me.
8. I'm afraid that this person may abandon me.
9. I worry that this person won't care about me as much as I care about him or her.

strongly disagree
1
2
3
4
5
6
7

strongly agree

PLEASE ANSWER THE FOLLOWING QUESTIONS ABOUT YOUR FATHER OR A FATHER-LIKE FIGURE.

1. It helps to turn to this person in times of need.
2. I usually discuss my problems and concerns with this person.
3. I talk things over with this person.
4. I find it easy to depend on this person.
5. I don't feel comfortable opening up to this person.
6. I prefer not to show this person how I feel deep down.
7. I often worry that this person doesn't really care for me.
8. I'm afraid that this person may abandon me.
9. I worry that this person won't care about me as much as I care about him or her.

strongly disagree
1
2
3
4
5
6
7

strongly agree

PLEASE ANSWER THE FOLLOWING QUESTIONS ABOUT YOUR DATING OR MARITAL PARTNER.

Note: If you are not currently in a dating or marital relationship with someone, answer these questions with respect to a former partner or a relationship that you would like to have with someone.

1. It helps to turn to this person in times of need.
2. I usually discuss my problems and concerns with this person.
3. I talk things over with this person.
4. I find it easy to depend on this person.
5. I don't feel comfortable opening up to this person.
6. I prefer not to show this person how I feel deep down.
7. I often worry that this person doesn't really care for me.
8. I'm afraid that this person may abandon me.
9. I worry that this person won't care about me as much as I care about him or her.

strongly disagree
1
2
3
4
5
6
7

strongly agree

S-I INVENTORY

PLEASE RATE TO WHAT EXTENT YOU AGREE WITH THE FOLLOWING STATEMENTS:

1. When people really care for someone, they often feel worse about themselves.
2. When someone gets too emotionally close to another person, they often feel lost.
3. When people really get angry at someone, they often feel worthless.
4. It is when people start getting emotionally close to someone that they are most likely to get hurt.
5. People need to maintain control over others to keep from being harmed.
6. I find that people seem to change whenever I get to know them.
7. It is easy for me to see both good and bad qualities that I have at the same time.
8. I find that people either really like me or they hate me.
9. I find that I really vacillate between really liking myself and really disliking myself.
10. I find that others often treat me as if I am just there to meet their every wish.
11. When I am by myself, I feel that someone is missing.
12. I need other people around to not feel empty.
13. I sometimes feel that part of me is lost whenever I agree with someone else.
14. Like others, whenever I see someone I really respect and to whom I look up, I often feel worse about myself.
15. I find it easy to see myself as a distinct individual.
16. Whenever I realize how different I am from my parents I feel very uneasy.
17. In my experience, I almost always consult my mother before making an important decision.
18. I find it relatively easy to make and keep commitments to other people.
19. I find that, when I get emotionally close to someone, I occasionally feel like hurting myself.
20. I find that either I really like someone or I can’t stand them.
21. I often have dreams about falling that make me feel anxious.
22. I find it difficult to form mental pictures of people significant to me.
23. I have on more than one occasion seemed to wake up and find myself in a relationship with someone and not be sure of how or why I am in the relationship.
24. I must admit that, when I feel lonely, I often feel like getting intoxicated.
25. Whenever I am very angry with someone, I feel worthless.
26. If I were to tell my deepest thoughts, I would feel empty.
27. In my experience, people always seem to hate me.
28. Whenever I realize how similar I am to my parents, I feel very uneasy.
29. Often, when I am in a close relationship, I find that my sense of who I am gets lost.
30. I find it difficult for me to see others as having both good and bad qualities at the same time.
31. I find that the only way I can be me is to be different from other people.
32. I find that when I get emotionally too close to someone, I sometimes feel that I have lost a part of
   who I am.
33. Whenever I am away from my family, I feel very uneasy.
34. Getting physical affection itself seems more important to me than who gives it to me.
35. I find it difficult to really know another person well.
36. I find that it is important for me to have my mother’s approval before making a decision.
37. I must admit that whenever I see someone else’s faults I feel better.
38. I am tempted to try to control other people in order to keep them close to me.
39. I must admit that whenever I get emotionally close to someone I sometimes want to hurt them.
   Strongly disagree
   Disagree
   Somewhat disagree
   Somewhat agree
   Agree
   Strongly agree

PSYCHOLOGICAL SEPARATION INVENTORY (PSI), MATERNAL SCALE

THE FOLLOWING LIST OF STATEMENTS DESCRIBES DIFFERENT ASPECTS OF
PEOPLE’S RELATIONSHIPS WITH THEIR MOTHER. PLEASE RATE HOW WELL EACH
STATEMENT APPLIES TO YOU FROM “NOT AT ALL TRUE OF ME” TO “VERY TRUE
OF ME”. IF THE STATEMENT DOES NOT APPLY ENTER “1”.

1. I like to show my friends pictures of my mother.
2. Sometimes my mother is a burden to me.
3. I feel longing if I am away from my mother for too long.
4. I feel like I am constantly at war with my mother.
5. I blame my mother for many of the problems I have.
6. I wish I could trust my mother more.
7. My mother is the most important person in the world to me.
8. I have to be careful not to hurt my mother’s feelings.
9. I wish that my mother lived nearer so I could visit her more frequently.
10. I sometimes feel like I’m being punished by my mother.
11. Being away from my mother makes me feel lonely.
12. I wish my mother wasn’t so over protective.
13. I wish my mother wouldn’t try to manipulate me.
14. I wish my mother wouldn’t try to make fun of me.
15. I sometimes call home just to hear my mother’s voice.
16. I feel that I have obligations to my mother that I wish I didn’t have.
17. My mother expects too much from me.
18. I wish I could stop lying to my mother.
19. While I am home on a vacation I like to spend most of my time with my mother
20. I often wish that my mother would treat me more like an adult.
21. After being with my mother for a vacation I find it difficult to leave her.
22. I am often angry at my mother.
23. I like to hug and kiss my mother.
24. I hate it when my mother makes suggestions about what I do.
25. I decide what to do according to whether my mother will approve of it.
26. Even when my mother has a good idea I refuse to listen to it because she made it.
27. When I do poorly in school/work I feel I’m letting my mother down.
28. I wish my mother wouldn’t try to get me to take sides with her.
29. My mother is my best friend.
30. I argue with my mother over little things.
31. I seem to be closer to my mother than most people my age.
32. My mother is sometimes a source of embarrassment to me.
33. Sometimes I think I am too dependent on my mother.
34. I am sometimes ashamed of my mother.
35. I care too much about my mother’s reactions.
36. I get angry when my mother criticizes me.
37. My attitudes regarding sex are similar to my mother’s
38. I sometimes feel like an extension of my mother.
39. When I don’t call my mother often enough I feel guilty.
40. I feel uncomfortable keeping things from my mother.
41. I often have to make decisions for my mother.
42. I’m not sure I could make it in life without my mother.
43. I sometimes resent it when my mother tells me what to do.

Not at all
A little bit
Moderately
Quite a bit
Very

SEMANTIC DIFFERENTIAL

PLEASE RATE A SERIES OF WORDS ACCORDING TO HOW THEY RELATE TO YOU SPECIFICALLY. PLEASE CHOOSE THE NUMBER THAT BEST DESCRIBES YOU BASED ON THE WORD PAIRS. THE SCALE IS TO BE UNDERSTOOD AS FOLLOWS:

For example:
Good 1 2 3 4 5 6 7    Bad
1 represents “extremely good”
2 represents “very good”
3 represents “slightly good”
4 represents “equally good and bad”
5 represents “slightly bad”
6 represents “very bad”
7 represents “extremely bad”

CHOOSE ONE NUMBER FOR EACH WORD PAIR AND DON’T SKI EP ANY

MYSELF

Good
1
2
3
4
5
<table>
<thead>
<tr>
<th></th>
<th>Bad</th>
<th>Cruel</th>
<th>Kind</th>
<th>Fair</th>
<th>Unfair</th>
<th>Honest</th>
<th>Dishonest</th>
<th>Strong</th>
<th>Cowardly</th>
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</tr>
</tbody>
</table>
7
Brave

Humorous
1
2
3
4
5
6
7

Serious

Violent
1
2
3
4
5
6
7

Gentle

Passive
1
2
3
4
5
6
7

Active

Tense
1
2
3
4
5
6
7

Relaxed

Calm
1
2
3
4
5
6
7
Excitable

Definite
1
2
3
4
5
6
7

Uncertain

PLEASE RATE A SERIES OF WORDS ACCORDING TO HOW THEY RELATE TO YOUR FATHER SPECIFICALLY. PLEASE CHOOSE THE NUMBER THAT BEST DESCRIBES HIM BASED ON THE WORD PAIRS. THE SCALE IS TO BE UNDERSTOOD AS FOLLOWS:

For example:

Good 1 2 3 4 5 6 7 Bad
1 represents “extremely good”
2 represents “very good”
3 represents “slightly good”
4 represents “equally good and bad”
5 represents “slightly bad”
6 represents “very bad”
7 represents “extremely bad”

CHOOSE ONE NUMBER FOR EACH WORD PAIR AND DON’T SKIP ANY

MY FATHER

Good
1
2
3
4
5
6
7

Bad

Cruel
1
2
3
4
5
6
7

Kind
Fair
1
2
3
4
5
6
7
Unfair

Honest
1
2
3
4
5
6
7
Dishonest

Weak
1
2
3
4
5
6
7
Strong

Cowardly
1
2
3
4
5
6
7
Brave

Humorous
1
2
3
4
5
6
7
Serious

Violent
PLEASE RATE A SERIES OF WORDS ACCORDING TO HOW THEY RELATE TO YOUR MOTHER SPECIFICALLY. PLEASE CHOOSE THE NUMBER THAT BEST DESCRIBES
HER BASED ON THE WORD PAIRS. THE SCALE IS TO BE UNDERSTOOD AS FOLLOWS:

For example:

<table>
<thead>
<tr>
<th>Good</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>Bad</th>
</tr>
</thead>
<tbody>
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<td>representing “extremely good”</td>
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<td>representing “slightly good”</td>
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<td>4</td>
<td>representing “equally good and bad”</td>
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<td>5</td>
<td>representing “slightly bad”</td>
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<tr>
<td>6</td>
<td>representing “very bad”</td>
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<tr>
<td>7</td>
<td>representing “extremely bad”</td>
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</tr>
</tbody>
</table>

CHOOSE ONE NUMBER FOR EACH WORD PAIR AND DON’T SKIP ANY

MY MOTHER

Good
1
2
3
4
5
6
7
Bad

Cruel
1
2
3
4
5
6
7
Kind

Fair
1
2
3
4
5
6
7
Unfair

Honest
1
2
3
Dishonest

Weak

Strong

Cowardly

Brave

Humorous

Serious

Violent

Gentle

Passive
5
6
7
Active

Tense
1
2
3
4
5
6
7
Relaxed

Calm
1
2
3
4
5
6
7
Excitable

Definite
1
2
3
4
5
6
7
Uncertain

PLEASE CHOOSE ONE RESPONSE FOR EACH QUESTION.

1. Which parent do you feel you are most like at the present?
   Neither parent
   Father
   Mother

2. Which parent did you feel closer to as a child?
   Neither parent
   Father
   Mother

FEMALE SEXUAL SUBJECTIVITY INVENTORY

PLEASE RATE EACH OF THESE STATEMENTS ACCORDING TO HOW MUCH EACH ONE APPLIES TO HOW YOU SEE YOURSELF.
1. It bothers me that I’m not better looking
2. It is okay for me to meet my own sexual needs through self-masturbation
3. If a partner were to ignore my sexual needs and desires, I’d feel hurt
4. I would not hesitate to ask for what I want sexually from a romantic partner
5. I spend time thinking and reflecting about my sexual experiences
6. I worry that I am not sexually desirable to others
7. I believe self-masturbating can be an exciting experience
8. It would bother me if a sexual partner neglected my sexual needs and desires
9. I am able to ask a partner to provide the sexual stimulation I need
10. I rarely think about the sexual aspects of my life
11. Physically, I am an attractive person
12. I believe self-masturbation is wrong
13. I would expect a sexual partner to be responsive to my sexual needs and feelings
14. If I were to have sex with someone, I’d show my partner what I want
15. I think about my sexuality
16. I am confident that a romantic partner would find me sexually desirable
17. I think it is important for a sexual partner to consider my sexual pleasure
18. I don’t think about my sexuality very much
19. I am confident that others will find me sexually desirable
20. My sexual behavior and experiences are not something I spend time thinking about

Not at all true for me
A little bit true for me
Moderately true of me
Quite a bit true of me
Very true of me

BODY IMAGE SELF-CONSCIOUSNESS SCALE

PLEASE INDICATE HOW OFTEN YOU AGREE WITH EACH OF STATEMENT OR HOW OFTEN YOU THINK IT WOULD BE TRUE FOR YOU. THE TERM PARTNER REFERS TO SOMEONE WITH WHOM YOU ARE (OR WOULD BE) ROMANTICALLY OR SEXUALLY INTIMATE.

1. I would feel very nervous if a partner were to explore my body before or after having sex.
2. The idea of having sex without any covers over my body causes me anxiety.
3. While having sex I am (would be) concerned that my hips and thighs would flatten out and appear larger than they actually are.
4. During sexual activity, I am (would be) concerned about how my body looks to my partner.
5. The worst part of having sex is being nude in front of another person.
6. If a partner were to put a hand on my buttocks I would think, “My partner can feel my fat.”
7. During sexual activity it is (would be) difficult not to think about how unattractive my body is.
8. During sex, I (would) prefer to be on the bottom so that my stomach appears flat.
9. I (would) feel very uncomfortable walking around the bedroom, in front of my partner, completely nude.
10. The first time I have sex with a new partner, I (would) worry that my partner will get turned off by seeing my body without clothes.
11. If a partner were to put an arm around my waist, I would think, “my partner can tell how fat I am.”
12. I (could) only feel comfortable enough to have sex if it were dark so that my partner could not clearly see my body.
13. I (would) prefer having sex with my partner on top so that my partner is less likely to see my body.
14. I (would) have a difficult time taking a shower or bath with a partner.
15. I (would) feel anxious about receiving a full-body massage from a partner.

Never
Rarely
Sometimes
Often
Usually
Always

FEMALE GENITAL SELF-IMAGE SCALE


1. I feel positively about my genitals.
2. I am satisfied with the appearance of my genitals.
3. I would feel comfortable letting a sexual partner look at my genitals.
4. I think my genitals smell fine.
5. I think my genitals work the way they are supposed to work.
6. I feel comfortable letting a healthcare provider examine my genitals.
7. I am not embarrassed about my genitals.

Strongly disagree
Disagree
Agree
Strongly agree

SEXUAL DESIRE INVENTORY

THIS QUESTIONNAIRE ASKS ABOUT YOUR LEVEL OF SEXUAL DESIRE. BY DESIRE, WE MEAN INTEREST IN OR WISH FOR SEXUAL ACTIVITY. FOR EACH ITEM, PLEASE CHOOSE THE NUMBER THAT BEST SHOWS YOUR THOUGHTS AND FEELINGS.

1. During this last month, how often would you have liked to engage in sexual activity with a partner (for example, touching each other’s genitals, giving or receiving oral stimulation, intercourse, etc.)?
2. During this last month, how often have you had sexual thoughts involving a partner?
3. During this last month, how often would you have liked to behave sexually by yourself (for example, masturbating, touching you genitals, etc.)?
4. When you have sexual thoughts how strong is your desire to engage in sexual behavior with a partner?
5. When you first see an attractive person, how strong is your sexual desire?
6. When you spend time with an attractive person (for example, at work or school), how strong is your sexual desire?
7. When you are in romantic situations (such as a candle-lit dinner, a walk on the beach, etc.) how strong is your sexual desire?
8. Compared to other people of your age and sex, how would you rate your desire to behave sexually with a partner?
9. How strong is your desire to engage in sexual behavior by yourself?
10. Compared to other people your age and sex, how would you rate your desire to behave sexually by yourself?

No desire
0
1
2
3
4
5
6
7
8
Strong desire

11. How important is it for you to fulfill your sexual desire though activity with a partner?
12. How important is it for you to fulfill your desires to behave sexually by yourself?

Not important
0
1
2
3
4
5
6
7
8
Extremely important

13. How long could you go comfortably without having sexual activity of some kind?
Forever
A year or two
Several months
A month
A few weeks
A week
A few days
One day
Less than one day

HURLBERT INDEX OF SEXUAL DESIRE

THE FOLLOWING ITEMS WILL ASK YOU TO RATE STATEMENTS ABOUT YOUR SEXUAL THOUGHTS AND FEELINGS. PLEASE SELECT THE CHOICE THAT BEST FITS YOUR EXPERIENCE OF SEXUAL DESIRE.

Note: If you are not currently in a romantic or sexual relationship with someone, answer these questions with respect to a former partner or a relationship that you would like to have with someone.

1. Just thinking about having sex with my partner excites me.
2. I try to avoid situations that will encourage my partner to want sex.
3. I daydream about sex.
4. It is difficult for me to get in a sexual mood.
5. I desire more sex than my partner does.
6. It is hard for me to fantasize about sexual things.
7. I look forward to having sex with my partner.
8. I have a huge appetite for sex.
9. I enjoy using sexual fantasy during sex with my partner.
10. It is easy for me to get in the mood for sex.
11. My desire for sex should be stronger.
12. I enjoy thinking about sex.
13. I desire sex.
14. It is easy for me to go weeks without having sex with my partner.
15. My motivation to engage in sex with my partner is low.
16. I feel I want sex less than most people.
17. It is easy for me to create sexual fantasies in my mind.
18. I have a strong sex drive.
19. I enjoy thinking about having sex with my partner.
20. My desire for sex with my partner is strong.
21. I feel that sex is not an important aspect of the relationship I share with my partner.
22. I think my energy level for sex with my partner is too low.
23. It is hard for me to get in the mood for sex.
24. I lack the desire necessary to pursue sex with my partner.
25. I try to avoid having sex with my partner.

1 All of the time
2 Most of the time
3 Some of the time
4 Never
INTIMATE RELATIONS INVENTORY OF SEXUALITY

USING THE KEY BELOW, PLEASE RATE TO WHAT EXTENT EACH STATEMENT BEST DESCRIBES YOU.

Always=100% of the time
Often=more than 50% of the time
Sometimes=less than 50% of the time
Rarely=less than 5-10% of the time
Never=0% of the time

1. I enjoy changing sexual partners rather quickly.
2. I change partners rather quickly when my sexual interest fades.
3. I can’t feel sexual desire for the person I love.
4. I am troubled by my inability to control my sexual thoughts.
5. I have to struggle to control my sexual thoughts.
6. My daydreams about sex interfere with my day-to-day.
7. I am preoccupied with sexual thoughts that would get me into serious trouble.
8. I have sex to keep my partner interested.
9. I need sex to feel good about myself.
10. Partners I’ve been involved with tell me that I am obsessed with sex.
11. I pursue sex at all costs.
12. I regret what I end up doing for sex.
13. I feel out of control when it comes to sex.
14. Offering sex helps me to get what I want.
15. I use sex to escape bad feelings.
16. Keeping more than one lover protects me from getting hurt.
APPENDIX III

Do you feel like you have low levels of sexual desire?

Do you feel like you have high levels of sexual desire?

JOIN A STUDY ON FEMALE SEXUAL DESIRE!

We are conducting a study at City University of New York to learn more about women’s experiences of their sexual desire.

You may be eligible to participate if you are:

* Female
* Between the ages of 18 and 35
* Heterosexual
* Not pregnant or breastfeeding
* Not menopausal

Study participation involves filling out a confidential on-line survey.

Willing participants may participate in additional interview

ALL INFORMATION WILL BE CONFIDENTIAL

CHANCE OF WINNING $50 Amazon.com & OTHER COMPENSATION FOR ADDITIONAL INTERVIEW

For more information, please click on the link below.

YOUR PARTICIPATION WILL ENHANCE OUR UNDERSTANDING OF WOMEN’S SEXUAL EXPERIENCES!
APPENDIX IV

ENTER THE RAFFLE TO WIN

$50-AMAZON.COM GIFT CERTIFICATE

1. There will be 20 raffle drawings during the course of the study

2. One drawing will occur for every 30 participants who participate in the study

3. Participants will have 1 in 30 chance of winning the raffle

4. If you choose to stop filling out the survey or skip any questions, you will still be able to participate in the raffle

By clicking YES, you are giving permission to enroll you in the raffle.

1. YES

2. NO

Please provide your name and email below so that the gift certificate can be sent to you if you win the raffle. You will not be included in the raffle without this information. (This info will be used only for this raffle.) This information will not be used for any other purposes than to contact you if you win this raffle.

Name:__________________________________________________________

Email:________________________________________________________

ALL INFORMATION WILL BE CONFIDENTIAL
APPENDIX V

FURTHER PARTICIPATION

Would you like to participate in PHASE 2 of the study?

If you choose to participate and you are selected...

♦ You will be asked to talk about specific experiences of sexual desire and how it feels in your body

♦ You will be asked to describe yourself, your parents and your significant other (if applicable)

♦ The interview will last 1-1 ½ hours.

♦ The interviews will be audio-recorded but your name or any other info that can identify you will not be on the recordings

♦ You will receive $30 for your participation in PHASE 2 of the study.

ALL INFORMATION WILL BE CONFIDENTIAL

***Whether or not you participate in PHASE 2 will not affect your chances of winning the raffle for the $50-Amazon.com gift certificate***

By clicking “YES,” you are giving permission to the Principal Investigator of the study to contact you to set up an appointment for PHASE 2.

YOU MUST BE ABLE TO ATTEND AN INPERSON SESSION IN MANHATTAN, NY.

☐ YES

☐ NO

Please provide your name, telephone number(s), and email so that we can contact you to set up an appointment for PHASE 2. This information will be used only for the purpose of contacting you for PHASE 2 of the study. Your contact information will not be used for any other purposes.

Name: __________________________________________________________

______________________________________________________________

Telephone (#1) ( ) - OK to leave a message Yes

No
APPENDIX VI

Intro:
I'm going to ask you to tell me about some experiences of your sexual desire. I'm interested in how women experience sexual desire and how it feels in their bodies. Feel free to stop me at any time if you have questions or if you feel uncomfortable. These are very personal questions so it's understandable to feel anxious or uncomfortable.

How did you find out about this study? What drew you to choose to participate in this study? Have you participated in a study like this before? What was that like? What was it like for you to answer the questions online? How do you feel answering questions about your sexuality or sexual experiences? Is this a topic you talk about frequently? With whom? With your friends, family, romantic or sexual partners? Why or why not?

Now to get a better sense of your sexual experiences in the past and right now:
Have you engaged in sexual activity? Intercourse? When was the first time you had sex?
Any type of sexual activity? How many partners (sexual intercourse) have you had approximately?
Do you consider yourself to be heterosexual, bisexual, lesbian? Have you had sexual experiences with men, women, both?
Are you currently in a sexual or romantic relationship? Are you sexually active? What kind of relationship(s) is (are) it (they)? Do you have one or multiple partners?
Do you masturbate? How often? How do you feel about it? Do you fantasize, watch pornography, read erotica, look at erotic or pornographic images? Do you do this alone and/or with a partner?

Now to get a better sense of how you experience sexual desire:

DEFINITION OF SEXUAL DESIRE

Sexual desire can mean different things to different women. How do you know when you are experiencing sexual desire? How would you describe it? What is sexual desire about? How does that make you feel? How old were you when you first remember feeling it? How frequently do you think you feel sexual desire? For example, when was the last time you felt it? What do you feel when you feel sexual desire? Happy, guilty, excited, peaceful, anxious, angry, upset, frustrated, uncomfortable, ashamed, exhilarated, etc.

How often do you engage in sexual activity of any kind? Does your desire tend to correspond with to how often you engage in sexual activity?

TRIGGERS OF SEXUAL DESIRE

Some women talk about things that trigger desire for them whereas other women do not. What kinds of things spark sexual desire for you? What is the thing that turns you on the most? What is that about? How do you understand that? What do you make of that?

SPONTANEOUS VS. RESPONSIVE DESIRE

Do you tend to experience desire spontaneously or in response to an arousing situation? What would that be? What do you do when you experience desire?

EXTINGUISHERS OF SEXUAL DESIRE
What extinguishes or turns off your sexual desire? When do you not feel sexual desire? How do you understand that?

EXPRESSING SEXUAL DESIRE

How do you express your sexual desire? If so, how? With or without partner? Do you tend to act on it? By yourself? With a partner? If not, why not?

What makes you feel really good or ecstatic about your sexual desire? What makes you most uncomfortable about feeling sexual desire?

PLEASURE

What is sexual pleasure to you? How does that relate to your sexual desire? Do you tend to experience more pleasure when you feel more desire? Or do you feel more desire when you feel more pleasure? Do you think the two are related for you?

Now to ask you some questions about your body:

How do you feel about your body? What's your favorite aspect of your body? Your least favorite? What do you consider to be your sexual body – what do you consider to be sexual aspects or parts of your body (it does not have to be a body part)? How do you feel about it? How do you know when you’re feeling desire in your body? What does your body do when you are feeling desire? What happens in your body when you feel desire? How does that make your feel? What happens in your body when you don’t feel desire? How does that make you feel? How aware are you of what happens in your body when you are feeling desire?
I'm going to ask you to tell me some stories about experiencing sexual desire and how it felt in your body. Try to give me as much detail as possible as you would when telling any story. Tell me when this was happening, where you were, who you were with, what you were feeling and thinking, and what was happening in your body. I'll ask some questions to follow up.

6 scenarios:

1. Tell me about your earliest memory of sexual desire. Context: How old were you? Who were you with? What was the context/where were you? What triggered it? How do you remember feeling at the time? How did it feel in your body? How did you know it was desire? If with partner, did he know? How did he respond? How did you communicate it? What did you do about it? Why or why not? What enhanced it or What extinguished it? What about his desire?

2. Tell me your most exciting memory of sexual desire. Context: When, where, with whom? What makes this your most exciting memory of sexual desire? What triggered it? How did you feel at the time? What came of it? Were you alone or with someone else? How did your body feel? How did your body respond? If with partner, what did he do? What extinguished it, if anything?

3. Tell me about a time when you felt sexual desire by yourself. Context: Where, when, how, why? What triggered it? What did you do about it? How did you feel about being alone and feeling desire? How did it feel in your body? How was it different from the times when you felt it with a partner(s)? Did you feel good about it? Did you enjoy it? Were you able to satisfy it? Or was it frustrating? Did you masturbate? Fantasize? Watch pornography/read erotica/look at erotic/pornographic images?
4. Tell me about a negative or upsetting or disappointing experience of sexual desire. Context: Where, when, how, why? Why was it upsetting? What did you feel? Were you alone or with partner? How did it feel in your body? What was happening with your bodily response? What did you do about it? How do you understand what happened? What triggered it or brought it on?

5. Tell me about a time when you didn’t feel sexual desire. Context: Where, when, how, why? Why do you think you didn't feel desire? What was it like in your body? What did you do about the absent desire? How do you understand what was happening?

6. Do you fantasize? Do you feel desire when you fantasize? Tell me about a fantasy you’ve had. When do you have this fantasy? What were you feeling and thinking when you had this fantasy? How did your body feel while you were fantasizing?

**Conclusion of the interview:**

I really appreciate your sharing your experiences with me. How was this interview for you? Is there anything else that you feel is important to share with me? Is there anything that made you feel uncomfortable? Were there things you particularly enjoyed talking about? Have you had an opportunity to talk in this way about your sexual desire before? How did your body feel talking about this? Tense, relaxed, aroused, uncomfortable, etc? Do you have any questions for me?
Bibliography


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