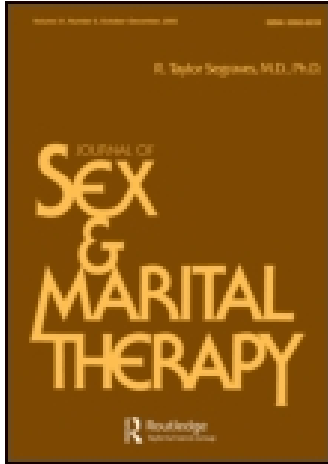


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Using a Different Model for Female Sexual Response to Address Women's Problematic Low Sexual Desire

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An intimacy-based sex response cycle was used in the assessment of 47 women referred with low sexual desire. All could relate to the model and multiple breaks in the cycles were identified. Emotional intimacy to motivate the women to find sexual stimuli to elicit arousal was insufficient in 50%. Sexual stimuli and context were minimal in 53%. Psychological factors diminishing arousability were identified in 85%, depression contributing in 43%. Androgen deficiency (the cause suggested by referring doctors) contributed in 25%. Identifying missing components of their "normal" but currently problematic sex response cycles was itself therapeutic.

INTRODUCTION

When a relatively large percentage of a community sample perceives itself to be abnormal, the validity of the standard of normality might well be questioned. Some 30% to 50% of women (Michael, Gagnon, Laumann, & Kolata, 1994; Garde & Lunde, 1980; Frank, Anderson, & Rubinstein, 1978) report low sexual desire and we might ask to whom they are comparing themselves. Some might identify their male partners (less often their female partners), fictional women they have watched on films or whose stories they have read, or their own experiences early on in a new relationship. This author has seriously questioned the relevance of the traditional human sex response cycle as depicted by Masters and Johnson (1966) and expanded by Helen Singer Kaplan (1979) to a large number of women (perhaps the majority)

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in long-term monogamous relationships (Basson, 2000). A paucity or absence of markers of sexual desire, including apparently spontaneous sexual thoughts and fantasies, and a sexual need to self-stimulate, does not preclude receptivity to sexual stimuli, including those provided by the sexual partner (Cawood & Bancroft, 1996). This receptivity, however, is somewhat vulnerable for three reasons. Firstly, the motivational force to capitalize on the ability to respond to sexual cues, despite lack of innate sexual neediness, is the wish to enhance intimacy. Clearly, the multitude of potential factors that lessen intimacy can reduce this force. Secondly, an emotionally and physically rewarding outcome of a sexual experience is needed to enhance that intimacy. Leiblum (1998) and Tiefer (1991) have stressed the importance of the nongenital components of women's sexual satisfaction. These components stem from intimacy needs and, in turn, nurture intimacy. Thus, lack of tenderness, mutuality, respect, communication, or pleasure from sexual touching, undue focus on the act of intercourse itself, or physical or emotional discomfort from any cause will preclude achievement of the overall goal—enhanced intimacy. Thirdly, being largely receptive, this desire is dependent on the presence of whatever sexual stimuli are necessary for each individual woman. The appeal and effectiveness of the stimulation may well depend more on its context (e.g., the caring, consideration, safety and privacy) than on the details of the physical stimulation itself. This model posits a receptive type of desire stemming from arousal which itself results from the deliberate choice to find and be receptive to sexual stimuli. See Figure 1.

When a woman senses a potential opportunity to be sexual with her partner, although she may not “need” to experience arousal and resolution for her own sexual well-being, she is nevertheless motivated to deliberately

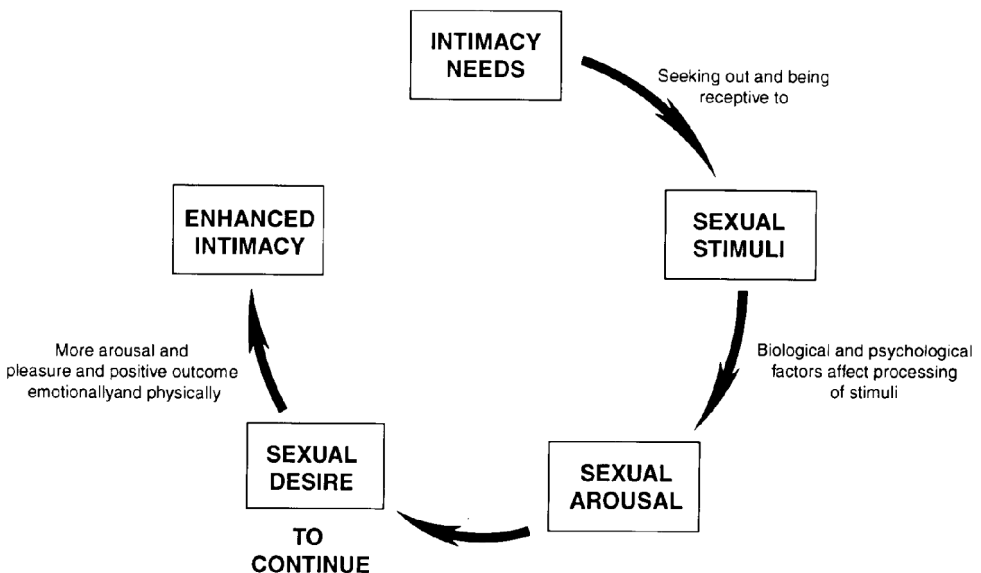


FIGURE 1. Alternative model of Female Sex Response Cycle.

do whatever is necessary to facilitate a sexual interaction as she expects potential benefits that, though not strictly sexual, are very important. The increased emotional closeness, bonding, commitment, tolerance of each other's imperfections, and expectation of increased well-being of the partner all serve as highly valid motivational factors that activate the cycle. She moves from a state of sexual neutrality, to open mindedness or willingness to be receptive to stimuli, to a degree of sexual pleasure and arousal. A sense of sexual desire to continue the experience then follows. Subsequently she may experience higher arousal and possibly orgasmic release. If the emotional aspect of the interaction, as well as the physical aspect, is positive, intimacy is enhanced and the cycle strengthened. In contrast, the traditional "human sex response cycle" of Masters and Johnson and Kaplan, depicts sexual desire as a spontaneous force that itself triggers sexual arousal. See Figure 2.

Note, there is no mention of a driving force of intimacy nor of the necessity of sexual stimuli. Sometimes, of course, this traditional cycle is relevant for the woman in a long-term relationship (as it may well have been at the beginning of the relationship)—especially after physical or emotional distancing or perhaps just after ovulation in the premenopausal woman. In such cases, arousal is facilitated by a sense of sexual hunger that appears to her to be devoid of external triggering. However, the alternative cycle may be a far more common experience for her.

METHODS

In order to assess its clinical usefulness, this alternative model was presented to a series of 47 women with a referral diagnosis of low sexual desire who were seen consecutively at the Vancouver Hospital & Health Sciences Centre

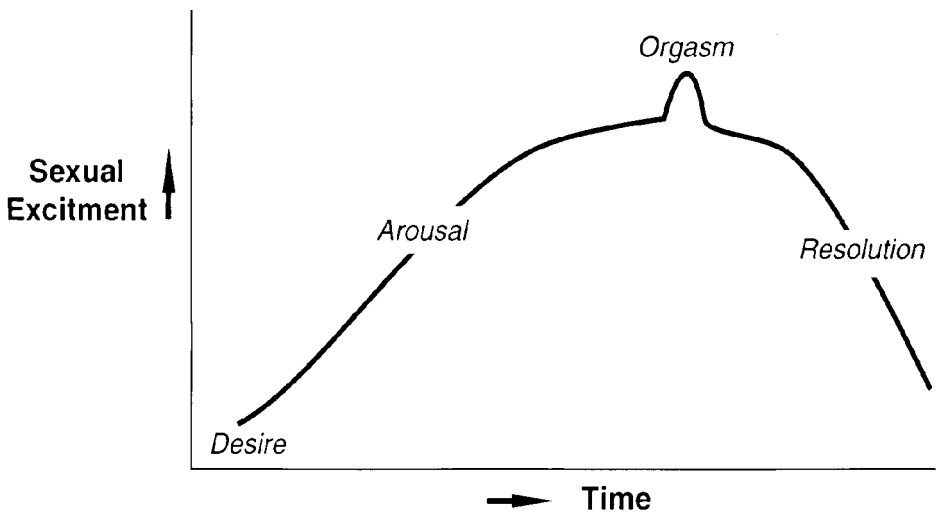


FIGURE 2. Traditional Human Sex Response Cycle—No inclusion of "Intimacy" or "Stimuli."

for Sexuality, Gender Identity and Reproductive Health between October 1998 and May 1999. Women and their partners were assessed usually over two extended visits by the author, together with a resident from the Department of Obstetrics and Gynecology in 29 cases and with a cotherapist colleague in 9 cases. Women with ongoing dyspareunia or other sexual pain were excluded. Factors (usually multiple) causing interruption in the cycle depicted in the model were identified, including those related to presence or absence of stimuli, psychological and biological factors affecting processing of the stimuli, factors pertaining to emotional intimacy in the nonsexual aspect of the relationship, and factors relating to the outcome of the sexual experience.

Some of the factors were likely to be amenable to therapeutic intervention (e.g., depression, androgen deficiency, partner sexual dysfunction). Others were somewhat less readily amenable to intervention (e.g., insufficient emotional intimacy, long-standing psychological issues). The women were therefore asked at follow-up 1 to 2 months later the following questions:

1. Could you relate to the model of women's sex response that we discussed?
2. Did it increase your understanding of your situation to know that a number of different factors were likely involved?
3. Whether or not you two as a couple can actually make the needed changes, is the situation now more tolerable for you?
4. To the partner: whether or not you two can actually make the changes that are needed, is the situation now more tolerable for you?

The women whose data contribute to this manuscript did not participate in any formal study. Collecting their data in no way altered the assessment and management of their cases. The author has been developing this model over a number of years and is simply reporting the contributing factors clarified by its use, along with women's assessment of the usefulness of the model. Thus, no ethical approval was sought.

TABLE 1. Demographic Details of 47 Women with Low Sexual Desire

N =	47
Age range:	26–63
Mean age:	46.1
Heterosexual:	47
Married or cohabitating:	
< 5 years:	6
5 to 10 years:	8
10 to 20 years:	19
over 20 years:	14
Postmenopausal:	17
Perimenopausal:	19
Premenopausal:	11

TABLE 2. Factors Interrupting the Cycle of Receptive Desire in 27 Women

Insufficient Emotional Intimacy (to drive cycle): 24 women
 Insufficient emotional intimacy associated with partner depression: 4

Factors to Do with Sexual Stimuli: 25 women
 Required stimuli lacking: 23
 Genital stimulation ineffective due to estrogen deficiency: 5
 Genital stimulation ineffective due to autonomic nerve damage: 2

Psychological Factors Influencing Processing of Stimuli: 40 women
 Non-sexual distractions: 16
 Past history of dyspareunia: 8
 “Dysphoric arousal”: 10
 Lifelong feeling of being “substandard”: 8
 Learned lack of feelings associated with previous losses and traumas: 5

Biological Factors Influencing Processing of Stimuli: 30 women
 Treated depression (in past only): 8
 Treated depression currently: 7
 Depression previously undiagnosed: 6
 Antipsychotic medication: 1
 Hypothyroidism previously undiagnosed: 1
 Androgen deficiency: 12

Unsatisfactory Sexual Outcome—Partner Sexual Dysfunction: 7 women
 Associated with premature ejaculation: 2
 Associated with erectile dysfunction: 5
 Associated with delayed ejaculation: 2

Previous Discounting of Receptive, Intimacy Driven Desire as “Normal: 5

RESULTS

Demographic details of the 47 women are shown in Table 1.

At least two factors interrupted the cycle for all women, as shown in Table 2.

The usefulness of this model in the very short term was assessed at follow-up. The previously outlined questions yielded the results shown in Table 3.

DISCUSSION

Management of low sexual desire is notoriously difficult. Perceiving oneself to be dysfunctional reduces sexual self-image, thereby compounding the problem. Living with and having an understanding of a type of sexual desire

TABLE 3. Follow-up of Couples Presenting with Female Low Sexual Desire

	Yes	No
Response to question 1	47	
Response to question 2	47	
Response to question 3	41	6
Response to question 4	26	21

which, although perhaps not optimal, is “within accepted normal limits” and amenable to nurturing and enhancing, may be less difficult. A sense of hope and of normality can in itself be therapeutic to both partners.

The belief that emotional intimacy is highly relevant to the experience of sexual desire is not new. Accepting it as a legitimate driving force, rather than searching in vain for a means of experiencing spontaneous sexual thoughts and sexual neediness, is perhaps new to some. If it could be so accepted, there would be reason to give priority to its nurturing. Some 50% of the study women considered insufficient emotional intimacy as a relevant factor in their low desire.

Addressing the concept of lack of sexual stimuli, the most common needs expressed were those outside of the bedroom—an appropriate atmosphere, partner’s consideration, respect, and warmth and physical affection such that sexual interaction is a continuation of nonsexual intimacy, rather than a hurdle, a threat or a “task” that distracts and causes sadness and guilt. In the area of sexual activity itself, leisurely, nongenital pleasuring was a common need as was genital but nonintercourse pleasuring.

The majority of postmenopausal and perimenopausal women were using estrogen replacement therapy (ERT). Clearly, lack of vasocongestion of erectile tissue of the vestibular bulb, periurethral area, and clitoris, precludes the genital component of sexual arousal and pleasure on which the cycle is dependent. While conscious awareness of the state of vasocongestion of the vulval structures may be minimal (Laan & Everaerd, 1995), pleasure from physical stimulation of the engorged tissues, along with subjective mental excitement, constitute the woman’s appreciation of arousal. (Basson, 2000). Women who had previously chosen not to use systemic ERT were more accepting of the use of local vaginal ERT in the form of an estrogen ring, placed high in the vagina and changed every 3 months, or the use of a very small amount of estrogen cream placed in the vagina once or twice a week. Future possible options may well include vasoactive drugs that enhance nitric oxide activity or vasointestinal polypeptide activity (Levin, 1998).

Regarding the psychological factors influencing the processing of stimuli, remembered dyspareunia and the expectation of pain was still a powerful distraction for 8 women (even though intercourse was now usually entirely painless). This focus likely affected them not only at the time of possible sexual activity, but throughout the day, thereby preventing sexual cues from being registered.

Mental discomfort with sexual arousal (dysphoric arousal) was reported by 10 women, most with a history of childhood sexual abuse or of relationships that were now deemed undesirable or, in fact, abusive. Five other women reported expressing few emotions as they went about their mostly productive and successful lives. They gave histories of coping (well) with adversity as children and teenagers, largely by suppressing feelings. They found it particularly difficult to share with us any emotions surrounding the life experiences they recounted. Striving always to please and to be as close

to perfection as possible (again, often stemming from childhood circumstances), caused another 8 women to feel sexually substandard. These women had an admitted tendency to self-monitor their sexual experiences and their ability to sexually please their partners.

When considering biological factors affecting the processing of stimuli, it is possible, or even likely, that other clinical samples of women with low sexual desire might include more women with a diagnosis of depression. Because our clinic is largely a tertiary or quaternary referral center, depression is likely to have been diagnosed and managed prior to referral. In fact, of the 47 referring doctors, the majority (31) questioned the possibility of androgen deficiency. Androgen deficiency, diagnosed in 12 women, was defined as follows:

1. Coincident with menopause there was loss of
 - a. Sexual arousal from mental, visual, auditory stimuli
 - b. Sexual arousal from physical nongenital stimulation
 - c. Sexual arousal from genital stimulation
 - d. Former ability to reach orgasm
 - e. Intensity of orgasm
 - f. Sexual thinking, fantasy, and need to self-stimulate
2. Bioactive (or free) testosterone is immeasurable or at the lower level of normal for women (Basson, 1999; Kaplan, 1993). It is accepted that testosterone-receptor sensitivity cannot be measured and levels of testosterone needed for women's sexual response are unknown. Nevertheless, high or high normal levels of testosterone would point against this diagnosis. The diagnosis is primarily clinical (1). Biochemical "support" rather than true confirmation is then sought (2).

Caution is needed in arriving at this diagnosis for a woman who is also depressed, debilitated for any medical reason, or on any medication that could account for the suppression of her desire and sexual response.

The 12 women diagnosed with androgen deficiency syndrome also reported other causes of interruption of the cycle, most commonly a lack of necessary stimuli. It may be that women who notice the most profound sexual changes with lessening of ovarian androgen are those who had a higher number of sexual thoughts and fantasies prior to menopause, along with higher sexual neediness, such that they may not have fully explored their potential receptivity to stimuli. It is suggested that women already used to capitalizing on their responsive desire (having little innate desire), may notice less change with menopause. The use of ERT often coincided with symptoms of androgen deficiency, probably because of an increase in sex hormone binding globulin (SHBG) from exogenous estrogen administration, especially when given orally (Nachtigall, Raju, Banerjee, Wan, & Levitz, 2000).

Of the study group, 5 women described ongoing healthy receptive desire. They or their partners had discounted this theory of intimacy-driven

ability to respond to sexual cues and stimulation. At least in the short term, it appeared they were able to accept their experience as being “within a normal range” and to be encouraged that for them there were no breaks in the cycle.

At least in the short term, the proposed model appears to increase women’s understanding of their difficulties and provides hope that changes in a number of areas can make this cycle more efficient. Relief that they were considered “normal” was expressed by virtually all women, many adding that they were now prepared for the first time to tackle some challenging areas, including those of emotional intimacy and past psychological issues. The 6 women who felt that their new understanding failed to make their situation more tolerable persisted in a search for spontaneous desire and remained convinced that was what they “should” experience. While the vast majority of male partners also could accept the model as relevant to some women, including their own partners, only 26 out of the 47 men felt that even if no changes were made, their situation was now rendered more tolerable by the improved insight. The remaining men (21) felt that simply an improved understanding of their situation (without any changes being made), did not ease their frustration, sadness, or disappointment. For each of these 21 men and their partners, insufficient emotional intimacy was one of the factors contributing to the interruption of the cycle. The 6 women who remained convinced they “should” be able to have ongoing spontaneous sexual hunger were partners to 6 of these 21 men.

CONCLUSION

Insufficient emotional intimacy to drive the sex response cycle was a factor in 50% of the 47 couples assessed, commonly associated with lack of awareness of the need of useful stimuli or little motivation to provide them. Psychological factors negatively influencing the processing of sexual stimuli included dysphoric arousal in 10 women, nonsexual distractions in 16, a past history of dyspareunia in 8, and a past learning “not to feel” in 5. The majority of referring physicians questioned androgen deficiency, which was found to be a contributing factor in 12 peri/postmenopause associated of the 47 women. Despite the tertiary nature of the referral process, depression was diagnosed in 6 women and felt to still be a major factor for 7 additional women on antidepressant medication. An unsatisfactory outcome associated with partner sexual dysfunction was present for 7 women.

Application of this alternative model of female sexual response, perhaps more often accurate for women in long-term relationships, appears to increase women’s understanding of their situation when they report concerns with ongoing low sexual desire. Moving from a feeling of inferiority and dysfunction because spontaneous sexual neediness is rare or absent, they come to accept the need for useful stimuli and the extreme relevance of

their emotional intimacy, given that this is their driving force. Women also report that they can now desist from simply trying to expedite any sexual experience as much as possible, to expanding it to allow their own physical pleasure even if it is not “needed” on a truly sexual basis. Once the mind set is altered, the experience is quite different. Those women whose sexual concerns reflect much larger issues (e.g., a paucity of feelings and emotions as a result of survival techniques learned to endure childhood traumas and losses) can see the need for ongoing psychotherapy (as opposed to any sexual therapy). Rather than finding the variety of contributing factors overwhelming, most couples reported increased hope because there were a number of possible changes they could make, each with a potential for improving their situation to some degree.

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